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Premium Compensation Due to Short Staffing

AN IN-DEPTH DISCUSSION IN TODAY'S ENVIRONMENT

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Introduction

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Agenda

- Realities and the Challenges Ahead
- Consider Alternatives
- Why Pay Compensation Premiums
- Valuation Approach and Considerations
- Case Studies
- Questions

Industry Realities

October 11, 2021 *Healthcare Finance* article:

"Hospitals and Health Systems paying $24B more per year for qualified clinical labor than they did pre-pandemic."

"Labor costs up an average of 8% per day compared to 2019 baseline, translating to $17M in additional labor expenses for the average 500-bed facility."

"Hospitals nationwide will lose an estimated $54B over the year, even taking in to account the $176B in CARES Act funding in 2020."

IMPORTANT NOTE: These realities were published before the new reality of the significant inflation pressures of 2022.

Research Conducted

Conducted general research and observation and added to PYA collective experience

Interviewed 10 healthcare executives across the U.S. – Connecticut to Arizona and points between

Considered feedback and strategies from client interactions

Challenges Ahead

The Great Resignation and The Great Renegotiation	Chronic understaffing has accelerated labor concerns Burnout of seasoned workers Competition for staff from new competitors Population shifts from metropolitan areas to suburbs[1]
The Fight to Retain	Increased use of telehealth has created a new category of remote worker Labor costs continue to rise Chronic staffing shortages may cause concern for patient safety
Filling the Pipeline	Projected shortage of 122,000 physicians by 2032[2] Training opportunities for medical school graduates limited Visa process for international workers stalled by the pandemic

[1]https://www.unacast.com/post/united-states-migration-patterns-covid-19 and https://www.brookings.edu/research/pandemic-population-change-across-metro-america-accelerated-migration-less-immigration-fewer-births-and-more-deaths/. Accessed on October 17, 2021.

[2]https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7430533/#:~:text=The%20Association%20of%20American%20Medical,also%20specialist%20physicians%20%5B1%5D. Accessed on April 10, 2022.

“To a man with a hammer, everything looks like a nail.”

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Alternatives to Consider

The Great Resignation and The Great Renegotiation

- Non-traditional recruiting
- Flexible work locations and schedules
- Boomerang employees and/or retirees

The Fight to Retain

- Compensation hygiene
- Alignment of values
- Flexible and creative benefits

Filling the Pipeline

- Ensure staffing model is consistent with how you want to do business
- Create sustainable recruiting and retention infrastructures

[1]https://www.unacast.com/post/united-states-migration-patterns-covid-19 and https://www.brookings.edu/research/pandemic-population-change-across-metro-america-accelerated-migration-less-immigration-fewer-births-and-more-deaths/. Accessed on October 17, 2021.

[2]https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7430533/#:~:text=The%20Association%20of%20American%20Medical,also%20specialist%20physicians%20%5B1%5D. Accessed on April 10, 2022.

Why Pay Compensation Premiums

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Hard to fill shifts

Nights

Holidays

Weekends

Hard to find specialties

Emergency Department coverage (i.e., call)

Recruiting needs

Gap coverage

FMLA

Services outside of normal work

Other emergent needs

Types of Compensation Premiums[1]

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Shift Differential

- Undesirable shifts
- Add-ons to existing shift

Call-back Premiums

- Workplace emergency-type situations

Weekend and Holiday Premiums

- When such work is not part of the normal schedule

Hazard Pay

- When directly exposed to hazards when working

Recruiting Premiums

- Difficult to recruit specialties
- Undesirable locations
- Key providers/Renown leaders

CAUTION: If the minimum work standard or need is not clearly defined, it will be difficult to determine what defines the exception and cause for the premium.

[1] SHRM, 2022 *"What Are Some Common Types of Differential and Premium Pay?"*

Hazard Pay During COVID-19

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What constitutes "hazard pay"?

Defined by the U.S. Department of Labor as "additional pay for performing hazardous duty work involving *physical hardship*. Work duty that causes extreme *physical discomfort and distress* which is not adequately alleviated by protective devices is deemed to impose a *physical* hardship." [1]

COVID-19, at times = Highly communicable disease + nationwide shortage of PPE

Hazard premiums vary, but non-healthcare industry data indicates up to 25% of base pay.

[1] https://www.dol.gov/general/topic/wages/hazardpay

Valuation Approach

Define the need	What service? Why does it require a premium? Is it beyond the minimum work standard? How long has the need been unfilled? How much organizational stress?
Determine organizational consistency	What are you paying others for similar services? Examine as a $ and a %
How much?	Market approach Cost approach?

Market Approach

Review Benchmark Resources

- Hospitalist vs. Nocturnist (Night vs Day)
- Inpatient vs. Outpatient (Specialty)
- Call Pay Data (Weekend/Holiday)

Review Other Market Data

- Hazard Pay – 25% of base[1]
- U.S. Military – 15% to 25% of annual median salary
- Overtime (FLSA) – 50% of hourly rate
- Physician societies – Indicate 200% in *emergent short-term situations*
- Review locum tenens data
- Other local market comparables

PYA experience suggests premiums ranging from 110% to 135% of the provider's base rate.

[1] https://www.govinfo.gov/content/pkg/CFR-2012-title5-vol1/pdf/CFR-2012-title5-vol1-part550-subpartI-appA.pdf. Assumes the hazardous duty has not already been taken into account.

Call Pay Premiums as a Proxy[1]

Only 30% of providers paid a compensation premium for call pay for evenings, weekends, or holidays.

Evening Premiums Ranged from 135% to 145% of Hourly Rate for Shift Type

Weekend Premiums Ranged from 133% to 181% of Hourly Rate for Shift Type

Holiday Premiums Ranged from 138% to 200% of Hourly Rate for Shift Type

[1] *2020 Physician On-Call and Telemedicine Compensation Survey Report,* SullivanCotter, Inc.

Premium Compensation Must-Haves

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- Fair Market Value
- Commercially Reasonable
- Not create unintended consequences

Case Study 1 - Fact Pattern Employed Physician

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- Physician is providing a blend of inpatient and intensive outpatient psychiatry services
- The employer has proven difficulty in recruitment and retention in the specialty
- National evidence provided indicating a shortage of psychiatrists, especially in the inpatient setting
- The services are provided in a mental health HPSA
- The services will be provided in a highly utilized inpatient psychiatry service
- The services are provided in a Level II Trauma Center
- The number of psychiatrists in the market is low (limited alternatives)

Case Study 1 – Analysis Employed Physician

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- Reviewed differentials in benchmark data between inpatient, outpatient and general psychiatry
  - Study revealed a premium ranging from 0% to 20% for inpatient psychiatrists, with an average of 6%
- Reviewed the compound annual growth rate for psychiatry compensation as a proxy to accommodate for delay in survey data compared to current market data
  - Study revealed a 3% compound annual growth rate (CAGR)
  - Caution should be utilized when applying a CAGR premium
- Consideration was given for the favorable/unfavorable position of the services provided – highly utilized inpatient services attached to a Level II Trauma Center located in a mental health HPSA with low psychiatry physician supply and high psychiatry physician demand
- Applied judgement regarding organizational compensation philosophies and norms

Case Study 1 – Conclusion Employed Physician

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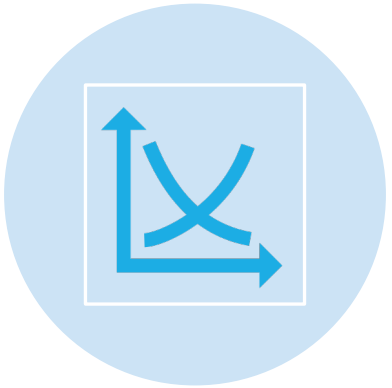
Compensation premiums totaling approximately 12% of median benchmark data for general psychiatry were applied to the physician's compensation assessment related to:

INPATIENT PSYCHIATRY DIFFERENTIAL

(USING BENCHMARK DATA ANALYSIS)



PSYCHIATRY SUPPLY/DEMAND

(USING MARKET AVAILABILITY OF ALTERNATIVES)

HOSPITAL AND MARKET SPECIFIC FORCES

(USING INPATIENT PSYCHIATRY METRICS INDICATING PATIENT DEMAND)

Case Study 2 - Fact Pattern
Call Coverage

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- Independent neurosurgery practice provides unrestricted call coverage to Level II Trauma Center
- The panel size is reducing from 3 physicians to 2 physicians
- Practice intends to recruit a new provider to the market; however, recruiting times span 1-3 years
- Payer mix contains high concentration of governmental payers
- No alternatives to the arrangement, other than locum tenens
- Call coverage is intense with many telephone consults and on-site examinations and procedures

Case Study 2 – Analysis
Call Coverage

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- Reviewed differentials in benchmark data between "all respondents" and trauma center data for unrestricted coverage
  - Study revealed wide variation between surveys in terms of dollars and number of respondents
- Compared the number of neurosurgeons in the call panel to national averages
  - Study revealed the average number of providers in the panel is 4.
- Consideration was given to lack of alternatives (i.e., cost of locum tenens, cost to employ, etc.), time required to recruit, payer mix (i.e., collections for call services will be less than average), and overall annual spend for the call coverage
- Applied judgement regarding organizational compensation philosophies and norms

Case Study 2 – Conclusion
Call Coverage

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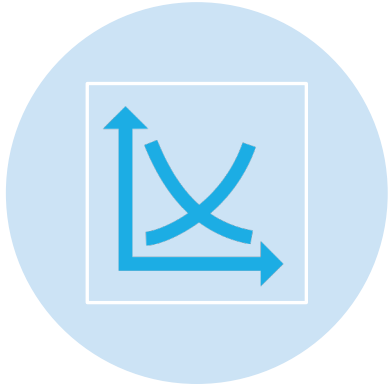
Compensation premiums totaling approximately 35% of median benchmark data for unrestricted neurosurgery call coverage at a trauma center were applied to the physician's compensation assessment related to:

CALL PANEL SIZE

(USING BENCHMARK DATA ANALYSIS, ANALYSIS OF OVERALL ANNUAL SPEND)



NEUROSURGERY SUPPLY/DEMAND

(USING MARKET AVAILABILITY OF ALTERNATIVES)

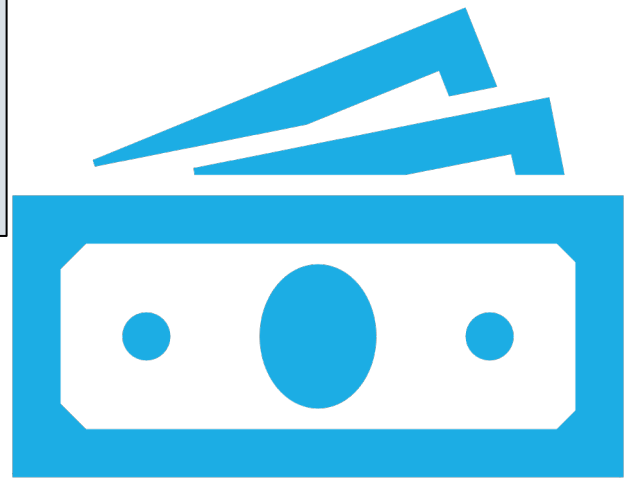
ABILITY OF PRACTICE TO COLLECT

(USING BENCHMARK DATA AND PAYER MIX ANALYSIS)

Case Study 2 – Conclusion
Call Coverage Caution

When applying premiums to call coverage stipends, careful consideration should be given to the number of providers in the call panel.

If the premium is being applied primarily because of the additional burden and intensity of providing call coverage on a short-staffed call panel, consideration should be made to what happens when the call panel increases.



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