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2021 State of Healthcare Performance Improvement: COVID Creates a Challenging Environment

KaufmanHall

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Introduction

The COVID-19 pandemic continues to undermine performance improvement efforts at hospitals and health systems across the country. Supply chain disruptions and shortages have driven up prices and forced a return to the costs of carrying larger inventories of needed supplies. Labor shortages and high employee turnover are pushing up base salaries and recruitment costs and have led many organizations to implement retention bonus programs. Volumes in many service lines remain below pre-pandemic levels, putting downward pressure on revenues; clinical staff shortages make recovery even more difficult.

Signs of longer-term change are evident in the responses to our survey. A strong majority of respondents predict that the pandemic will result in permanent changes to the workforce, with 66% saying that the ratio of administrative staff working remotely will continue at levels reached during the pandemic, and another 11% predicting that the percentage of remote workers will continue to increase. Almost half of respondents say the pandemic has driven their organization to adopt new processes, positions, or departments that will be continued going forward.

Hospitals and health systems have had little reprieve from the pandemic as new surges in infections have continued to stretch their resources. Still, the changes that have occurred to date—workforce

“We are losing more money than we can count through premium labor charges.”

— CFO, large urban health system

realignments, a rapid push into telehealth and digital care delivery, shifts in utilizations and volumes—point to the need for transformative change that touches most facets of operations. Hospital and health system leaders will need to address questions of access to care, supply chain management, patient throughput, workforce deployment, service line development, and physical footprint.

Few health systems will have the resources to take on these challenges alone. A fundamental question will be what they need to control and where they can seek out strategic partnerships—with independent physician groups, payers, retailers, third-party vendors, community organizations, and others—that enable them to focus on their core business strategy while expanding the services and optimizing the efficiency, accessibility, and affordability of care they provide to their communities.

Survey Highlights



100% of survey respondents face issues with clinical staff, including burnout, difficulty filling vacancies, wage inflation, and high turnover rates.



99% have experienced challenges in supply procurement, including shortages of key items and significant price increases.



92% are having difficulties attracting and retaining support staff, and almost 90% have increased base salaries.



75% have experienced adverse revenue cycle impacts during the pandemic, including a higher percentage of Medicaid patients and increased rates of denial.



54% identify a “pain point” at an investment (or subsidy) per physician of \$250,000 or less. The average investment per physician at the end of Q2 2021 was \$232,583.



23% say that the ratio of administrative staff working remotely is likely to return to pre-pandemic levels. 66% said the ratio will remain at levels reached during the pandemic, and 11% said the percentage of staff working remotely will continue to increase.



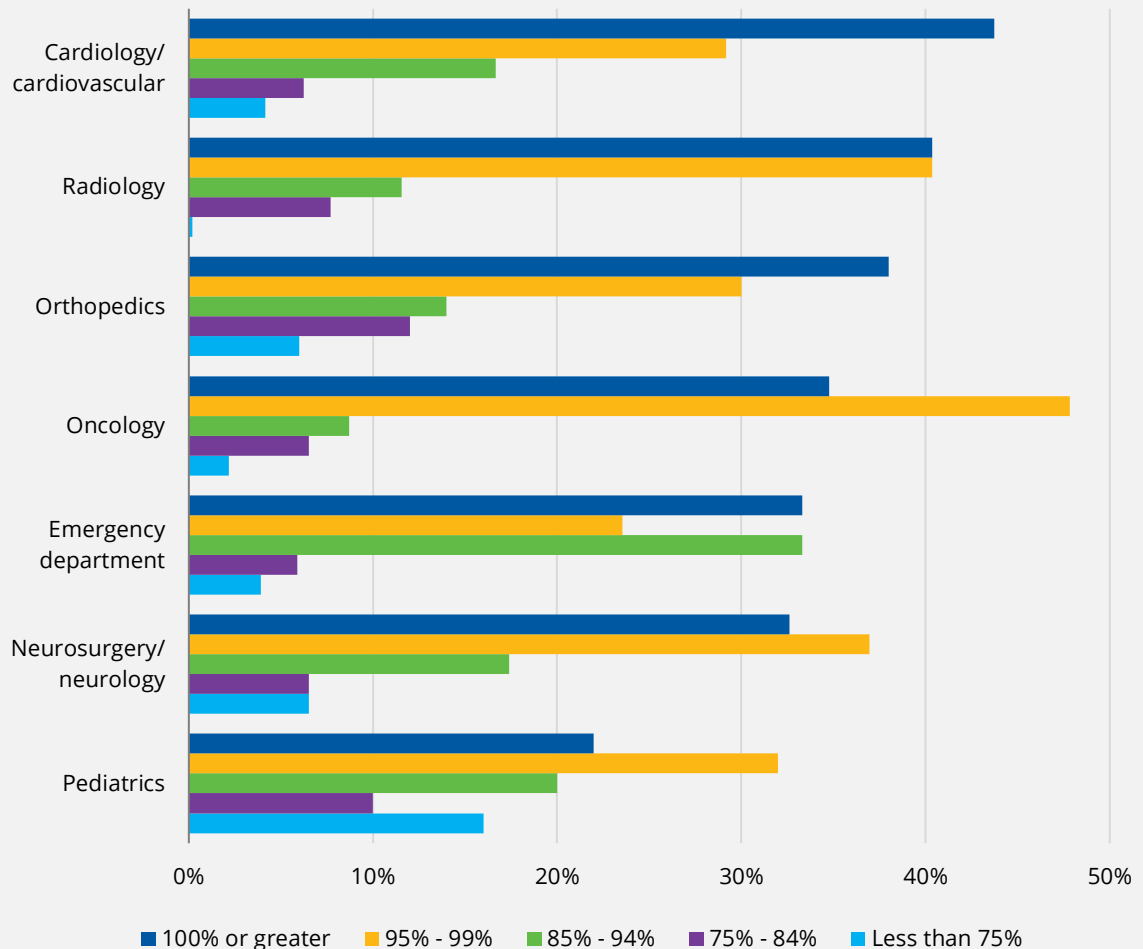
22% have seen pediatric services return to pre-pandemic levels, while 16% say pediatric volumes remain below 75% of pre-pandemic levels. Cardiology and cardiovascular services have seen the most significant rebound, but even here, just 44% of respondents have seen a return to pre-pandemic levels.

Volumes and Revenue

Volumes

Most respondents indicate suppressed volumes across many of their service lines compared with pre-pandemic levels. Pediatrics has been particularly hard hit; only 22% of respondents say pediatric volumes have recovered to pre-pandemic levels, and 16% say that pediatric volumes remain below 75% of pre-pandemic levels. Cardiology and cardiovascular services have had the strongest recovery to full pre-pandemic volumes, but still only 44% of respondents have seen volumes return to pre-pandemic levels. Several respondents interviewed for this report noted volume increases in areas such as cardiology or orthopedics that they attribute to delayed care. In some instances, patients are sicker than they would have been if they had sought care earlier in the pandemic, respondents note.

FIGURE 1: Percent of Volume Recovery in Key Service Areas

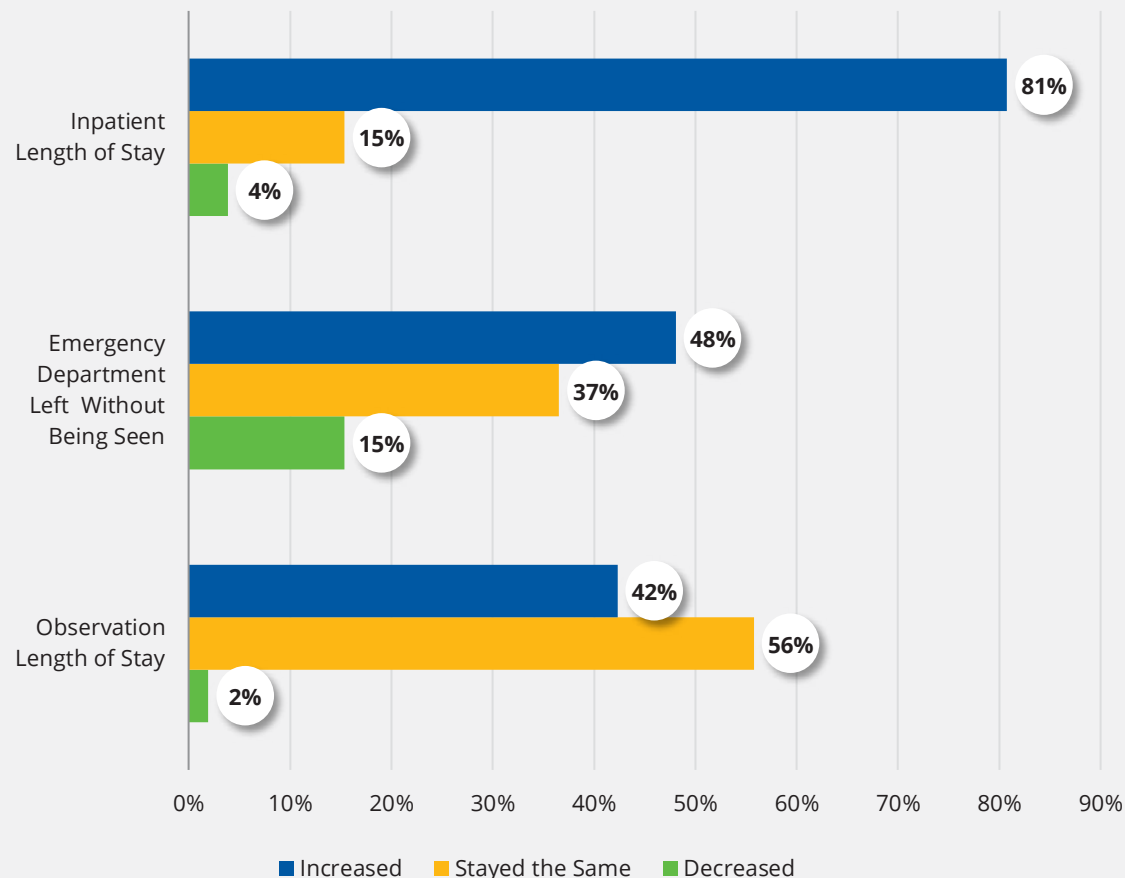


Volumes and Revenue (continued)

Respondents are also seeing increased length of stay (LOS), especially for inpatient cases, which leads to limited inpatient capacity; 81% of respondents report an increase in this area. Almost half of the respondents (48%) also report an increase in the number of patients who leave the emergency department (ED) without being seen.

An interviewee noted that increased inpatient LOS at their hospital in a rural community is attributable almost entirely to acute COVID-19 patients. Patients seeking emergency care or testing for COVID-19 are also straining the capacity of their ED; while the ED typically saw 60 patients per day pre-COVID, it is now seeing 90 patients. ED staff must prioritize care based on acuity, and “prioritization does not make people happy.” Another interviewee’s organization partnered with local payers on a consumer education campaign encouraging use of urgent care facilities instead of the ED for needs such as COVID testing to ease a surge in ED utilization.

FIGURE 2: Year-Over-Year Change in Length of Stay and ED Metrics



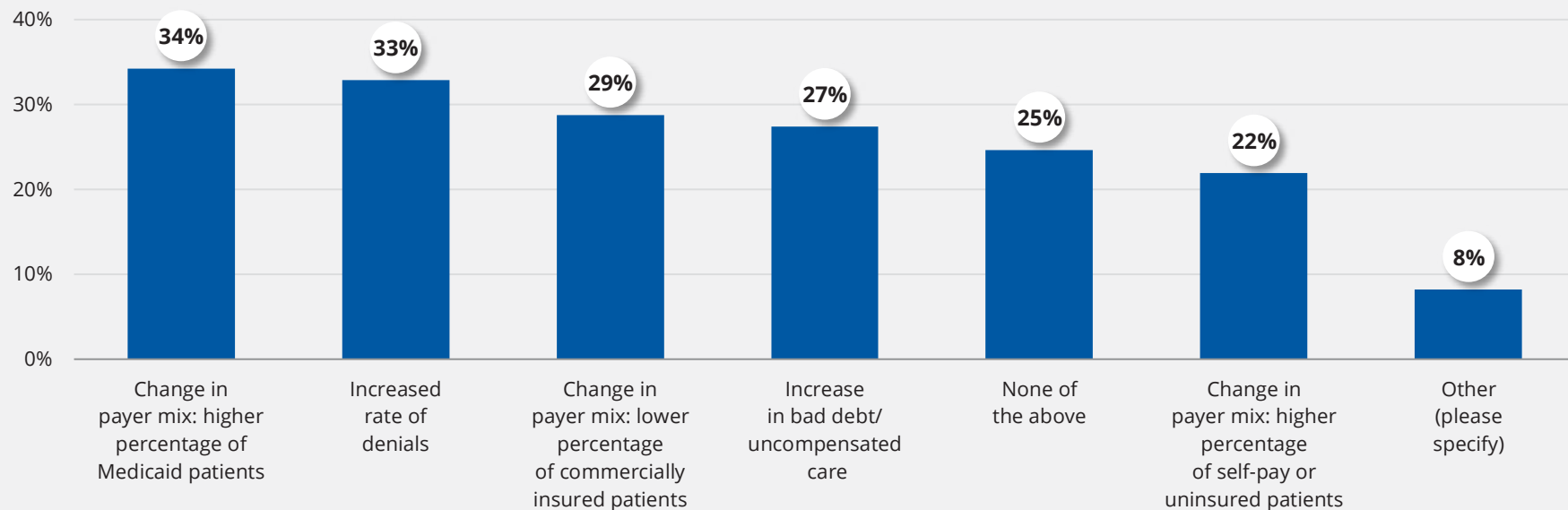
Volumes and Revenue (continued)

Revenue cycle

Only 25% of respondents report that they have not seen pandemic-related impacts to their revenue cycle. The most common impact is an increased percentage of Medicaid patients, followed closely by an increased rate of denials, a lower percentage of commercially insured patients, and an increase in bad debt and uncompensated care.

Based on interviewee observations, denial rate increases appear to be largely a function of local payer markets. One interviewee noted fewer issues with provider-based health plans, which have a better understanding of both the provider and payer sides of the equation. Another interviewee commented that several national health plans have instituted new site of care restrictions, which may be affecting markets in which these health plans have a significant presence.

FIGURE 3: Impacts on Revenue Cycle Over the Past Year



Note: Respondents were asked to choose all that apply.

*Volumes and Revenue (continued)***Action Items: Revenue Cycle**

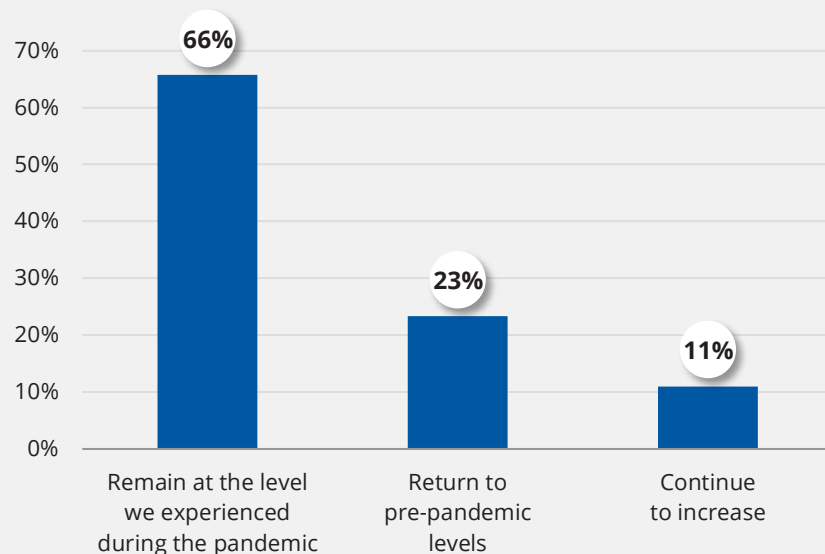
- **Establish an integrated clinical denial management model.**
Building a cross-functional team to link authorizations, providers, case management, clinical documentation improvement, and clinical denial appeals will help your organization quickly identify denial trends, determine root causes, and develop solutions to reduce these denials.
- **Increase focus on real-time monitoring and investigating of initial denials.** Rapid identification and analysis to determine the root causes and changes to payer reasoning for initial denials will allow providers to identify and adjust to changing payer requirements and behavior more proactively.
- **Thoroughly evaluate the tasks and responsibilities you might consider outsourcing.** For example, if considering outsourcing a segment of receivables, analyze the amount of staff effort involved in resolving open accounts by payer, age, and dollar value to determine where the lowest return on investment exists. These segments of “underperforming” accounts should be the top candidates for outsourcing.
- **Increase focus on and scrutiny of revenue cycle vendors.** All employers, including vendors, are facing challenges in attracting and retaining staff. Make sure your facility is receiving the attention and dedication it deserves by evaluating vendor performance, productivity, and effectiveness more regularly. Also validate that the vendor is continuing to prioritize staffing resources to provide committed levels of services and support.

Workforce

Administrative and support staff

More than three-fourths of respondents say that the pandemic has reset expectations for work-from-home arrangements for administrative staff; only 23% say they expect the ratio of administrative staff working from home to return to pre-pandemic levels. Most respondents (66%) say that the number of staff working remotely will stay at the level experienced during the pandemic, while another 11% say they expect that the number will continue to increase.

FIGURE 4: Estimated Change in Ratio of Administrative Staff Working From Home



Location likely plays a significant role. An interviewee at a rural facility noted that their staff were eager to return to the workforce, but also had minimal commute times compared to staff working in more urban locations. Another interviewee said that the work-from-home phenomenon has enabled the health system to expand its pool of candidates in a tight labor market. The human resources department has revised prior policies to enable more remote employees; about 25% of the health system's business intelligence team, for example, now lives outside the system's immediate market.

Job function is another significant factor. Several interviewees commented that the pandemic helped prove that certain technology-enabled or transactional job functions, such as coding, could be effectively performed by a remote workforce. For jobs that require more personal interaction, interviewees are looking at hybrid work models that require at least some days spent in the office.

Although more employees may be working remotely, most interviewees do not see significant opportunities to resize their administrative office footprint (one interviewee, however, said they plan to reduce their administrative space by 50%). One barrier to resizing is long-term leases. Another factor is that, although staff may not want to come into the office every day, they also do not want to give up their dedicated office space. Unless a reduction in office space could generate significant savings, it may be worth the cost of carrying space to keep the workforce happy. One interviewee said that the real savings may lie in not having to buy and repurpose *additional* space for administrative staff.

Workforce (continued)

For most respondents, the move to a more remote workforce and a tight labor market do not seem to have translated into a reconsideration of outsourced services, at least for revenue cycle functions. Only 14% of respondents say the pandemic's impact on the labor market has made them more likely to consider using outsourced revenue cycle services. One interviewee who is considering outsourced services plans to be selective, using

outsourced services to supplement areas, such as technical compliance, where they have difficulty keeping the needed expertise in-house. A primary concern is community response to revenue cycle outsourcing; patients are looking for local engagement and ownership. Another interviewee noted the importance of a well-functioning revenue cycle team to a health system's financial performance, which may make CFOs reluctant to outsource this function. Indeed,

FIGURE 5: Organization More Likely to Use Outsourced Revenue Cycle Services Because of COVID's Impact on the Labor Market

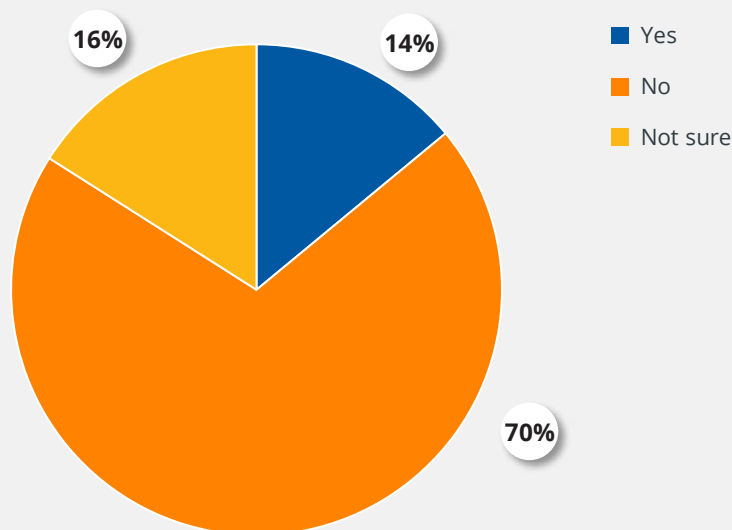
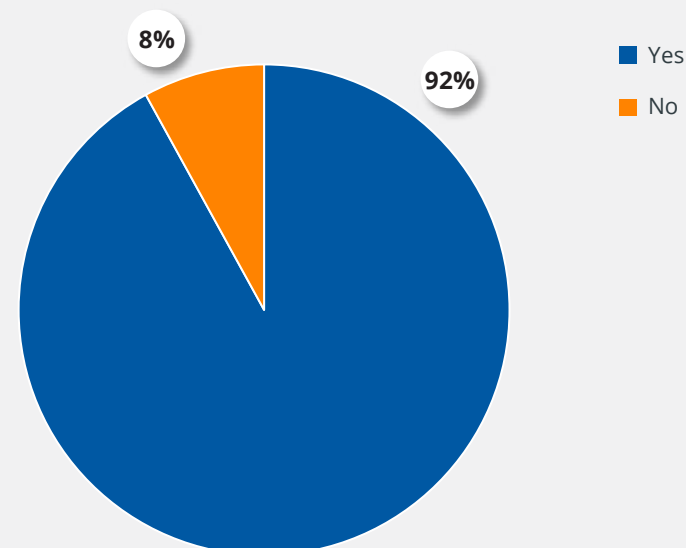


FIGURE 6: Organization Facing Challenges in Attracting and Retaining Support Staff (Dietary, Environmental Services, etc.)



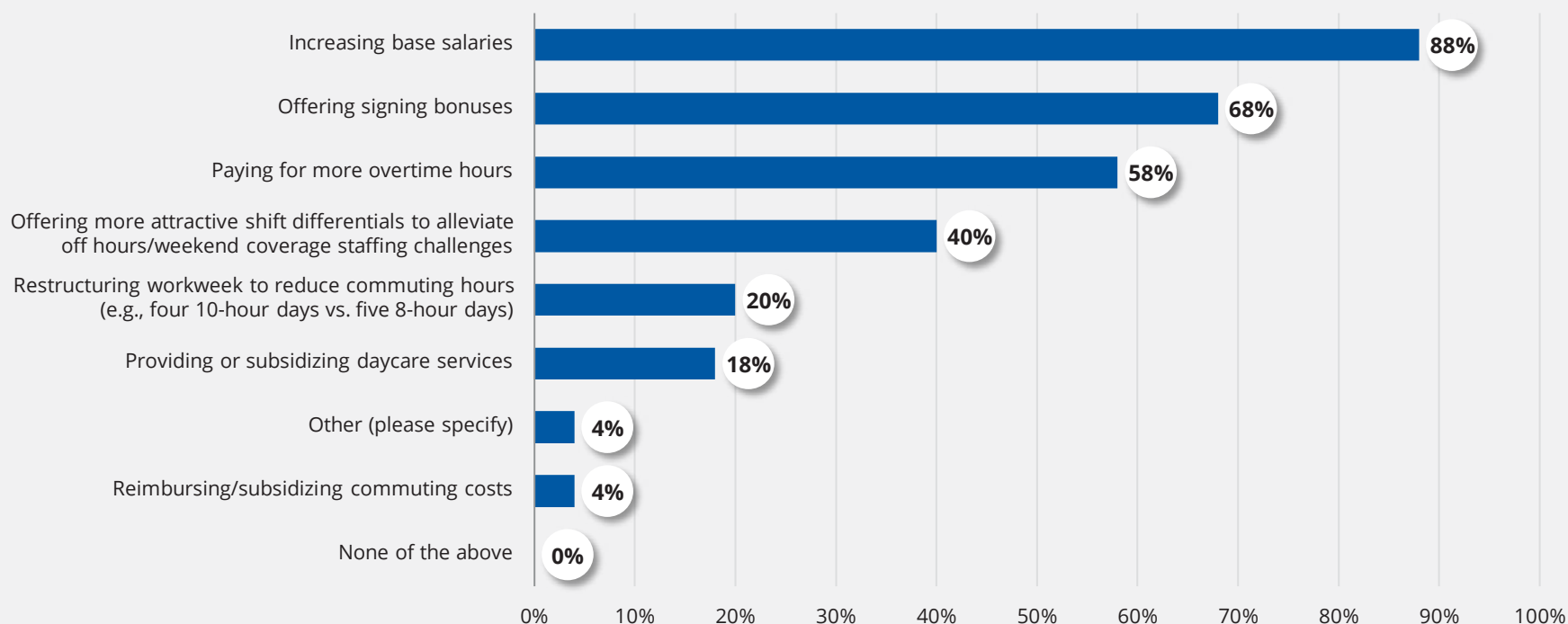
Workforce (continued)

while the survey focused on outsourced revenue cycle functions, interviewees appeared more open to outsourcing in other areas.

Most respondents (92%) face challenges recruiting and retaining support staff in areas such as dietary and environmental services.

Most (88%) have increased base salaries and more than half are offering signing bonuses (68%) or paying for more overtime hours (58%). An interviewee noted that the industry is likely experiencing a long-term, upward adjustment to wages; organizations will have to find solutions such as automation to offset higher labor expenses.

FIGURE 7: Percent of Respondents Pursuing Various Options to Attract and Retain Support Staff



Note: Respondents were asked to choose all that apply.

Workforce (continued)

Action Items: Administrative and Support Staff

- **Re-examine “fixed” departments.** If departments can be moved to more of a “variable” cost structure, staffing can align more closely with the ebbs and flows of workload.
- **Evaluate corporate services’ delivery, productivity, and staffing levels.** An understanding of these metrics will help your organization manage more prevalent work-from-home models and a volatile labor market.
- **Consider outsourcing opportunities.** Potential candidates include security, environmental services, FMLA tracking, and food and nutrition.
- **Benchmark by individual functions.** In human resources, for example, benchmark compensation, recruiting, and benefit functions separately, instead of using a traditional roll-up with high-level metrics.
- **Use technology to automate processes and streamline operations.** For example, automated boiler alerts for engineers could eliminate the need for a third-shift switchboard.

Clinical staff

All the survey respondents face challenges with their clinical staff. Ninety-four percent report difficulties filling vacancies and 92% are seeing staff burnout and early retirements. Two-thirds or more of respondents are dealing with wage inflation (73%) and high turnover (65%) with their clinical staff. One interviewee noted that nurses are resigning to work for agencies, and then are returning to work at a higher agency rate.

Efforts to address these challenges range from monetary incentives—including higher wages, signing and retention bonuses, and increased shift differentials—to greater reliance on traveling or agency staff, to new recruiting efforts or expanded nurse residency programs, to staff wellness and mental health support.

An above-average number of early retirements is a concern because it will take some time to ensure an adequate pipeline of trained clinical staff to fill the vacancies left by early retirees. The shortage could hamper efforts to return to pre-pandemic volume levels; one interviewee noted that their system was already paring down elective surgeries to accommodate staff shortages.

Another interviewee saw signs of hope—and cause for optimism—by looking at the clinical staff pipeline through a diversity, equity, and inclusion lens and addressing barriers that have discouraged some populations from pursuing professional clinical careers. Initiatives

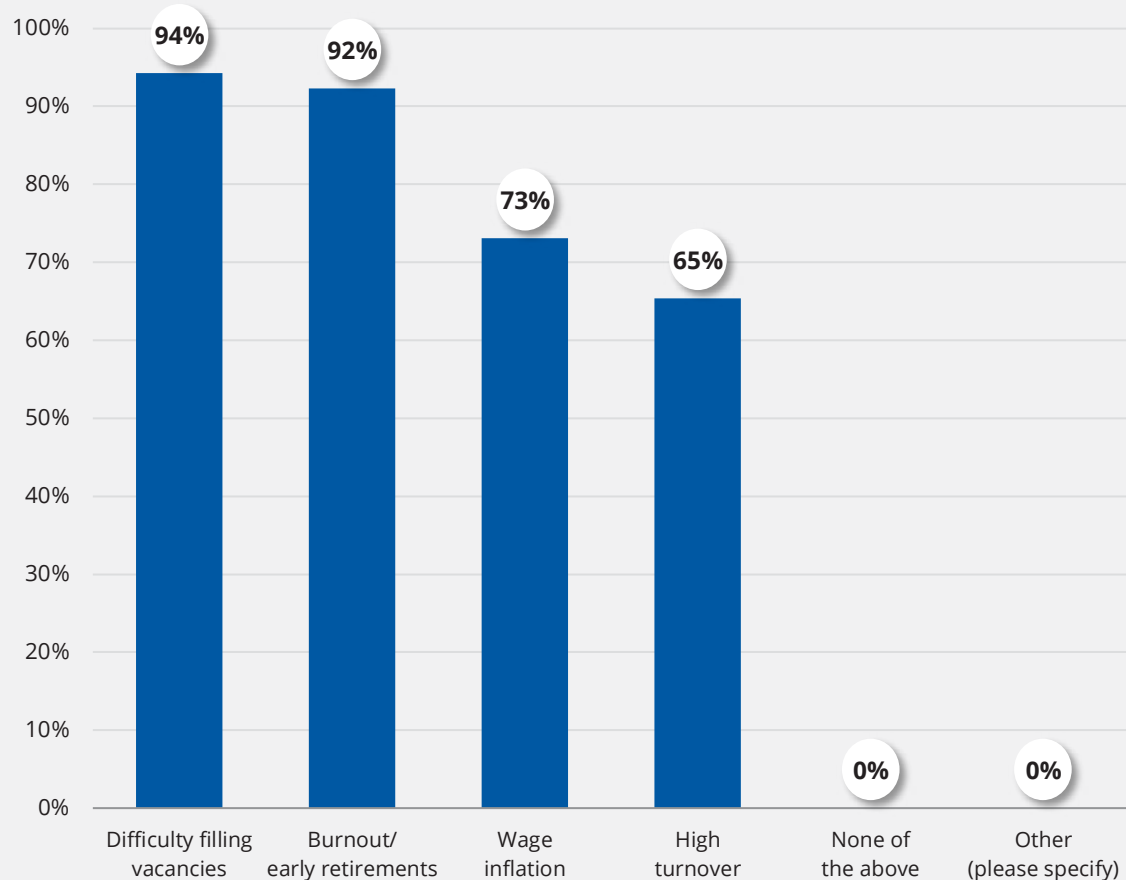
Workforce (continued)

such as early education efforts and revising professional entrance requirements to address potential areas of bias could have a significant positive impact on opening the pipeline for a new and more diverse clinical workforce.

Action Items: Clinical Staff

- **Redesign care models and processes.** Focus on mitigating staff shortages, promoting resources to ensure staff can operate at the top of their license, and eliminating waste and rework to enable more direct care time.
- **Introduce predictive analytic volume modeling and staffing forecasting tools.** These tools help optimize aligning staff to demand to reduce overtime or agency use and to appropriately staff based on care model requirements.

FIGURE 8: Issues Organization Is Facing with Clinical Staff



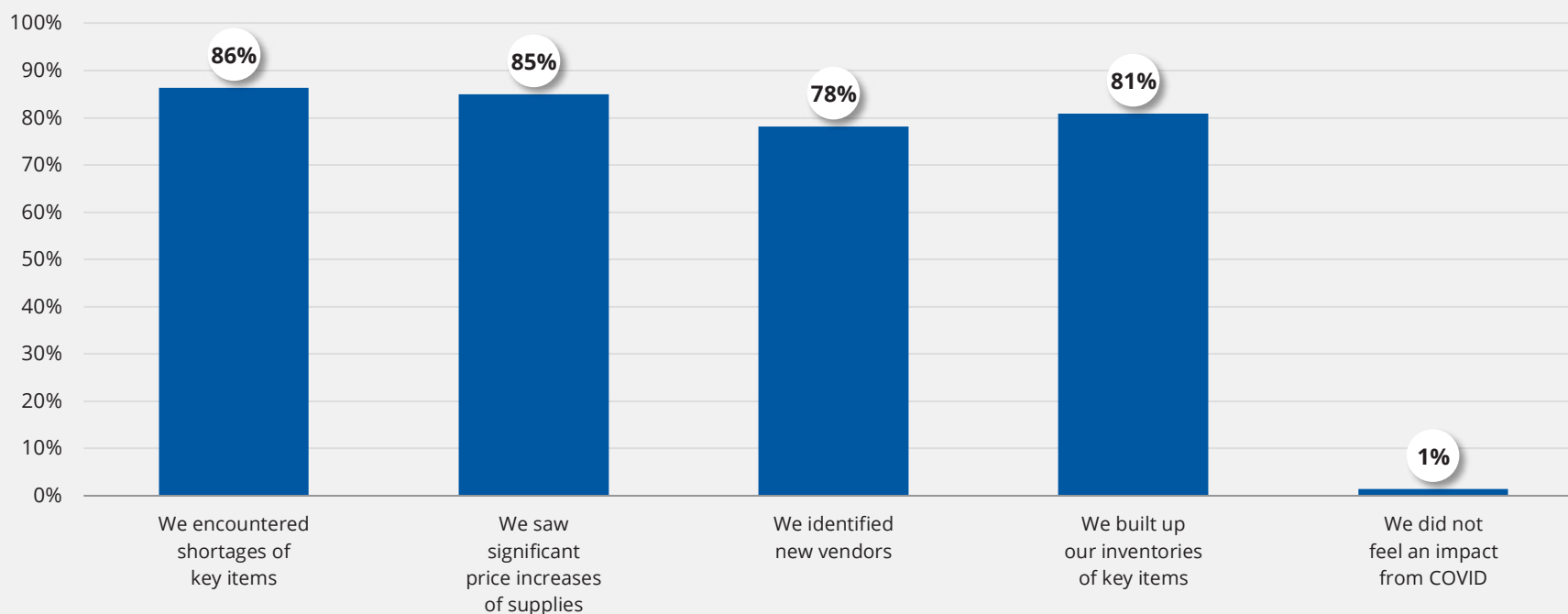
Note: Respondents were asked to choose all that apply.

Supplies

COVID-19 has had a widespread impact on supply procurement; only one respondent reported no impact from the pandemic. Eighty percent or more of respondents experienced supply shortages, saw significant price increases, and built up inventories of key items. Nearly the same percentage (78%) identified new vendors to procure needed supplies.

Most respondents found that their group purchasing organization (GPO) or preferred vendors were at least somewhat effective in helping to obtain vital patient care supplies; 25% said their GPO or preferred vendors were highly effective in providing help. Only 11% reported that their GPO or preferred vendor was not effective.

FIGURE 9: COVID's Impact on Ability to Procure Supplies



Note: Respondents were asked to choose all that apply.

Supplies (continued)

An interviewee who chose “highly effective” described a longstanding partnership with their GPO that had built a robust supply base over time, augmented during the pandemic by a “relentless” in-house purchasing team. The GPO also provides monthly reports that enable tracking on a monthly basis of savings attributable to the GPO.

One interviewee who chose “not effective” described being put on a supply allocation system that was not responsive to the hospital’s changing situation during the pandemic; representing a smaller

facility, this interviewee also felt more attention was given to larger clients. Maintaining an adequate supply of personal protective equipment—including gloves, gowns, and masks—was still an issue. At the same time, changing GPOs requires significant effort, with contractual obligations that are difficult to undo. As a result, very few respondents indicated that their relationship with their GPO or preferred vendors had changed as a result of their performance during the pandemic

FIGURE 10: Effectiveness of GPO/Preferred Vendors in Helping to Obtain Vital Patient Care Supplies

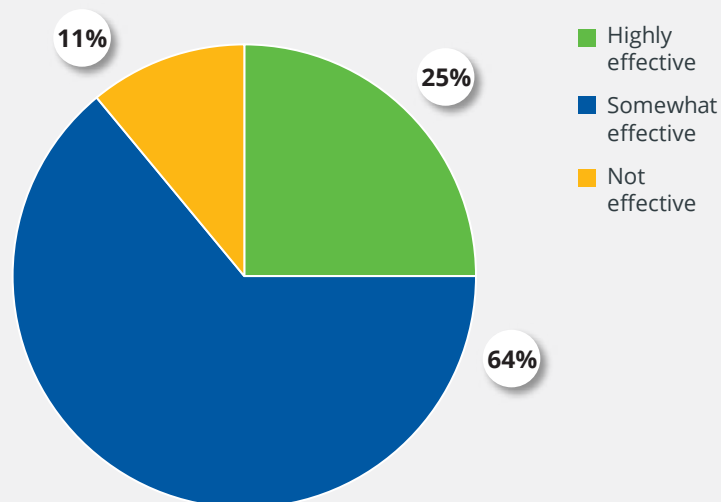
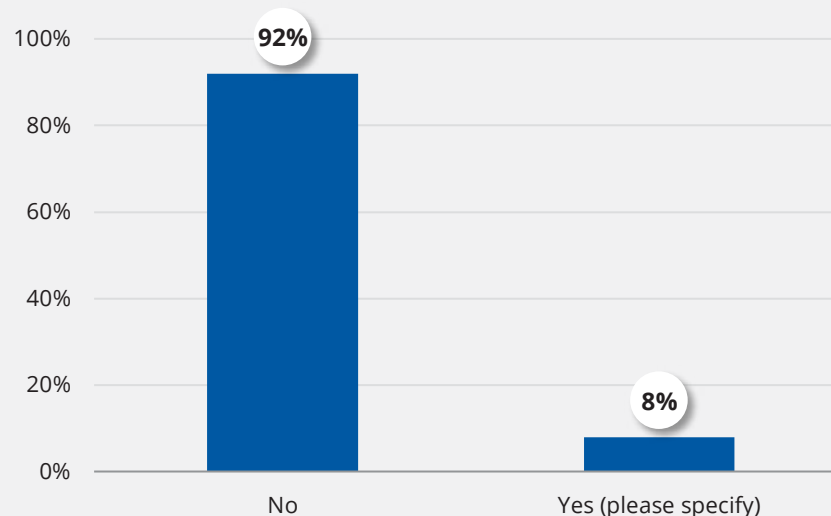


FIGURE 11: Organization Has Changed Relationship With GPO/Preferred Vendor as a Result of Performance During Pandemic



*Supplies (continued)***Action Items: Supplies**

- **Identify historically challenging supplies.** Develop acceptable substitutes, if possible, and diversify and partner with several alternative suppliers to ensure that critical needs are met. Leverage your prime med/surg distributor relationship in addition to your GPO relationships.
- **Focus on inventory management.** While supply chain staff must collaborate with clinical staff to ensure their inventory needs will be met, supply chain staff should have full responsibility for inventory management so clinical staff can focus their energy on delivering patient care. Utilize technology as economically feasible to gain early insight into issues and enhance maintenance, efficiency, and accuracy.
- **Gather supply chain data and build supply demand models per category or supply item.** Share this data with vendors, request the same supply chain visibility from them, and work together to evaluate and verify the accuracy of the data. Be conscious of variations in product demand from historical usage patterns, which may be attributable to short-term disruptions in patient census or the supply chain.
- **Manage vendors.** Thoroughly vet all vendors to understand past performance, initiate vendor business reviews with targeted vendors, and institute bilateral information and data sharing regarding supply availability.

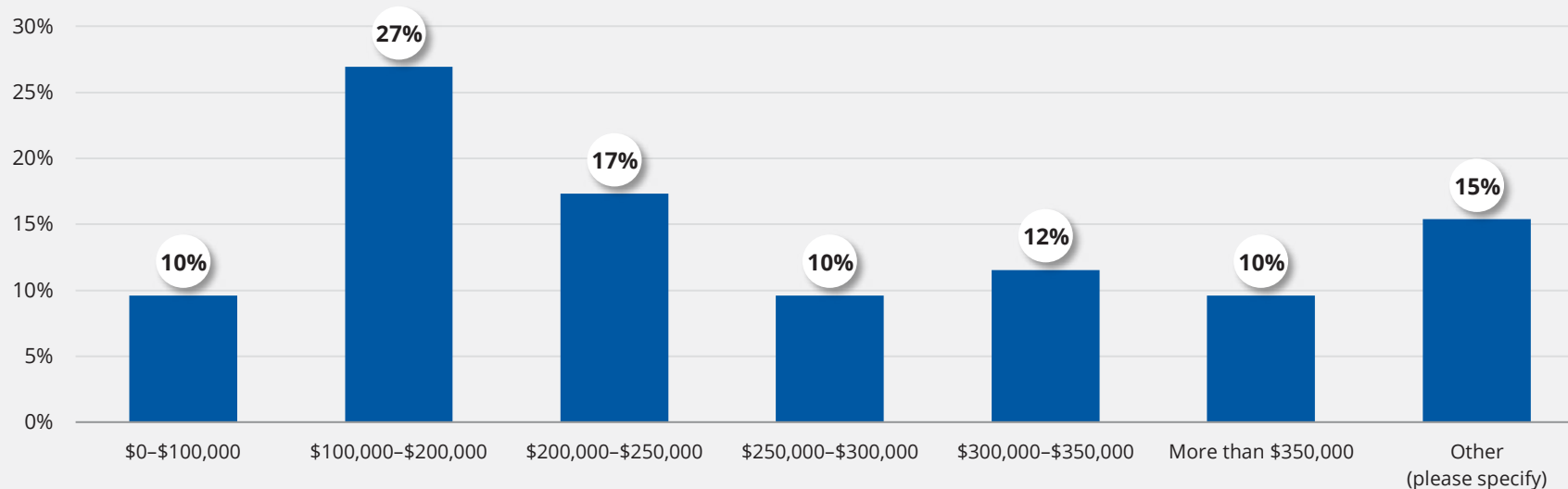
Physician Enterprise

Depressed volumes and increased expenses have put significant pressure on most health systems' physician enterprise throughout the pandemic, increasing the investment (or subsidy) that health systems are paying per physician.

Data from Kaufman Hall's Physician Flash Reports through the second quarter of 2021 indicate that the situation has improved, with increases

in physician productivity. The average investment per physician for Q2 2021 was \$232,583, which was an improvement from the preceding two quarters but still 16.5% above the amount for the last pre-pandemic quarter (Q4 2019). For more than half of survey respondents (54%), a \$232,583 average subsidy/investment per physician would be approaching or above their "pain point"—the point at which they would feel the need to take material action to reduce the amount.

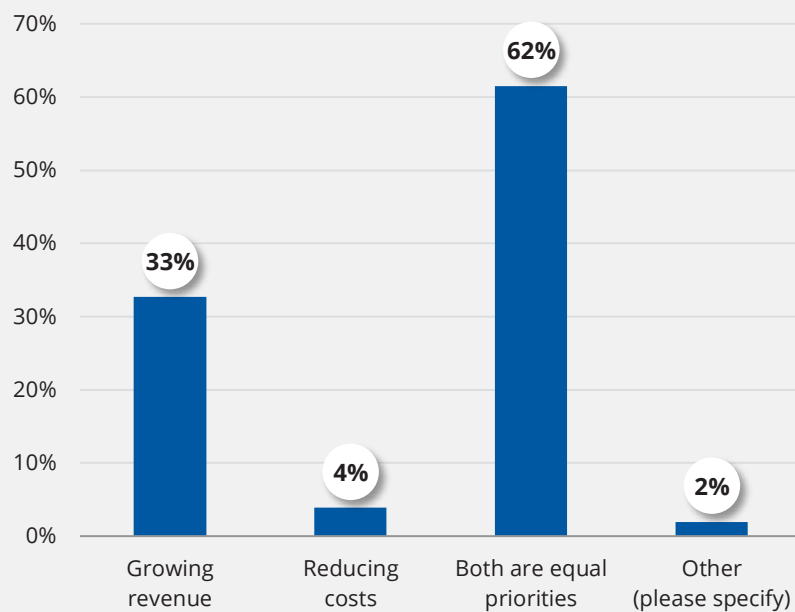
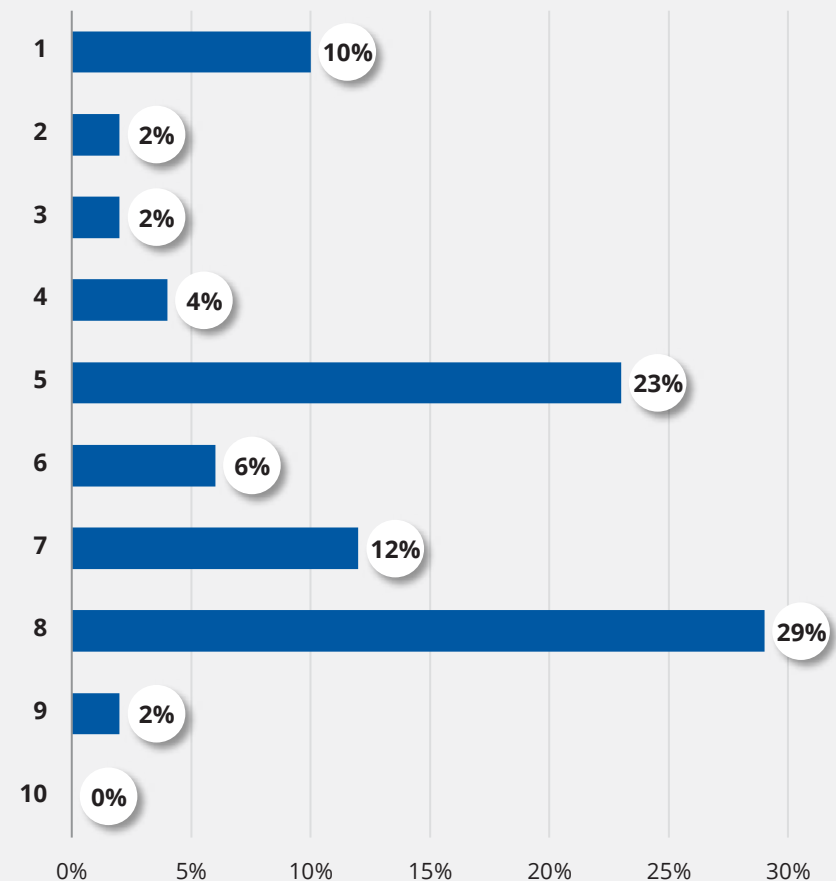
FIGURE 12: Level at Which Average Per Physician Investment/Subsidy Would Require Material Action to Address



Physician Enterprise (continued)

Significantly more respondents are looking to improve their physician enterprise's performance by growing revenue (33%) instead of reducing costs (4%), but most respondents are seeking to both grow revenue *and* reduce costs (62%).

Pursuit of revenue growth may be hampered if patients cannot easily access the physician enterprise. More than two-thirds of respondents (69%) ranked access to their physician enterprise as 7 or lower on a

FIGURE 13: Top Priority for Organization's Physician Enterprise**FIGURE 14: Rate Patient Access to Organization's Physician Enterprise on Scale of 1 to 10 (10 Highest)**

Physician Enterprise (continued)

1-to-10 scale. Interviewees cited issues ranging from de-centralized scheduling systems to setbacks in primary care physician retention due to early retirements or decisions to move closer to family.

An interviewee from a higher-ranking health system emphasized the importance of their “funnel” model in enhancing patient access. The health system has built a wider provider network with 130 clinic locations and made it easy to navigate. Scheduling is centralized across the clinics, so referral appointments can be made for patients immediately. Members of the medical group all report to the same leadership, and the network has made a heavy investment in technology, including experiments with geosensing that indicate when patients have arrived for their appointment.

Action Items:
Physician Enterprise

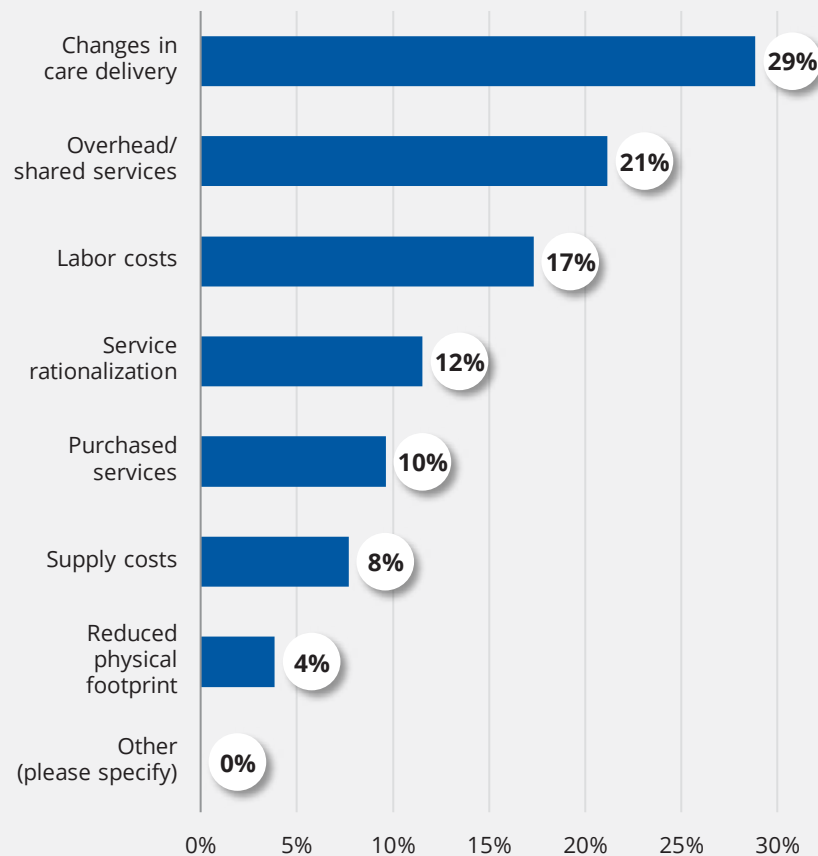
- **Examine physician investment (subsidy) levels against benchmarks and look for ways to bend the cost curve.** A critical step in this process is understanding the various cost drivers to identify outliers and owners to address them.
- **Look at both physician and provider investment levels by specialty.** This will help you understand opportunities, including how effectively you are leveraging advanced practice providers (APPs).
- **Enhance metrics tracking to identify and resolve patient access bottlenecks.** Patient access has reemerged as a major consumer issue as volumes return to the physician enterprise. If you are not seeing your patients in a timely fashion today, they may visit someone else tomorrow.

Opportunities Going Forward

A relatively low percentage of respondents (23%) said the pandemic revealed areas of excess cost that they were able to reduce. For those that did see opportunities, improved productivity and reductions in administrative overhead were most mentioned. A higher number of respondents (52%) said the pandemic had caused their organization to adopt new processes, positions, or departments that will continue going forward. Major areas for change included care delivery (including digital health, respiratory care, and hospital at home); safety and security enhancements; new productivity, recruiting, and staffing models; supply chain warehousing; and enhanced data analytics and predictive modeling.

When comparing this year's survey results to our last pre-pandemic survey in 2019, there has been one significant change in where our respondents see the greatest opportunities for cost reduction. The three top categories have stayed the same (labor costs, changes in care delivery, overhead and shared services), but labor costs have gone from the number one opportunity to number three. Changes in care delivery now take the lead, followed by savings in overhead and shared services. Based on other survey responses, this likely reveals the pressures of staff shortages and wage inflation that many organizations are seeing today.

FIGURE 15: Greatest Opportunity for Cost Reductions



Note: Respondents were asked to choose one response only.

Conclusion: A New Perspective on Performance Improvement

Most hospitals and health systems likely feel that their performance improvement efforts have been significantly eroded by the COVID-19 pandemic. Expenses are up, revenues are down, and the end is not clearly in sight.

We believe it is time for leadership to rethink their approach to performance improvement, and this will require rethinking the premise that not-for-profit hospitals and health systems can lower their costs while maintaining control over all aspects of their operations. Organizations are going to have to risk giving up some control and find partners who can perform some of their functions more effectively and efficiently.

For example, respondents to this survey indicated that they were reluctant to outsource revenue cycle services. Yet outsourcing, automation, and offshoring offer some of the most promising solutions to reducing corporate overhead and shared services costs. This is not without risk, and may require retraining programs for displaced employees, or having an onshore backup for offshored programs, but it is exactly what many U.S. corporations have done to contain their costs.

Organizations should also look at underperforming service lines, such as behavioral health, post-acute care, or home health. These are services that the community needs, but could they be delivered

“We need to figure out the efficiencies and investments we can make to reduce operating expenses over the long term.”

— CFO, small rural health system

more efficiently by a partner who has the specific skillsets, capabilities, and expertise that a health system might lack? Again, questions of operational and clinical control will arise, but these must be reconciled in a way that lets both parties execute the partnership successfully.

Hospital and health system leaders must be innovative and assertive in their efforts to take on costs in this incredibly challenging environment. They should calculate the full cost-reduction opportunity available to them if they pursued all available strategies to their maximum effect. With a full understanding of what the health system *could* do, it will be much easier to quantify the impact of decisions not to pursue a specific opportunity, and manage the degree of change that will be required for the organization to achieve its goals.

About the Report

This year's report was based on responses from 73 hospital and health system leaders across the country; most respondents are in executive (52%) or finance (29%) positions. Several respondents also volunteered to be interviewed; their observations and insights are included throughout the report.

Ninety-six percent of this year's respondents are based in a hospital or health system; the remaining 4% are in medical groups. All regions of the country are represented, with 33% of respondents from the Midwest, 29% from the Northeast and Mid-Atlantic, and 19% from both the South and the West. Thirty-five percent of respondents are in urban markets, 44% in suburban, and 21% in rural.

FIGURE 16: Size and Type of Respondents' Organizations

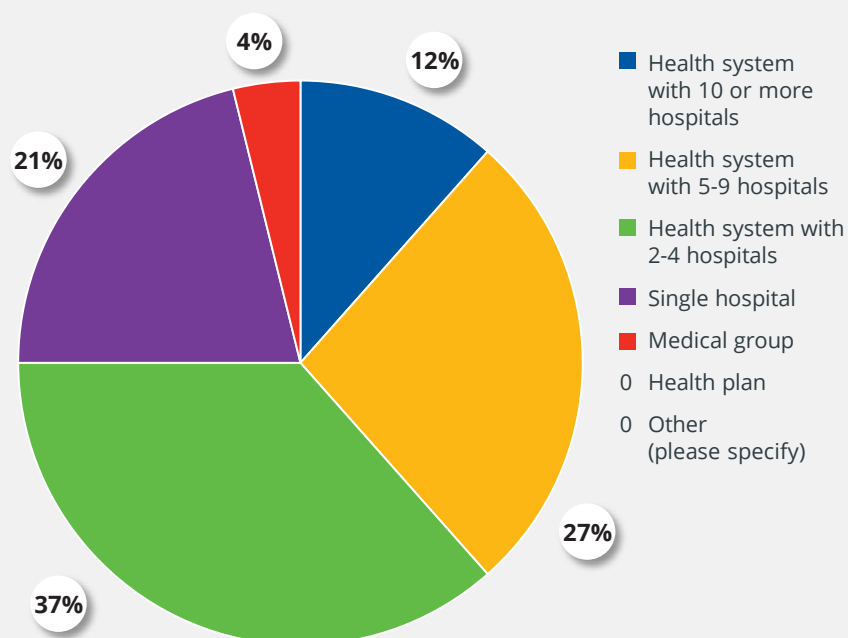
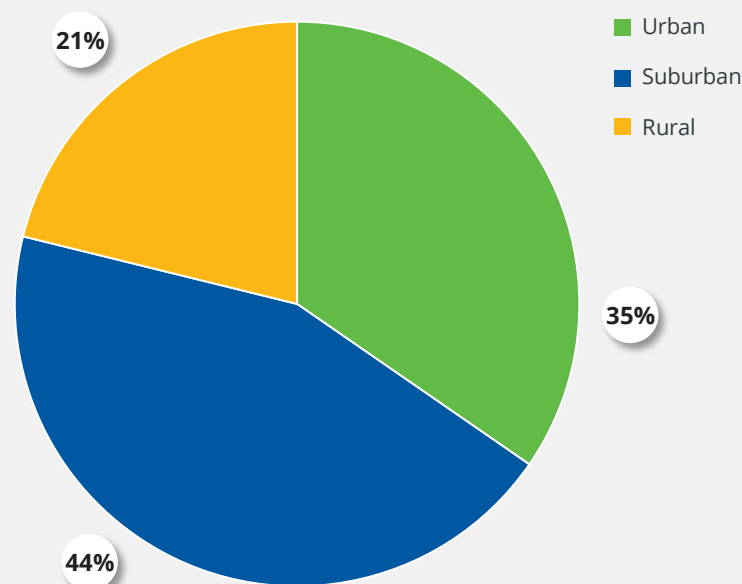


FIGURE 17: Respondent Organizations by Market



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