CARDINAL NEWS
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ECONOMY

Hospitals face 'broad and serious threats' as pandemic-related losses mount

Federal pandemic aid is mostly gone, and rising labor and supply costs – and static reimbursement rates – are forcing hospitals to rethink how they provide care. First of a two-part series.

by **Megan Schnabel**
October 3, 2022

Ballad's Bristol Regional Medical Center. Photo by Susan Cameron.

*This is the first of a two-part series. Read part two: **As staffing shortages continue, hospitals see labor costs soar**.*

As the COVID-19 pandemic took hold during the spring of 2020, hospital systems rushed to respond to the unprecedented surge in patients, and to the logistical challenges that accompanied a relatively unknown viral foe.

Alan Levine, president and CEO of Ballad Health, said the direction he got from his board was clear: "Don't worry about the financial issues. Just lean into solving the problems before they become big problems."

Ballad Health president and CEO Alan Levine. Courtesy of Ballad.

So his team stood up a dozen testing sites across Ballad's service area in Southwest Virginia and Northeast Tennessee. They bought cold storage units for the COVID vaccine well before doses were available. They decided that even as scores of elective surgeries were canceled, they wouldn't furlough any nurses.

But even during those earliest days, when hospitals were focused on caring for the influx of critically ill patients – and on trying to keep their own employees safe – health system leaders had to consider a sobering question:

How long can we afford to keep this up?

Two and a half years later, it's a question they're still asking, with increasing urgency.

Health systems in the U.S. are facing "broad and serious threats," and 2022 is on pace to be the most difficult year of the pandemic in terms of their financial performance, according to a September report by Kaufman Hall, a health care consulting company. Optimistic projections for 2022 show hospitals' margins down 37% relative to pre-pandemic levels; more pessimistic projections predict a decline of up to 133%.

Virginia hospitals lost $1.8 billion in revenues during the first six months of the pandemic, according to the Virginia Hospital and Healthcare Association. From the beginning of 2021 through June 2022, they saw operating income drop by more than half and investment income fall by 219%.

Billions of dollars in pandemic aid from the federal government helped stanch the bleeding. But most of those funds have dried up, while costs continue to rise thanks to inflation and ongoing staffing shortages – and while hospitals are barred from increasing what they can charge for procedures.

COVID cases keep coming, and COVID patients are requiring longer hospital stays than at any point during the pandemic.

> "Thank goodness we had some federal assistance, but it helped about half of what our losses were," Nancy Agee, president and CEO of Carilion Clinic,

said last month. The nonprofit health system has seen its income drop by $250 million so far during the pandemic; as of the end of June, Carilion had received more than $170 million in federal pandemic aid, according to Don Halliwill, Carilion's chief financial officer, and the health system's financial statements.

"Our losses are real," Agee said. "They've been going on for a while, and they're worsening. At this point, it's a simple math problem: Expenses are up, and we have no revenue elasticity – we can't charge more for our services just because our expenses are up."

Nancy Howell Agee, president and CEO of Carilion Clinic. Courtesy of Carilion Clinic.

(Disclosure: Carilion is one of our donors, but donors have no say in news decisions; see our policy.)

Roanoke-based Carilion has worked through financial challenges before, Agee said, but this is different: The pandemic caused a structural shift in how hospitals make and spend money, and the old ways of tightening belts and increasing efficiencies aren't enough.

Ballad's Levine worries that without significant systemic changes – Medicare and Medicaid reimbursement rates rising to keep pace with inflation, more nurses entering the workforce – the U.S. will see a rash of hospital closures and consolidations, particularly in rural areas.

"It's very easy to presume that hospitals are just doing fine because of the recovery money they've gotten," said Levine, whose nonprofit health system had received more than $230 million in federal and other pandemic aid through the end of March, according to Ballad's most recent financial statements. But when even a marquee name like Cleveland Clinic reports an operating loss of more than $100 million in a recent quarter, something is seriously wrong, he said.

"When this is happening throughout the country, policymakers need to take note," he said. "And if they wait until these systems are in crisis, it's going to be painful for everybody."

Hospital consolidations and closures have already begun, said J.B. Silvers, interim co-dean and a professor of health care finance at the Weatherhead School of Management at Case Western Reserve University. Some of the underlying challenges, like a shortage of nurses and a move toward outpatient treatment, existed before COVID hit, he noted. But the pandemic exacerbated them, and created even more problems.

He agrees that systemic changes are needed, and he believes that they must extend to the health systems themselves.

"Throwing money at it, per se, probably doesn't make sense, just because that's just going to prop it up a little while longer," he said. "But could you help systems to reconfigure in ways that they couldn't otherwise? I think you probably could."

COVID-19 Hospitalizations in Virginia

Source: Virginia Hospital and Healthcare Association
*Counts less than 11 are not displayed on the graph
^ During the period from July 24, 2021 to August 25, 2021 confirmed COVID-19 patients currently on ventilator support data was not collected from hospitals. Collection of this information resumed on August 25, 2021. Credit: VHHA

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On March 11, 2020, the World Health Organization declared COVID-19 a pandemic. The financial hits to hospitals quickly followed.

Health systems bought personal protective equipment, set up testing centers, paid overtime to keep overwhelmed COVID wards functioning.

At the same time, they lost a significant revenue stream, as they called a halt to all non-emergency surgeries to free up scarce resources for COVID care.

While Virginia's ban on elective procedures ended two months later, some hospitals found themselves reinstituting pauses again and again, as COVID caseloads rose and fell. Ballad, for instance, enacted another pause in October 2020, and a third the following August.

Hospitals lost more than $22 billion in revenue nationally due to these cancellations, according to a study published last year in the Annals of Surgery.

Elective surgeries have rebounded in many places; at Carilion, for instance, non-emergency surgeries are back at 97% of pre-pandemic levels.

But the pandemic has accelerated a shift that started some years ago: a move away from hospital-based care in favor of outpatient clinics and ambulatory surgery centers. One big driver, according to a March 2022 Moody's analysis, was the decision by the federal Centers for Medicare and Medicaid Services to allow more cardiac and orthopedic procedures to be performed in outpatient settings.

The shift has been "aided and abetted" by the necessary turn toward telehealth during the height of the pandemic, Silvers said. And it has meant that the patients who do come to hospitals tend to be sicker than before this shift, since less-critical cases can be treated at outpatient facilities or through video visits.

That has been the case at Carilion: The health system has admitted 16% fewer patients this year than in 2019, but they've been sicker and have stayed in the hospital longer. And because payments are fixed for most of Carilion's inpatient services, the longer a patient is in the hospital, the less favorable the financial impact, Halliwill said.

More broadly, overall patient volumes still hadn't fully rebounded to pre-pandemic levels at Virginia hospitals as of this March, according to Virginia Hospital and Healthcare Assocation data. Since March 2020, hospitals have seen an average cumulative decrease in inpatient numbers of 6.8%. Emergency department volumes are down 16.8%.

The numbers are better than they were, association spokesman Julian Walker said; early in the pandemic, emergency department volumes were down by around 30%.

"Hospital volumes … are on the road to recovery," he said. "But this data suggests that that road is still being traveled."

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Carilion Roanoke Memorial Hospital. Photo by Megan Schnabel.

Even as demand for their services lags, hospitals are watching their expenses rise.

Labor costs are the primary driver, as a wave of retirements and resignations has decimated employee ranks, especially among nurses. Ballad, for instance, last month had 2,500 vacancies out of a workforce of about 13,500; 1,000 of those openings were on the nursing staff.

Health systems have become increasingly reliant on so-called travel nurses to fill the gaps, and they've had to pay dearly for the help: The median hourly wage for these contract nurses has always been higher than for staff nurses, and it has more than doubled since 2019 – from $64 to $132 – according to Kaufman Hall. Wages for staff nurses rose, too, but only by 11%, from $35 to $39.

The solution has become part of the problem, as staff nurses have left hospital jobs to take better-paying travel gigs.

Contract workers accounted for 11% of hospitals' total labor expenses in the first quarter of this year, compared to just 2% before the pandemic, Kaufman Hall found.

But costs are up across the board. The U.S. inflation rate reached a 40-year high in June, hitting 9.1%. August's number was 8.3%.

Spending on supplies by hospital systems is projected to grow by $11 billion this year, Kaufman Hall estimates, and expenses are expected to remain 20% to 25% above pre-pandemic levels.

Coming Tuesday:

A closer look at the labor shortage in the health care industry.

And the same wild stock market fluctuations that have tanked private investors' retirement accounts this year have also erased hundreds of millions of dollars from health systems' investment portfolios.

"It's been devastating," Levine said.

These "more severe-than-expected macro headwinds," coupled with the ongoing labor shortage, prompted Fitch Ratings to revise its outlook for nonprofit hospitals and health systems to "deteriorating" in August. Fitch warned that many of these providers will violate debt service covenants this year, and that the industry may be in "a period of elevated downgrades and Negative Outlook pressure for the rest of 2022 and into 2023."

Carilion last October received a stable outlook from Moody's. In May, Ballad's outlook was deemed stable by Fitch and Standard & Poor's, and Lynchburg-based Centra Health's outlook was rated positive last month by Fitch.

Halliwill believes that it's the unknowns as much as anything that are causing the view that "for the next foreseeable future, it's going to be a bit of a bumpy ride."

"What's next with the pandemic?" he said. "Each time we come out of a wave or a variant, we're all optimistic that things will become that endemic stage, much like the flu on an annual basis, so there'll be a vaccine that you take and it will become more normalized. And then we have another variant that has some different characteristics."

The August Fitch outlook applies specifically to nonprofit health systems. But inflation and labor shortages are industry-wide challenges, as is the fact that hospitals are largely hamstrung when it comes to what they can charge for their services.

Health systems negotiate periodically with private insurers to set prices for their services, and those rates remain in effect for a year or more, despite changes – up or down – in real-world costs.

But hospitals have no control over how much they're paid to treat Medicare and Medicaid patients.

Don Halliwill, chief financial officer at Carilion Clinic. Courtesy of Carilion Clinic.

About 70% of patients at Ballad, Carilion and Centra are covered by the government-funded insurance programs for seniors and disabled or low-income residents.

The rates that hospitals are paid to care for these patients are set by the federal government. They're adjusted annually, but adjustments are based on historical data, rather than on real-time market changes. In a June letter to the administrator of the Centers for Medicare and Medicaid Services, the American Hospital Association noted that the 2023 rate adjustment will be based on market data from 2021, "resulting in woefully inadequate reimbursements for hospitals and health systems."

The Healthcare Financial Management Association reported that hospital costs had increased by 10.4% year to date through May, but that the next Medicare payment increase for inpatient services is proposed at 3.2%.

In fact, the actual Medicare increase would be significantly less, thanks to the revival of a 2% sequestration cut, which was enacted in 2011 as part of a budget control measure but had been on pause during the pandemic. It took full effect again July 1.

Even before the current wave of inflation set in, hospitals had become accustomed to payment rates that were below their actual costs. In 2020, according to the American Hospital Association, hospitals were reimbursed 84 cents for every dollar they spent caring for Medicare patients and 88 cents per dollar for Medicaid patients.

Carilion is used to operating in an environment in which the payments it receives don't reflect inflation, Halliwill said. The shortfall had been about 1% year over year, and Carilion leaders had made up the

difference through more efficient use of resources, he said.

But now they're looking at a 10% gap. "That's just a different impact for us," he said.

Hospitals can't just "raise the price of hamburger" to make up for higher costs, Levine said. With nowhere else to go, he expects to see the burden shift to commercial insurers – and to their employer clients – during the next round of contract negotiations. It's not fair, he said, but he doesn't think hospitals have much choice if Medicare and Medicaid reimbursements don't increase.

"It's basically a cost shift from the government to private industry," Levine said. "It's just a hidden backdoor tax increase, a massive tax increase, for employers."

He would like to see a change in how and when reimbursements are calculated to account for the pandemic, which he called "a material adverse event … that's dramatically, structurally changed the hospital cost structures."

"If I knew Medicare was going to pay for its share of this increase, that would have a direct effect on what I ask the commercial payers to pay," Levine said. "I don't think it's fair to ask Blue Cross of Tennessee to pay more than their share of the wage increases. I don't think it's fair to ask the employers to pay for what Medicare has agreed to pay for, but they're not paying for it."

He believes that hospitals, insurance companies and employers all recognize the problem. "None of us want this cost to be shifted to the commercial market," he said. "We've got to figure out how to be coordinating and communicating with Medicare."

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National Median Hospital YTD Operating Margin Index

In the first three months of 2022, U.S. hospitals saw dramatic declines in operating margins as CARES Act funding dried up but expenses continued to grow.

Source: **Kaufman Hall**

Health systems would have started feeling the crunch much sooner if not for $178 billion allocated through the COVID-19 Provider Relief Fund in the early days of the pandemic.

A study published in May in JAMA Health Forum found that while hospitals saw their operating margins drop significantly in 2020, their profits remained stable, thanks to those federal dollars.

But that money is mostly gone now, even as new COVID variants continue to rise and fall. The Urban Institute reported that as of February 2022, all of the $178 billion had been allocated and most of it distributed. (About $10 billion had been returned by recipients who didn't need it or couldn't meet the conditions attached.)

Hospital systems also may be eligible for reimbursement for some COVID-related expenditures from the Federal Emergency Management Agency. As of last week, the agency had paid about $76 million for claims by Virginia hospital systems and health care providers, a FEMA spokeswoman said. Another $191 million of expenses has been submitted to FEMA and is under review.

Halliwill said the industry expected that the government assistance that was keeping them at or slightly above the break-even point in 2020 and 2021, and even into the early part of 2022, would be enough to carry them until the worst part of the pandemic had subsided.

"And that just has not been the case," he said. "The government assistance … we used the last of that earlier this year, in 2022, and for the past several months we have been recording relatively significant

operating losses."

Carilion's operating loss for the first nine months of its recently ended fiscal year was approximately $35 million, he said.

Halliwill expects to see "some pretty substantial and mounting losses" across the industry as the loss of federal funding sinks in.

Ballad reported an operating loss of $37.3 million in the quarter that ended March 31, compared to year-earlier income of $16.0 million, according to its financial statements.

Ballad has raised the average nursing wage by 40% and the average overall wage by 20% to counteract pandemic-related staffing shortages; those increases weren't baked into the health system's budget, Levine said, and without the incremental revenue to offset those costs, the impacts are likely to show up in Ballad's cash flow, which will hurt its ability to capitalize.

He's had to prioritize spending to avoid digging into cash reserves, he said, and has deferred some capital outlays, like technology upgrades and some new equipment, until he has a better understanding of what Ballad's cash flow looks like.

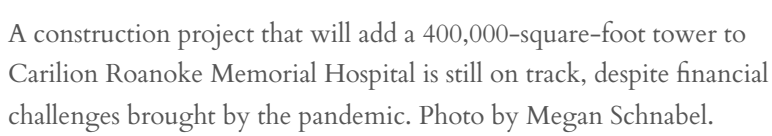
Levine believes that Ballad has so far avoided more painful cost-cutting measures because it went through a wave of consolidations and closures following its 2018 creation through the merger of two existing health systems. Among other changes, Ballad consolidated two neonatal intensive care units in Tennessee into one location and closed one of three hospitals in Wise County. (Ballad in 2021 also reopened a hospital in Lee County that had been closed for years.)

"A lot of the things that were very painful to do, that made a lot of people angry at us, had we not done them we would be in really bad shape right now," Levine said.

That doesn't mean that the hard decisions are all in the past, he warned. "Do I anticipate there'll be some more? Yeah," he said. Ballad might look at consolidating additional ICUs, for example.

"Those are the types of things that we are looking at, and I suspect that will be done," he said. "They won't be popular, but the other option is to close the hospital, and that's a much less appetizing option for people."

A high-profile expansion of Carilion Roanoke Memorial Hospital – a $400 million, 400,000-square-foot tower – is moving forward as initially designed, Halliwill said. A planned expansion of Carilion's psychiatric facilities was put on pause earlier this year, but Agee said that decision was made not for financial reasons but to rethink some aspects of the project in light of what the health system has learned during the pandemic.



A construction project that will add a 400,000-square-foot tower to Carilion Roanoke Memorial Hospital is still on track, despite financial challenges brought by the pandemic. Photo by Megan Schnabel.

But the pandemic has caused Carilion, like the industry as a whole, to be "more measured" about deploying capital, Halliwill said. Carilion's operational team is focusing on how to be more efficient and how to manage costs differently. There will be a need to renegotiate contracts with insurers going forward, he said.

"We don't believe that most of those inflationary pressures are going to subside," he said. "Wage rates aren't going to go back down, people aren't going to take less money. Workforce shortages are going to continue to keep the supply and demand a little bit out of balance, and so we don't see a rollback in the inflationary pressures."

That structural change is forcing what Agee calls "care redesign" – a top-to-bottom reassessment of how Carilion serves its patients. The focus is on how to make the fullest use of every potential caregiver and every available technology – looking at whether paramedics could work in emergency departments to alleviate staffing shortages, for instance, or at how robots and artificial intelligence could be deployed in hospitals to make processes more efficient.

Telehealth is likely to play a growing role as well, she said, assuming that the regulatory path is clear. During the pandemic, rules about how telehealth could be used were loosened and Medicare and Medicaid reimbursements were boosted to match regular outpatient rates. It remains to be seen whether those emergency provisions become permanent.

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Doug Davenport, Centra Health's chief financial officer, remembers precisely when he realized that the pandemic was going to have a significant long-term impact on the industry.

It was the day in the late fall of 2020, during COVID's second surge, when he was asked to rent a refrigerated truck to store bodies.

"That's when I knew the world had changed," he said.

In the two years since then, Centra hasn't had to scale back service lines or defer capital expenditures, he said. But he and his team have looked for ways to streamline operations, like opening a consolidated warehouse that allows them to better manage supplies. That one move this year has saved a little over $10 million, he said.

Doug Davenport, chief financial officer of Centra Health. Courtesy of Centra Health.

For the first six months of this year, Centra reported an operating income of $32.5 million, compared to $60.2 million a year earlier, according to its financial statements. The health system has received about $105 million in federal aid, he said.

He suspects another round of federal funding might be coming this winter, because as long as people don't take precautions to protect themselves, variants will continue to proliferate and hospitals will continue to see COVID surges.

Silvers predicts more hospital closures, consolidations and conversions to urgent care clinics, particularly in rural areas where hospitals were struggling long before the pandemic. But he believes that throwing more federal money at the crisis without understanding the underlying issues is "problematic at best."

Instead, he sees the crisis as an opportunity for a reboot of the industry.

What if, he said, the government provided another round of aid, but this money would be used not to maintain the status quo but instead to rethink how hospital systems provide care? Stakeholders would collaborate to determine what kind of services make sense from both a community health and a fiscal standpoint – not so different from the certificate of need process that already oversees hospital expansions in some states, including Virginia.

It's an idea he's just started thinking about, he said, so he can't say exactly how it might work. There would have to be a way to ensure that clinical capacity was maintained for the next time a health emergency strikes; it's not cost-effective for a hospital to stockpile equipment like ventilators when it's otherwise trying to be more efficient. Perhaps this could be another area of federal intervention, he

suggested: The capacity could be built through the military health system, or federal subsidies could help hospital systems maintain beds and equipment.

Agee said she expects to see continued changes throughout the industry; the care redesign underway at Carilion is different from anything the health system has ever attempted, she said.

“As the days and months and years go along, we will continue to have a lot of learning from this pandemic,” she said.

Coming Tuesday in Cardinal News: a closer look at the labor shortage in the health care industry.

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ECONOMY

As staffing shortages continue, hospitals see labor costs soar

Hospitals' labor expenses have increased by more than a third from pre-pandemic levels, thanks to a shortage of staff, especially nurses.

by **Megan Schnabel**
October 4, 2022

A shortage of nurses was looming even before COVID-19 struck. But the pandemic exacerbated the problem. Courtesy of Carilion Clinic.

This is the second of a two-part series. Read part one: Hospitals face 'broad and serious threats' as pandemic-related losses mount.

When the pandemic hit in early 2020, Ballad Health stopped all non-emergency surgeries and furloughed about 1,200 people.

None of them were nurses.

There was little need for nursing staff in departments like surgical or post-op, and the loss of surgeries was a big blow to Ballad's bottom line. The normal practice would have been to send those employees home, but the health system instead did the opposite: It kept them on and guaranteed their hours.

Ballad, which operates hospitals and other health care facilities across Southwest Virginia and Northeast Tennessee, couldn't risk losing any of its nurses, said president and CEO Alan Levine – not at the beginning of a global health crisis, and not in the middle of what was already a nursing shortage.

"We knew we were taking a big financial hit, but we were trying to dodge what we knew would become a bullet later," Levine said.

Alan Levine. Courtesy of Ballad Health.

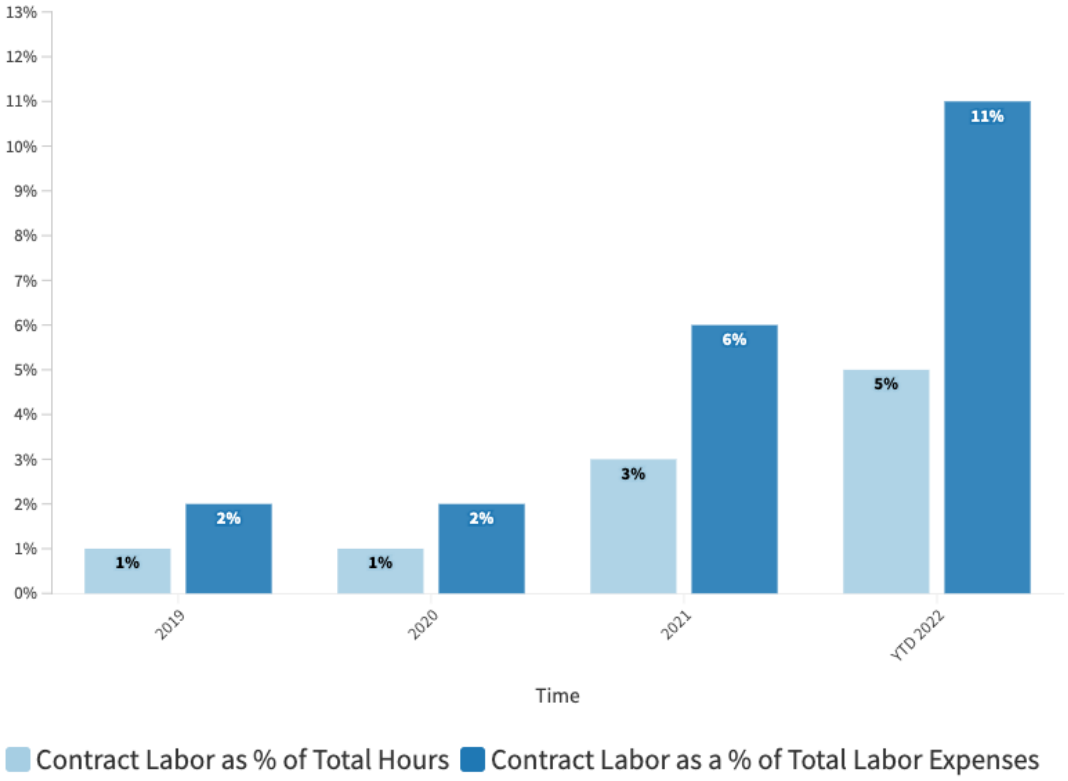
The strategy got them through the first big COVID surge. But the bullet eventually found its target, and not just at Ballad.

A May report by Kaufman Hall, a health care consulting firm, found that almost 1 in 5 health care workers quit their jobs during the pandemic. The pain has been felt across hospital workforces, but it has been particularly dire among nursing staffs.

The impacts to hospitals' bottom lines are continuing to mount. The shortfall prompted health systems to raise nurses' wages and offer signing bonuses. When that didn't work, they turned to staffing agencies to fill shifts, paying hourly rates double and even triple what they paid their own staff nurses.

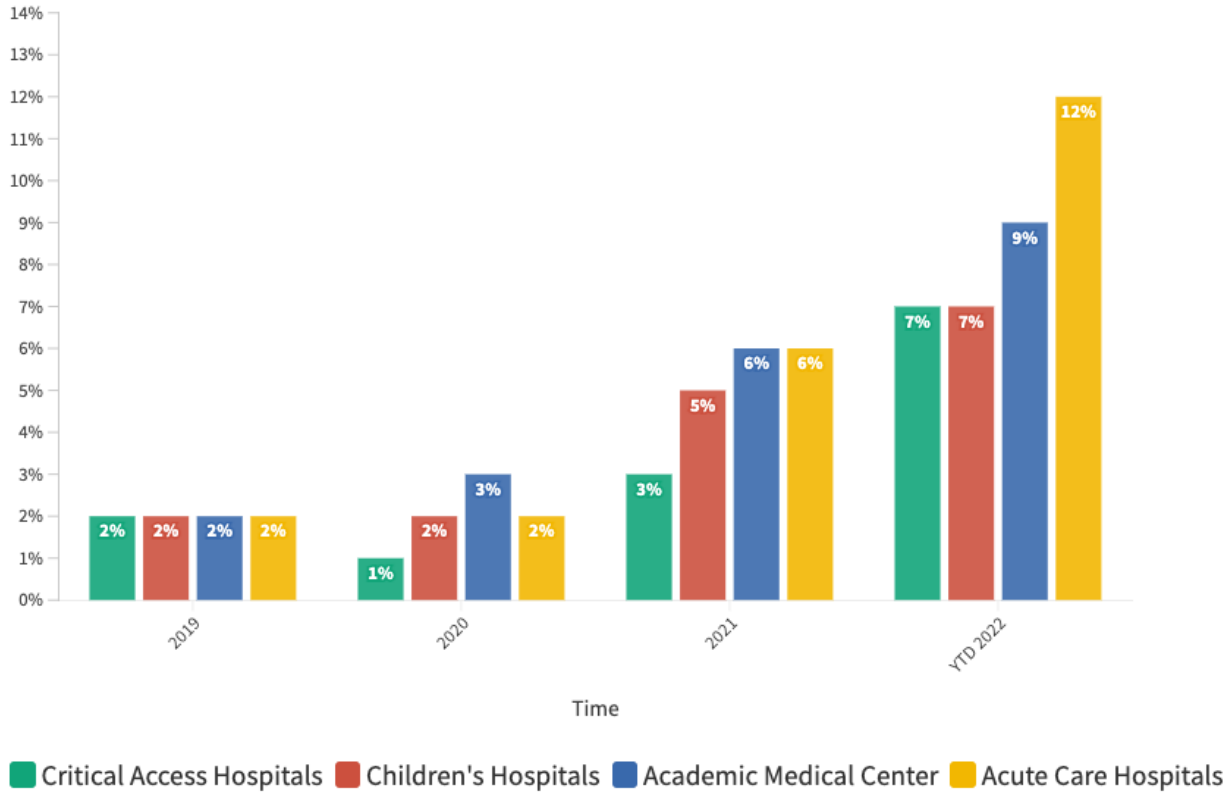
The staffing shortage has been one of the primary reasons hospital systems have struggled financially during the pandemic. Hospital labor expenses have increased by more than a third from pre-pandemic levels, Kaufman Hall found.

Contract Labor as a Percentage of Total Hours and Total Labor Expenses



Source: Kaufman Hall

Contract Labor as a Percentage of Total Labor Expense



Source: Kaufman Hall

But even the increased spending hasn't guaranteed that hospital operations would return to normal. More than 30% of respondents to a survey of rural hospital leaders this summer by the Chartis Group said nurse staffing shortages have led them to suspend or consider suspending services. More than a third told the health care consultant that a lack of nurses had limited how many patients they'd been able to admit within the last 60 days.

In September, Ballad had 2,500 staffing vacancies, representing more than 18% of its workforce. A thousand of those open jobs were in nursing. Roanoke-based Carilion Clinic was looking to hire 685 nurses. Centra Health in Lynchburg, 200.

"The nursing crisis is not going to go away. It's there," said J.B. Silvers, interim co-dean and a professor of health care finance at the Weatherhead School of Management at Case Western Reserve University.

Nurses are opting out of the traditional employment market because they want more money and more control over their schedules, he said.

"They've opted out by going to the agencies, by going to the traveling nurse market, which then lets them get twice as much money as they would otherwise," he said. "What's wrong with this picture? It's not sustainable."

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As of last month, Carilion Clinic was looking to hire 685 nurses across the health system. Courtesy of Carilion Clinic.

Experts had been warning for years that a nursing shortage was coming.

Members of the massive baby boom generation were aging and would soon need more medical care. At the same time, a wave of nursing retirements was looming, and nursing schools were struggling to meet the demand because of hiring pressures of their own.

[Read Cardinal News' previous coverage of the nursing shortage here.]

COVID-19 exacerbated the crash. After months of dealing with the strain of the pandemic, many experienced nurses took early retirement. Some younger nurses, fresh out of school, decided this wasn't what they'd signed up for and left the profession.

And many others decided to give up their staff jobs for lucrative travel gigs, creating further shortages.

Contract nurses were generally paid more than staff nurses even before the pandemic; the job, which can require being away from home for months on end, needed to pay well to attract strong candidates.

But those wage disparities have ballooned, according to Kaufman Hall. In 2019, the median hourly wage for contract nurses was $64. By the beginning of this year, it had reached $132.

Over the same period, the median hourly wage for staff nurses rose from $35 to $39.

Median Hourly Wage Rates for Employed and Contract Nurses

Source: Kaufman Hall

Hospitals' overall labor expenses are projected to increase this year by $86 billion over 2021, Kaufman Hall reported.

Just as the staffing shortage wasn't caused by COVID-19, it isn't likely to abate even as COVID shifts to its endemic phase, a May report by McKinsey & Co. found. In fact, the lingering effects of the pandemic – such as cases of long

Local health systems' contract labor expenses

As the nursing shortage continues, hospitals increasingly have come to rely on contract nurses to fill shifts.

COVID or COVID-related kidney damage – are likely to drive increased hospitalizations for some years; the consulting firm predicted that by 2025, inpatient hospitalization days will have increased by up to 12% over 2019.

And highly contagious coronavirus variants continue to sweep across the U.S., leading to more patients – and more illness among staff. Earlier this fall, when the BA.4 and BA.5 subvariants were prevalent in Southwest Virginia, up to 250 employees were calling out sick every day in Carilion Clinic's system, CEO Nancy Agee said.

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There are two ways to ease the health care staffing shortage: create (or keep) more employees, or figure out how to get the job done with fewer people.

Ideas for how to do the former are being debated and tested, and have been since before the pandemic brought the nursing problem into such stark relief: expand the size of nursing schools, change how clinical rotations are done, offer scholarships, proselytize about the benefits of the job to ever-younger kids, raise pay, offer signing bonuses, increase schedule flexibility.

The staffing help comes at a cost: While the median hourly wage for staff nurses was $39 at the beginning of the year, it was $132 for contract nurses.

- Carilion Clinic paid $39 million a year for contract labor before the pandemic. In the current fiscal year: $137 million.
- Centra Health paid $17.8 million in contract wages in 2020. In the first six months of 2022: $50.4 million.
- Ballad Health paid $22.9 million for contract labor in the first three months of 2021. The same period this year: $41.2 million.

Source: Kaufman Hall, health systems' financial statements, interviews.

"No profession has been more negatively affected by COVID than the nursing profession," Ballad's Levine said. "They've been abused for two and a half years. They've been overworked, they've been short-staffed. They go to work every day wearing a mask for 12 hours, and dealing with PPE [personal protective equipment] and dealing with people who for a long time didn't even believe it when we told them they had COVID."

The shortage is as bad as he's seen in 30 years, he said.

"We've got work to do as an industry to recapture the imagination of young people … to inspire them about what a noble profession nursing is and get them interested in the profession," he said. "I'm very concerned about this."

Ballad last year worked with East Tennessee State University to create the Appalachian Highlands Center for Nursing Advancement. HCA, the for-profit health system that operates LewisGale hospitals in Southwest Virginia, is offering scholarships to nursing students who commit to working in the region for a year.

At the same time, hospital systems are increasingly trying to figure out how to make do with the staff they have, instead of the staff they used to have, or the staff that they want.

Agee, at Carilion, wants to explore using paramedics in emergency departments and home health settings, something that's not currently allowed in Virginia but that she thinks could alleviate some staffing shortages. Carilion also is looking at ways to use technology – anything from robots to artificial intelligence – to free up clinical staff to focus on the patients who need them the most.

Health systems might be able to learn a few things from other industries, the McKinsey report suggested. Airlines, for instance, have embraced a model that has customers now doing much of the work that employees used to do, like booking flights. Health care may never be as do-it-yourself as budget travel, but some providers are testing the waters: In Sweden, health care providers have launched self-dialysis, where patients perform their own dialysis and nurses follow up remotely.

The report also suggested that providers turn to technologies like predictive analytics and artificial intelligence to better match staffing with clinical needs.

Levine's understanding of the staffing shortages goes well beyond what he sees in his job. His wife, an intensive care unit nurse, went back to work during the pandemic to help. As of Friday, Ballad had 18 COVID patients in ICUs, and a total of 77 patients hospitalized with COVID.

When Levine's mother fell this summer in Atlanta, it took an hour for an ambulance to arrive. Once she got to the hospital, she lay on a gurney for 10 hours with a broken hip and wrist before a doctor saw her, he said.

He was upset for her, he said, but not angry with the hospital because he understands the pressure that it must have been under. (The hospital, Atlanta Medical Center, announced recently that it's closing Nov. 1 after losing more than $100 million in the last year. It's also the hospital where Levine was born.)

“This is happening to patients every day,” Levine said. “There are people here who believe that Ballad Health created this. It breaks my heart to hear it because I know how hard our team is working to mitigate the problem.”
