Market Response to COVID-19:

Physician and Advanced Practice Provider Compensation Practices Survey: Report II

May 27, 2020

INTRODUCTION

SullivanCotter distributed the results of the first installment of our ***COVID-19 Physician and Advanced Practice Provider Compensation Practices Survey*** series on April 15, 2020. The series is intended to provide clients with ongoing data-driven insight into the physician and advanced practice provider compensation and benefits-related practices that are being considered or implemented in response to COVID-19. This is the second survey in the series.

The ***COVID-19 Physician and Advanced Practice Provider Compensation Practices Survey Report II*** includes responses collected between May 6-13, 2020, from 104 leading health care organizations across the country with 71% of these participating in the first COVID-19 survey. These organizations represent some of the nation's largest integrated, academic, and pediatric hospitals and health systems ranging in size from $400 million to $14 billion in annual net revenue. The median annual net revenue of all participating organizations is $2.4 billion.

We expect that workforce practices will continue to evolve. In order to keep our clients up to date on emerging workforce issues related to COVID-19, SullivanCotter will monitor developments in real time. If you have additional questions or want to better understand how organizations are using the data, please reach out to a SullivanCotter consultant, call 888.739.7039 or email **covidinsights@sullivancotter.com** for the latest information and insights.

This report is organized into the following sections:

The following guidelines are used in this report:

- Organization-specific data are confidential. While participating organizations are identified in **Appendix A**, no attribution to an organization's actual data is provided.
- Participant counts (n) listed are based on the number of organizations that responded to each question unless otherwise noted.
- The survey reflects clinical leaders (see **Appendix B** for included positions), physicians and advanced practice providers (APPs).

Please note there is a companion ***COVID-19 Executive and Employee Compensation Practices Survey Report II*** available upon request.

As these are proprietary materials, we ask that you do not distribute or share this information with anyone outside of your organization without written consent from SullivanCotter. Your cooperation in this regard is greatly appreciated.

EXECUTIVE SUMMARY

April 2020 proved to be one of the most difficult months ever recorded for the health care industry given challenges related to the COVID-19 pandemic. These include:

- Loss of patient and employee lives and the need to develop treatment protocols for an unknown disease.
- Workplace safety issues created by the virus and personal protective equipment (PPE)/treatment shortages.
- Conversion of physical spaces to expand capacity for potentially overwhelming surges of COVID-19 patients.
- Increase in expenses related to ensuring COVID-19 readiness and greater financial instability resulting from the loss of revenue, the decline in volume, and the suspension of numerous patient care operations.
- Redeployment of the workforce to serve on clinical front lines and maintain operations remotely.
- Workforce layoffs and furloughs in situations of significant financial distress and/or patient care delivery disruption.

Relief from the CARES Act has modestly lessened the financial impact, but the future remains uncertain.

At the center of these challenges, the health care workforce remains an incredibly valuable asset. However, as compensation and benefits are often an organization's largest expense, this group has become increasingly vulnerable. Clinical and service workers have become heroes in fighting this battle, but some will find their livelihoods and economic security at risk. Additionally, hospitals and health systems are faced with escalating safety concerns for their workforce, patients and families.

Relative to workforce issues, health care organizations are responding to the crisis in a variety of ways. These actions are best classified as mitigation strategies as they plan their path to recovery. In situations of significant financial distress and/or disruption in patient services, many have begun to take more aggressive compensation-related actions.

This report provides an overview of our findings on the compensation and benefits-related decisions impacting each role. It also provides context as to how these decisions vary across the following data cuts:

- National (all participating organizations).
- Academic Medical Centers (AMCs).
- New Jersey, New York and Connecticut Tri-State Metro Area (Tri-State Metro Area).
- Faith-Based Institutions (any organization that identifies with a religious affiliation).
- Pediatric Institutions.
- Financial Performance Ranking: Assess financial sustainability, including cash ratio, total debt-to-capitalization and earnings before interest, depreciation and amortization (EBIDA) margin (see **Appendix B** for definitions).

Below is a comparison between the Phase I and Phase II survey results:

Organization-Wide Workforce Survey Findings

- Organizations have made more compensation-related changes as opposed to layoffs or furloughs, which is consistent with the initial report. However, given recent media reports and increasing financial pressure, we expect more layoffs or furloughs in the coming months.

Physician Workforce Survey Findings

- **Cash Compensation Protections:** There has been a decrease in the utilization of cash compensation protections from 58.5% to 47.6%. For those with cash compensation protections, slightly more than 40.0% have kept salaries whole based on historical compensation across all plan types and another 40.0%, approximately, have provided 75.0%-90.0% of historical compensation across all plan types.
- **Repayment of Cash Compensation Protections:** The prevalence of organizations considering repayment of cash compensation protections post-COVID-19 increased from 13.2% to 21.8% as organizations grapple with the financial realities of the protections they have provided.
- **Incentive Plan Changes:** Consistent with the initial report, the prevalence of incentive plan modifications remained unchanged (approximately 38.0%). The most prevalent considerations have been to reduce or eliminate the incentive plan. However, few have actually implemented the change.

APP Workforce Survey Findings

- **Redeployment:** 71.3% of organizations have redeployed or plan to redeploy non-front line APPs to front line specialties (compared to 78.6% initially).
- **Premium Compensation:** The prevalence of premium pay for APPs has remained consistent with 14.3% in the initial report and 16.8% in the current report.

Given increasing sensitivity to burnout, workforce retention has also been reported as a key concern in the health care community. As the crisis evolves and the industry makes plans for financial recovery and operational transformation, many changes are expected that will, in turn, affect the workforce and cause additional disruption in an already stressful environment.

Health care remains in unchartered territory as the industry faces a number of very serious challenges created by this pandemic. Organizations are relying on leadership instinct, ability and a commitment to mission to manage through these times and ensure workforce stability.

The following section provides more detailed observations and insights from the survey.

SECTION I: OBSERVATIONS AND INSIGHTS

Practices Applicable to Clinical Leaders, Physicians and APPs

Furloughs and Layoffs

- Approximately one-fifth (20.6%) of organizations reported that they are considering or have implemented layoffs or furloughs. Among these organizations, the prevalence of layoffs or furloughs for staff physicians and APPs outpace those of clinical leaders.

Compensation and Benefits

- Nearly half (48.5%) of organizations have reduced total cash compensation. This is more prevalent among clinical leaders than staff physicians and APPs.
  - Slightly less than one-third (31.6%) of organizations have implemented pay reductions for APPs and another 24.8% are considering. Similar results were reported for physicians with 39.6% of organizations having already implemented pay reductions and 29.7% considering pay reductions.
  - Typical reductions range from 10.0% to 15.0%.
- Approximately one-third (34.7%) of organizations are considering or have implemented changes to benefit programs. These changes include both enhancements as well as reductions to existing benefit plans.

Physicians

Premium Pay for Front Line Physicians

- Consistent with the initial report, 10.0% of organizations are considering or have implemented premium pay for front line physicians. The most common action reported is a one-time stipend/bonus.

Compensation Floors for Non-Front Line Physicians

- Nearly one-half (47.6%) of organizations have implemented a compensation floor to help stabilize the clinical workforce in the absence of elective procedures and normal patient volumes.
- The table below details the prevalence of the compensation floor structure by plan type:

Compensation Floor Structures	Prevalence by Plan Type			
	Productivity-Based Specialties (n=34)	Salary-Based Specialties (n=21)	Combination of Salary + Incentive (n=21)	Shift-Based Specialties (n=12)
Guarantee 100% of historical cash compensation	44.1%	42.9%	47.6%	41.7%
Guarantee between 75.0%-90.0% of historical cash compensation	41.2%	38.1%	38.1%	41.7%
Guarantee between 50.0%-74.9% of historical cash compensation	14.7%	9.5%	4.8%	8.3%
Other	0.0%	9.5%	9.5%	8.3%

Incentive Plan Actions

- For organizations with incentive plans for physicians (75.8%), nearly two-fifths (37.4%) are considering or have implemented changes to these plans in 2020. Actions reported include reducing or eliminating the incentive opportunity. However, to date, few organizations have yet to implement any formal incentive plan change. These results are consistent with the initial report.

Repaying Compensation Protections Post-COVID-19

- Approximately one-fifth (21.8%) of organizations plan to recoup compensation protections put in place during COVID-19. This percentage is higher than what was initially reported (13.2%).

Future Compensation Plan Changes

- Approximately one-quarter (24.5%) of organizations reported that they anticipate making changes to physician compensation plans as a result of COVID-19.
- The most prevalent anticipated change is a move away from a linear relationship between pay and productivity (40.9%). Another 18.2% indicated they are considering eliminating or delaying market adjustments and/or making reductions to physician compensation. Some organizations (13.6%) indicated plans to change the measurement period for incentive compensation.

Our Observations

- Given the financial pressures, we expect the use of premium pay practices to remain infrequent.
- As the situation evolves and the full financial impact of the pandemic hits, we anticipate more organizations will implement layoffs or furloughs as well as reduce and/or eliminate 2020 incentives.

Advanced Practice Providers

Premium Pay for Front Line APPs

- A slightly higher percentage of organizations reported providing premium pay to front line APPs as compared to physicians (16.8% vs. 10.0%). For those providing premiums, the most prevalent practice is to apply the premium to clinical work effort exceeding a 1.0 FTE.

Incentive Plan Actions

- Of organizations with incentive plans for APPs (63.3%), approximately one-quarter (22.4%) plan to modify these for 2020. The most prevalent actions reported include elimination of incentives altogether and reduction of incentive opportunity.

Future Compensation Plan Changes

- Fewer organizations indicated anticipated compensation plan changes for APPs than for physicians (15.8% vs. 24.5%). Salary freezes and reductions were equally reported as expected changes.

Our Observations

- Fewer organizations have made incentive plan changes for APPs as compared to physicians in response to COVID-19.
- Additionally, fewer reported anticipated post-COVID-19 structural changes to compensation plans. However, as states expand APPs' ability to practice independently, we may see a market shift as organizations look to more closely align physician and APP compensation and incentive practices.

COVID-19 Compensation Trends by Market Segment

COVID-19-related compensation policies and practices vary greatly across the country. Overall, among survey respondents, AMCs, those in the Tri-State Metro Area and organizations that came into COVID-19 with strong financial positions are taking less aggressive pay actions in comparison to the national market.

Below are other general trends by health care industry segment and financial performance ranking.

- **Academic Medical Centers (AMCs)**
  - AMCs are making fewer workforce changes relative to other health care organizations. Specifically, less than 5% of AMCs reported plans to lay off or furlough clinical leaders and staff compared to 30.6% of non-AMCs.
  - AMCs also reported a higher prevalence of premium compensation for front line physicians (20.0%) and APPs (25.6%) as compared to non-AMCs who reported 3.3% for physicians and 11.3% for APPs.
  - For physician and APP clinical leaders, 62.5% of AMCs reported no reductions were being made to pay or hours as compared to 44.3% of non-AMCs.

- **New Jersey, New York and Connecticut Tri-State Metro Area**
  - The Tri-State Metro Area continues to experience high patient demand and a decline in revenue due to COVID-19. Slightly more than three-fifths (62.5%) of Tri-State Metro Area organizations report that they are not expecting furloughs or layoffs for clinical leaders, physicians or APPs. The remaining indicated that they "do not know".
  - To help stabilize the workforce, the Tri-State Area reported a higher prevalence of compensation floors compared to the overall market (62.0% vs. 47.5%).
  - Additionally, only 25% of these organizations have implemented cash compensation cuts as compared to 48.5% of the national market.
  - In contrast, 50.0% have added premiums for front line physicians and 75.0% have added premiums for front line APPs (as opposed to 10.0% and 16.8% nationally, respectively). The most prevalent action reported is a one-time stipend.

- **Faith-Based Institutions**
  - More aggressive workforce and pay actions are being considered or implemented in faith-based institutions. Specifically, 36.4% reported that they are considering or have implemented layoffs or furloughs of clinical leaders and staff as compared to 20.6% of the national market.
  - Nearly three-quarters (70.0%) reported considering or having implemented total cash compensation reductions as compared to 48.5% of the national market.
  - Half (50%) have already modified or plan to modify 2020 incentive plans, 20% have eliminated the incentive, and 20% have reduced the incentive opportunity. This is compared to 37.4% of the national market.

- **Pediatric Institutions**
  - Compensation-related policies and actions that have been considered or implemented in pediatric institutions are comparable to the national market.
  - Specifically, 25.0% reported expected layoffs or furloughs for the clinical workforce as compared to 20.6% nationally, and 41.7% are considering or have reduced total cash compensation as compared to 48.5% nationally.

- Slightly more than one-quarter (27.3%) reported plans to reduce or eliminate incentives in 2020 for APPs and 60% are considering changes to physician incentives by either eliminating or reducing the incentive opportunity.

- **Financial Performance Ranking:** SullivanCotter selected three financial ratios to assess financial sustainability (see **Appendix B** for definitions):
  - Cash ratio.
  - Total debt-to-capitalization.
  - Earnings before interest, depreciation and amortization (EBIDA) margin.

- Survey respondents were broken into three categories: 'top third', 'middle third' and 'bottom third'.
  - Organizations in the 'top third' category have made minor workforce and compensation-related changes. Only 9.1% are considering or have implemented furloughs or layoffs compared to 19.0% of the 'middle third' and 40.0% of the 'bottom third'.
  - One-third of 'top third' organizations have reduced total cash compensation for clinical leaders, physicians and APPs as compared to 61.9% of the 'middle third' and 60.0% of the 'bottom third'.

SECTION II: SURVEY RESULTS

ORGANIZATION-WIDE POLICIES AND PRACTICES

Chart 1: Prevalence of Redeploying Non-Front Line Physicians to Front Lines (n=101)

Almost three-fifths (59.0%) of organizations have redeployed physicians versus the 44.6% who had done so previously.

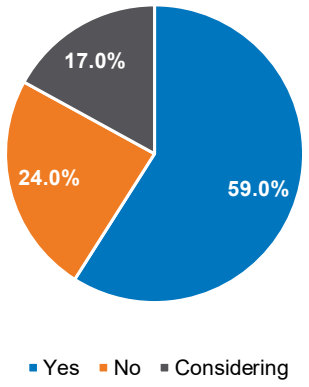


Chart 2: Prevalence of Temporary Compensation-Related Policies in Response to COVID-19 (n=104)

More than half (58.7%) of organizations have implemented temporary compensation-related policies for physicians and APPs. This practice is less common for physician and APP clinical leaders.

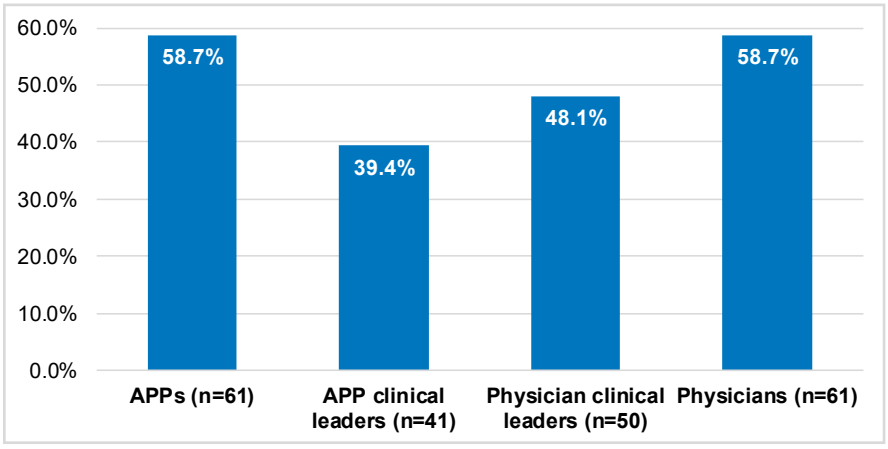


Chart 3: Prevalence of Layoffs or Furloughs as a Result of COVID-19 (n=102)

Only 20.6% of organizations have implemented or are considering COVID-19-related layoffs or furloughs. Furloughs have been implemented by 13.7% of organizations for APPs and 7.8% of organizations for physicians. To date, few organizations have implemented layoffs and the percentage of those considering layoffs remains less than 5% across all market segments. See **Chart 4** below for detailed responses.

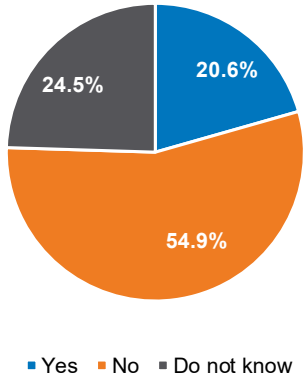


Chart 4: Layoffs or Furloughs by Position Category (n=102)

Position[1,2]	Layoffs		Furloughs		
	Considering	Implemented	Considering	Implemented	Average Furlough Length (Months)
Physicians	4.9%	1.0%	6.9%	7.8%	0.75
Physician clinical leaders	3.9%	0.0%	2.9%	2.9%	isd
APPs	3.9%	2.0%	4.9%	13.7%	1.00
APP clinical leaders	4.9%	0.0%	2.9%	5.9%	isd

[1]Note: Rows may not equal 100% due to 'Do not know' responses and columns will not add to 100% due to multiple response categories.
[2]Data in the table represent the number of respondents for each category divided by the total number of participants for each cut.

Chart 5: Prevalence of Cash Compensation Cuts Due to COVID-19 (n=101)

Less than half (48.5%) of organizations are considering or have implemented total cash compensation reductions for clinical leaders, physicians and APPs. The prevalence of this practice for physician and APP clinical leaders outpaces that of clinicians who are not in leadership roles. See **Chart 6** below for detailed responses.

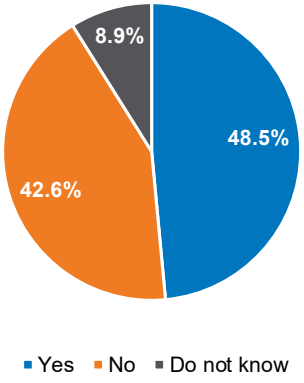


Chart 6: Cash Compensation Reductions by Position Category (n=101)

Position[1,2]	Considering	Implemented	Median Pay Cut
Front line physicians	11.9%	17.8%	11.0%
Non-front line physicians	17.8%	21.8%	15.0%
Physician clinical leaders	12.9%	29.7%	15.0%
Front line APPs	10.9%	15.8%	10.0%
Non-front line APPs	13.9%	15.8%	10.0%
APP clinical leaders	14.9%	19.8%	10.0%

[1]Note: Rows may not equal 100% due to 'Do not know' responses and columns will not add to 100% due to multiple response categories.
[2]Data in the table represent the number of respondents for each category divided by the total number of participants for each cut.

Chart 7: Prevalence of Benefits Program Changes (n=101)

Approximately one-third (34.6%) of organizations are considering or have implemented changes to benefits programs. Across all positions, the most prevalent actions reported have been to reduce retirement plan contributions, reduce CME allowances and/or days, and adjust paid time off (PTO — including increasing PTO allowance, requiring the use of PTO banks to cover reduced salaries or freezing PTO banks). See **Chart 8** on the following page for detailed responses.

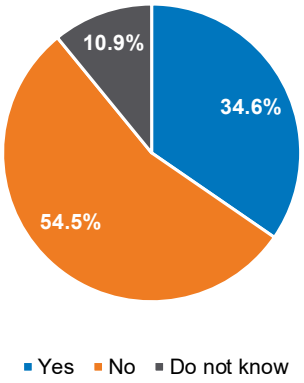


Chart 8: Benefits Program Changes by Position Category (n=101)

For organizations that have implemented benefits plan changes and provided additional clarity around those changes, the reported actions include the following:

- Eliminating or reducing retirement plan contributions and/or match.
- Changes to PTO policies including increasing the allowance, requiring the use of PTO banks to cover reduced salaries or freezing PTO banks.
- Eliminating or reducing the use of CME allowance (both days and CME expense reimbursement).

Benefit Plan Changes[1,2]	Clinical Leaders		Physicians		APPs	
	Considering	Implemented	Considering	Implemented	Considering	Implemented
Retirement contributions	6.9%	12.9%	6.9%	11.9%	5.9%	9.9%
CME allowances	5.0%	9.9%	5.0%	8.9%	5.0%	7.9%
Paid time off policies	7.9%	8.9%	7.9%	8.9%	5.9%	11.9%
Mental health benefits	3.0%	5.0%	3.0%	5.0%	3.0%	5.0%
Other	1.0%	3.0%	1.0%	2.0%	1.0%	2.0%

[1]Note: Rows may not equal 100% due to 'Do not know' responses and columns will not add to 100% due to multiple response categories.
[2]Data in the table represent the number of respondents for each category divided by the total number of participants for each cut.

EMPLOYED FRONT LINE PHYSICIANS

Chart 9: Prevalence of Compensation Premiums for Front Line Physicians (n=100)

For physicians in front line specialties, 10.0% of organizations are considering or have implemented premiums or one-time stipends. These findings are consistent with the initial report at 9.5%. See **Chart 10** below for detailed responses.

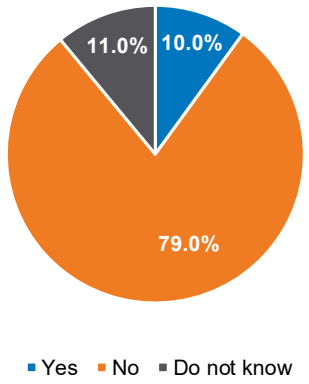


Chart 10: Premium Compensation Actions for Front Line Physicians (n=100)

Response[1,2]	Considering	Implemented
Premium applicable to all clinical coverage	0.0%	3.0%
Premium applicable only to clinical coverage above a 1.0 FTE expectation	1.0%	1.0%
One-time stipend/bonus	0.0%	5.0%

[1]Note: Rows may not equal 100% due to 'Do not know' responses and columns will not add to 100% due to multiple response categories.
[2]Data in the table represent the number of respondents for each category divided by the total number of participants for each cut.

NON-FRONT LINE EMPLOYED PHYSICIANS

Chart 11: Prevalence of Compensation Floors for Non-Front Line Employed Physicians (n=101)

Almost half (47.6%) of organizations are considering or have implemented temporary compensation floors to help physicians impacted by the elimination of elective visits and procedures. Another 15.8% indicated they 'do not know'.

Of the 36.6% who have not implemented a compensation floor:

- 36.1% are academic medical centers.
- 13.9% are pediatric institutions.
- 8.3% are cancer centers.
- 16.7% are in markets with significant capitated payor contracts.
- 25.0% are in other markets not identified above.

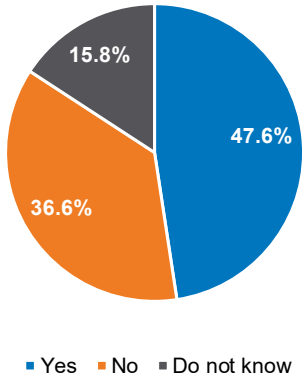


Chart 12: Prevalence of Compensation Floor by Plan Type (n=101)

Slightly less than one-third (31.7%) of organizations have implemented compensation floors for productivity-based specialties. Fewer organizations have implemented floors for salary-based specialties, combination (salary plus incentive) specialties and shift-based specialties — ranging from 15.8% to 23.8%.

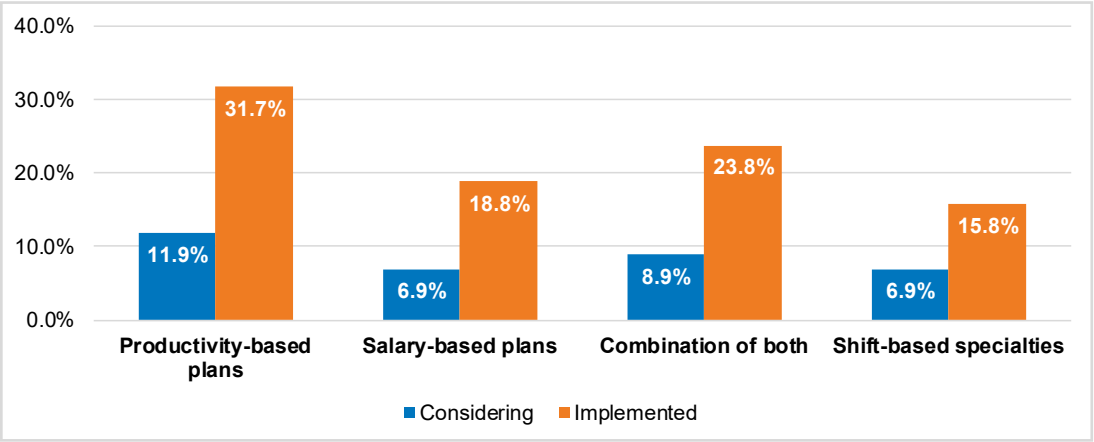


CHART 13: Actions to Address Temporarily Closed Clinics/Services for Non-Front Line Physicians (n=103)

Approximately two-fifths (40.8%) of organizations are considering or have implemented pay or workforce actions to address temporarily closed clinics/services for non-front line physicians. The most prevalent action reported is salary continuation (19.4%). Another 20.4% of organizations are considering or have implemented pay cuts. See **Chart 14** below for detailed responses.

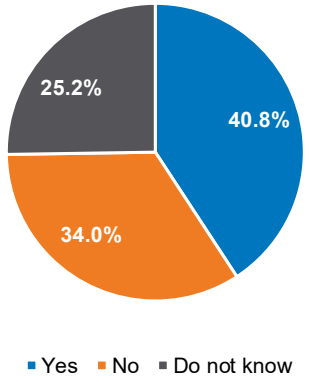


Chart 14.1: Pay Practice Actions for Temporarily Closed Clinics/Services (n=103)

Response[1,2]	Considering	Implemented
Require use of PTO banks	9.7%	10.7%
Take time without pay/furloughed	7.8%	8.7%
Salary continuation	5.8%	19.4%
Compensation reduction/pay cuts	11.7%	8.7%

[1]Note: Rows may not equal 100% due to 'Do not know' responses and columns will not add to 100% due to multiple response categories.
[2]Data in the table represent the number of respondents for each category divided by the total number of participants for each cut.

Chart 14.2: Workforce Practice Actions for Temporarily Closed Clinics/Services (n=103)

Response[1,2]	Considering	Implemented
Reduction in force	6.8%	1.0%
Redeploy physicians to front line areas	12.6%	21.4%

[1]Note: Rows may not equal 100% due to 'Do not know' responses and columns will not add to 100% due to multiple response categories.
[2]Data in the table represent the number of respondents for each category divided by the total number of participants for each cut.

ALL PHYSICIANS

Chart 15: **Prevalence of Modifying Non-Productivity-Based Incentives for 2020** (n=99)

Approximately three-quarters (75.8%) of organizations have incentives as part of their physician compensation program. Of these, approximately one-fifth (20.2%) are considering reducing the incentive opportunity. However, only 6.1% have implemented this action. Another 18.2% of organizations are considering eliminating the incentive opportunity for 2020, while 10.1% have already implemented this action. See **Chart 16** below for detailed responses.

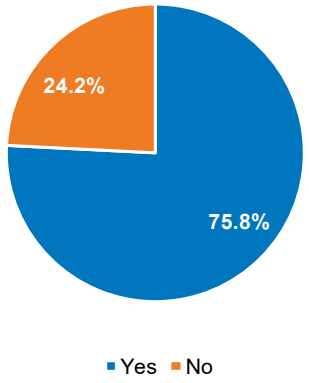


Chart 16: **Prevalence of Non-Productivity Incentive Plan Changes for 2020** (n=99)

Response[1,2]	Considering	Implemented
Modifying plan to add new incentive metrics related to COVID-19	11.1%	1.0%
Reducing the incentive opportunity	20.2%	6.1%
Eliminating incentive opportunity in 2020	18.2%	10.1%

[1]Note: Rows may not equal 100% due to 'Do not know' responses and columns will not add to 100% due to multiple response categories.
[2]Data in the table represent the number of respondents for each category divided by the total number of participants for each cut.

Chart 17: **Prevalence of Separate Compensation Policies for Physicians Developing COVID-19 Symptoms** (n=100)

Approximately one-third (34.0%) of organizations are considering or have implemented separate compensation policies for physicians developing symptoms of COVID-19. The two most common actions reported are full pay for the duration of the absence without requiring the use of PTO (17.0%) and providing the standard PTO and short-term disability policy (15.0%). See **Chart 18** on the following page for detailed responses.

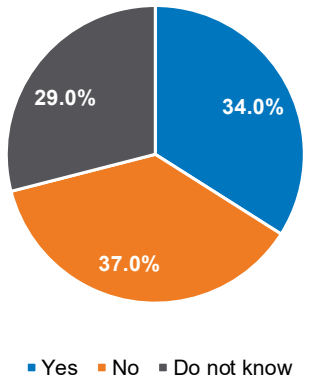


Chart 18: Actions Specific to Physicians Developing COVID-19 Symptoms (n=100)

Response[1,2]	Considering	Implemented
Full pay for the duration of their absence without requiring the use of PTO	2.0%	17.0%
Partial pay for the duration of their absence without requiring the use of PTO	3.0%	5.0%
Additional PTO available without penalty	2.0%	7.0%
Standard PTO and short-term disability policy	2.0%	15.0%

[1]Note: Rows may not equal 100% due to 'Do not know' responses and columns will not add to 100% due to multiple response categories.
[2]Data in the table represent the number of respondents for each category divided by the total number of participants for each cut.

ALL PHYSICIANS – POST-COVID-19

Chart 19: Prevalence of Repayment for Compensation Protections Post-COVID-19 (n=101)

Approximately one-fifth (21.8%) of organizations plan to require some level of repayment for compensation protections post-COVID-19. This is up from 13.2% in the initial report. Of those requiring repayment, 10.9% indicated a payback or future compensation withhold schedule will be implemented. Another 6.9% of organizations plan to require extended hours, extra shifts or weekends. See **Chart 20** below for detailed responses.

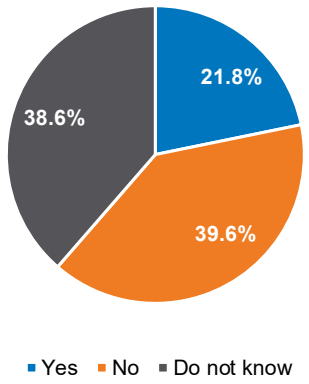
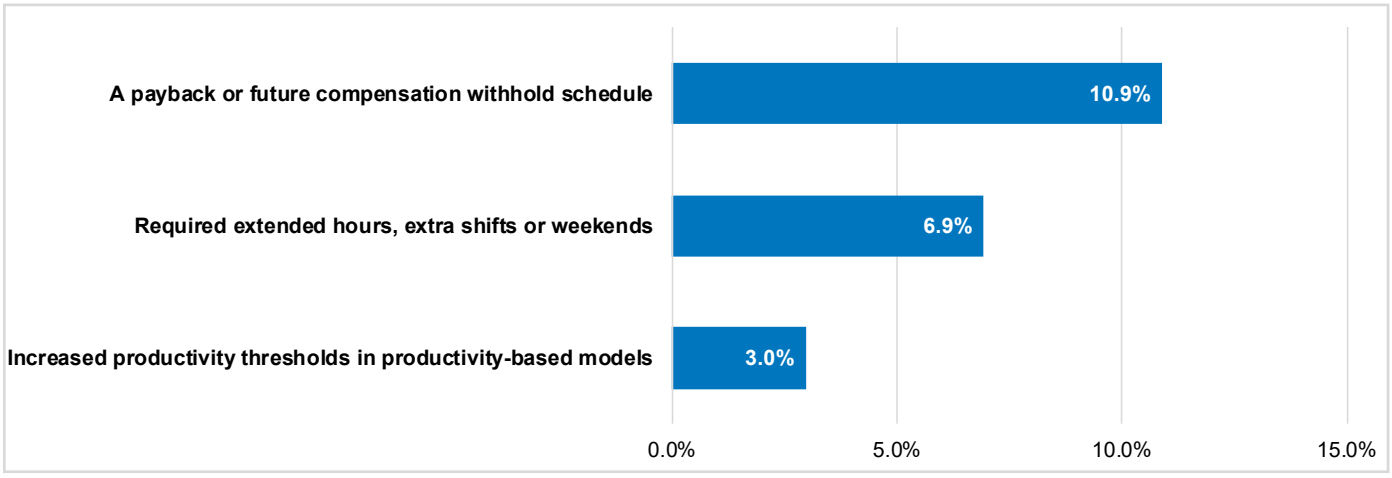


Chart 20: Repayment for Compensation Protections Post-COVID-19[1] (n=101)



[1]Note: Chart does not equal 100% due to multiple response categories.

Chart 21: Prevalence of Anticipated Compensation Changes Post-COVID-19 (n=102)

There is uncertainty related to potential impending design changes post-COVID-19 as 54.9% of organizations reported that they 'do not know'.

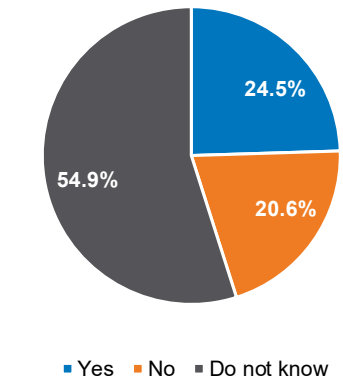
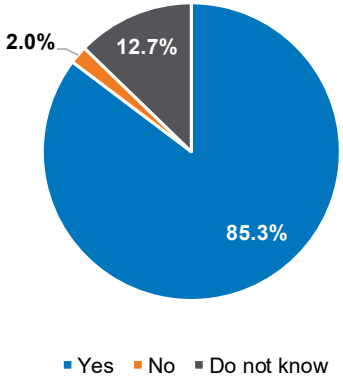


Chart 22: Intentions to Expand Telemedicine Activities Post-COVID-19 (n=102)

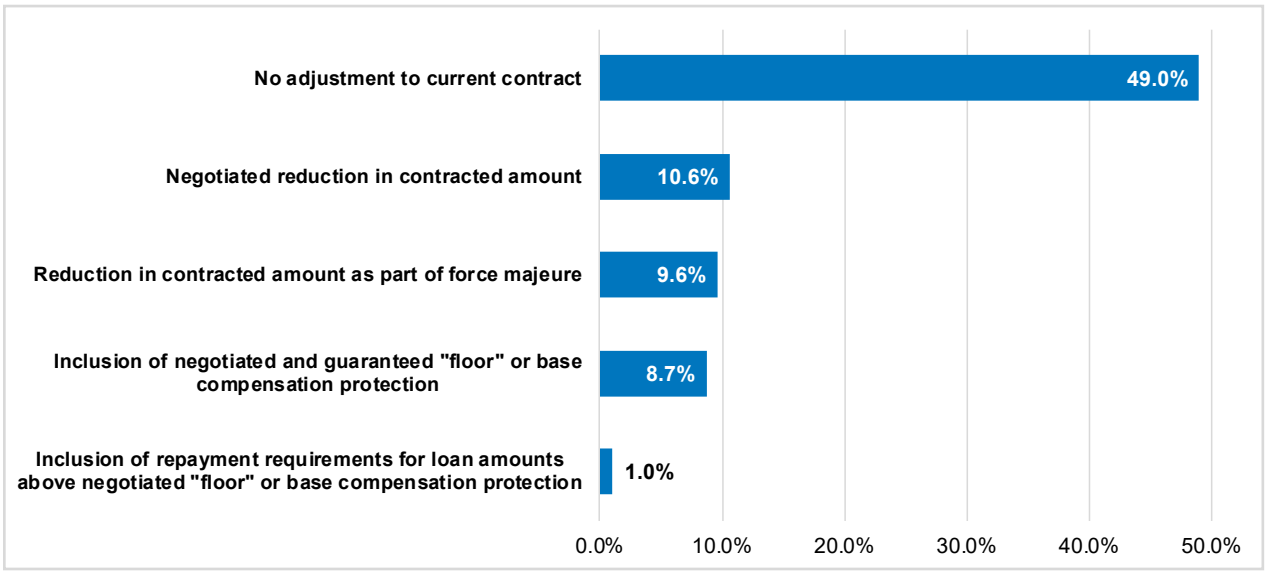
More than four-fifths (85.3%) of organizations reported plans to expand telemedicine activities post-COVID-19.



ALL PHYSICIANS – INDEPENDENT CONTRACTORS

Chart 23: **Prevalence of Compensation Actions for Independent Contractors**[1] (n=94)

Almost half (49.0%) of organizations have not made any adjustments to professional services agreements (PSAs) or other independent contractor arrangements. Another 10.6% of organizations indicated that reductions in contract amounts have already been negotiated, while 9.6% reduced the contracted amount as part of force majeure.



[1]Note: Chart does not equal 100% due to multiple response categories.

ADVANCED PRACTICE PROVIDERS

Chart 24: **Prevalence of Compensation Premiums for Front Line APPs** (n=101)

Consistent with the initial report (14.3%), 16.8% of organizations are considering or have implemented premiums or one-time stipends for APPs in front line specialties. The most prevalent practice is to apply the premium to shift/ hours outside of the standard expectation. However, this has been implemented by only 5.9% of organizations. See **Chart 25** on the following page for detailed responses.

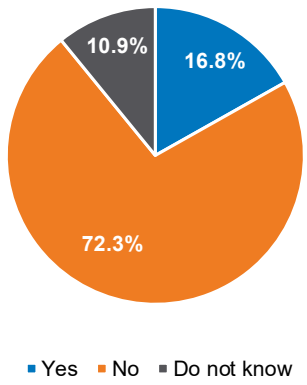


Chart 25: Premium Compensation Actions for Front Line APPs (n=101)

Response[1,2]	Considering	Implemented	Amount
Premium applicable to all clinical coverage	2.0%	3.0%	isd
Premium applicable only to clinical coverage above a 1.0 FTE expectation	2.0%	5.9%	isd
One-time stipend/bonus	3.0%	4.0%	isd

[1]Note: Rows may not equal 100% due to 'Do not know' responses and columns will not add to 100% due to multiple response categories.
[2]Data in the table represent the number of respondents for each category divided by the total number of participants for each cut.

Chart 26: Prevalence of Redeploying Non-Front Line APPs (n=101)

Slightly less than three-quarters (71.3%) of organizations have redeployed or plan to redeploy non-front line APPs to front line specialties. This is consistent with the initial report (78.6%).

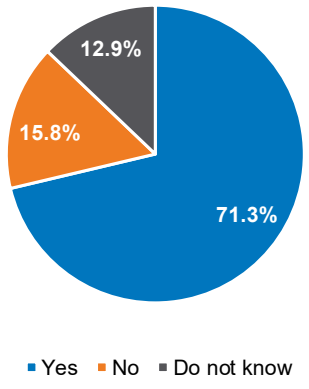


Chart 27: Actions to Address Temporarily Closed Clinics/Services for Non-Front Line APPs (n=100)

Less than half (44.0%) of organizations are considering or have already implemented pay and/or workforce actions to address temporarily closed clinics or services for non-front line APPs. Slightly more than one-quarter (27.0%) of organizations have redeployed APPs to front line specialties, which is higher than the 21.4% of organizations reported in the initial survey.

Almost one-fifth (18.0%) of organizations have implemented salary continuation as compared to 28.6% in the initial report. Conversely, the number of organizations requiring the use of PTO in temporarily closed clinics has increased from 9.5% to 19.0%. See **Chart 28.1 and 28.2** on the following page for detailed responses.

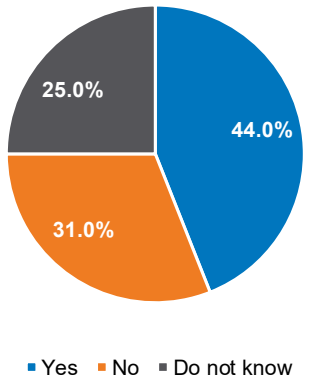


Chart 28.1: Pay Practice Actions for Temporarily Closed Clinics/Services (n=100)

Response[1,2]	Considering	Implemented
Require use of PTO banks	5.0%	19.0%
Take time without pay/furloughed	3.0%	16.0%
Salary continuation	5.0%	18.0%
Compensation reduction/pay cuts	7.0%	9.0%

[1]Note: Rows may not equal 100% due to 'Do not know' responses and columns will not add to 100% due to multiple response categories.
[2]Data in the table represent the number of respondents for each category divided by the total number of participants for each cut.

Chart 28.2: Workforce Practice Actions for Temporarily Closed Clinics/Services (n=100)

Response[1,2]	Considering	Implemented
Reduction in force	7.0%	2.0%
Redeploy APPs to front line areas	8.0%	27.0%

[1]Note: Rows may not equal 100% due to 'Do not know' responses and columns will not add to 100% due to multiple response categories.
[2]Data in the table represent the number of respondents for each category divided by the total number of participants for each cut.

Chart 29: Prevalence of Modifying APP Incentives for 2020 (n=62)

Of the 63.3% of organizations with APP incentives as part of the compensation structure, 22.4% plan to modify APP incentive plans for 2020. Of those organizations making incentive plan changes, 8.2% of organizations are considering reducing the incentive opportunity. However, this has been implemented by only 6.1% of organizations (up from 2.1% in initial report). Another 7.1% of organizations are considering eliminating the incentive opportunity (up from 6.2% in initial report), while 9.2% have already implemented this action. See **Chart 30** for detailed responses.

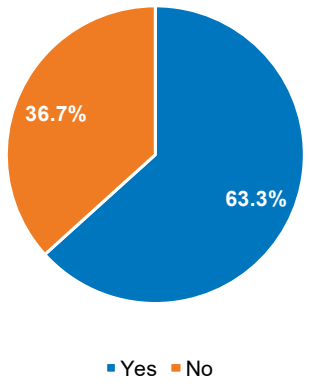


Chart 30: Prevalence of APP Incentive Plan Change Actions for 2020 (n=98)

Response[1,2]	Considering	Implemented
Modifying plan to add new incentive metrics related to COVID-19	7.1%	1.0%
Reducing the incentive opportunity	8.2%	6.1%
Eliminating incentive opportunity in 2020	7.1%	9.2%

[1]Note: Rows may not equal 100% due to 'Do not know' responses and columns will not add to 100% due to multiple response categories.
[2]Data in the table represent the number of respondents for each category divided by the total number of participants for each cut.

ADVANCED PRACTICE PROVIDERS – POST-COVID-19

Chart 31: Prevalence of Changes to APP Compensation Post-COVID-19 (n=101)

Approximately one-sixth (15.8%) of organizations plan to make changes to APP compensation post-COVID-19. Another 47.5% are unsure if compensation changes will be made in the next fiscal year. Responses were equally split between salary freezes and reductions (4.0%). See **Chart 32** for detailed responses.

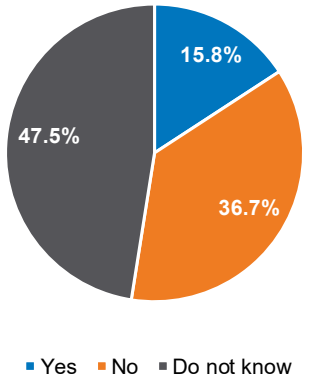
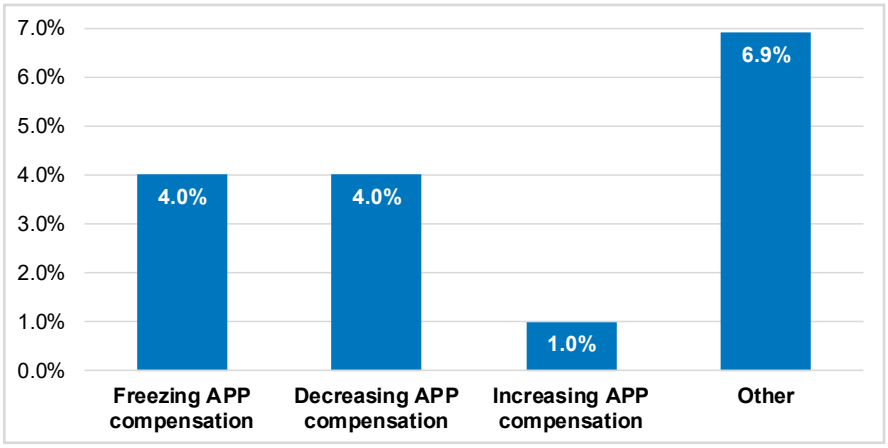


Chart 32: APP Compensation Changes Being Considered Post-COVID-19 (n=101)



[1]Note: Chart does not equal 100% due to multiple response categories

CLINICAL LEADERS

Chart 33: **Prevalence of Temporary Pay or Hours Reductions for Clinical Leaders** (n=101)

Approximately one-third (35.6%) of organizations are considering or have already implemented pay reductions or reductions in hours for clinical leaders. See **Chart 34** below for detailed responses.

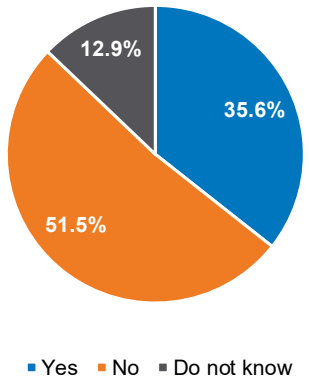


Chart 34: **Prevalence of Temporary Pay or Hours Actions for Clinical Leaders** (n=101)

Position[1,2]	Hours		Pay	
	Considering	Implemented	Considering	Implemented
Physician clinical leaders	8.9%	5.0%	6.9%	23.8%
APP clinical leaders	7.9%	6.9%	7.9%	16.8%

[1]Note: Rows may not equal 100% due to 'Do not know' responses and columns will not add to 100% due to multiple response categories.
[2]Data in the table represent the number of respondents for each category divided by the total number of participants for each cut.

APPENDIX A: SURVEY PARTICIPANTS

Organization	City	State
Adventist Health	Roseville	CA
Advocate Aurora Health	Downers Grove	IL
Albany Medical Center	Albany	NY
Allina Health System	Minneapolis	MN
Altru Health System	Grand Forks	ND
Aspirus	Wausau	WI
Atrius Health	Newton	MA
Banner Health	Phoenix	AZ
BayCare Health System	Clearwater	FL
Baylor College of Medicine	Houston	TX
Boston Children's Hospital	Boston	MA
Boston Medical Center	Boston	MA
Carilion Clinic	Roanoke	VA
Cedars-Sinai Health System	Los Angeles	CA
CentraCare Health	St. Cloud	MN
Children's Health System of Texas	Dallas	TX
Children's Healthcare of Atlanta	Atlanta	GA
Children's Hospital Colorado	Aurora	CO
Children's Minnesota	Minneapolis	MN
Children's National Health System	Washington	DC
CHOC Children's	Orange	CA
ChristianaCare	Wilmington	DE
Cook Children's Health Care System	Fort Worth	TX
Dana-Farber Cancer Institute	Boston	MA
Essentia Health	Duluth	MN
Excela Health	Greensburg	PA
Franciscan Missionaries of Our Lady Health System	Baton Rouge	LA
Geisinger Health	Danville	PA
Gundersen Health System	La Crosse	WI
Hackensack Meridian Health	Edison	NJ
Hartford HealthCare	Hartford	CT
Hennepin Healthcare System	Minneapolis	MN
Hospital for Special Surgery	New York	NY
Houston Methodist	Houston	TX
Indiana University Health	Indianapolis	IN
INTEGRIS Health	Oklahoma City	OK
Intermountain Healthcare	Salt Lake City	UT
Kelsey-Seybold Clinic	Houston	TX
Legacy Health	Portland	OR
Lehigh Valley Health Network	Allentown	PA
Lifespan	Providence	RI
Lucile Packard Children's Hospital at Stanford	Stanford	CA
Marshfield Clinic Health System	Marshfield	WI
Mayo Clinic Health System	Rochester	MN

Organization	City	State
Mayo Foundation	Rochester	MN
Memorial Health System	Springfield	IL
Memorial Healthcare System	Hollywood	FL
Memorial Sloan Kettering Cancer Center	New York	NY
Mercy	Chesterfield	MO
Michigan Medicine	Ann Arbor	MI
Moffitt Cancer Center	Tampa	FL
Mount Sinai Health System	New York	NY
New York-Presbyterian Healthcare System	New York	NY
Northwest Permanente	Portland	OR
Northwestern Memorial HealthCare	Chicago	IL
NYU Langone Health	New York	NY
Ochsner Health System	New Orleans	LA
OhioHealth	Columbus	OH
Oregon Health & Science University	Portland	OR
OSF HealthCare	Peoria	IL
Parkland Health & Hospital System	Dallas	TX
Penn State Health	University Park	PA
Presbyterian Healthcare Services	Albuquerque	NM
Renown Health	Reno	NV
Rochester Regional Health System	Rochester	NY
Rush University Medical Center	Chicago	IL
RWJBarnabas Health	West Orange	NJ
Saint Luke's Health System	Kansas City	MO
Sanford Health	Sioux Falls	SD
Sharp HealthCare	San Diego	CA
Southern California Permanente Medical Group	Pasadena	CA
SSM Health	St. Louis	MO
Sutter Health	Roseville	CA
Texas Children's Hospital	Houston	TX
The Carle Foundation	Urbana	IL
The Children's Hospital of Philadelphia	Philadelphia	PA
The Nemours Foundation	Jacksonville	FL
The Ohio State University Wexner Medical Center	Columbus	OH
The Queen's Health Systems	Honolulu	HI
The Southeast Permanente Medical Group	Atlanta	GA
The University of Texas Health Science Center at San Antonio	San Antonio	TX
Thomas Jefferson University	Philadelphia	PA
Tower Health	West Reading	PA
Trinity Health	Livonia	MI
UAB Medicine	Birmingham	AL
UCHealth	Fort Collins	CO
United Regional Healthcare System	Wichita Falls	TX
UnityPoint Health	West Des Moines	IA

Organization	City	State
University Hospitals	Cleveland	OH
University of California Health	Oakland	CA
University of Maryland Medical System	Baltimore	MD
University of Pennsylvania Health System	Philadelphia	PA
US Acute Care Solutions	Canton	OH
UVA Health	Charlottesville	VA
UW Health	Madison	WI
Valley Health System	Ridgewood	NJ
Vidant Health	Greenville	NC
Virginia Mason	Seattle	WA
Vituity	Emeryville	CA
Washington Permanente Medical Group	Seattle	WA
WellSpan Health	York	PA
WellStar Health System	Marietta	GA
WVU Medicine	Fairmont	WV
Yale New Haven Health System	New Haven	CT

APPENDIX B: SURVEY DEFINITIONS

Clinical Leaders:

- Program Directors
- Medical Directors/Chiefs
- Chairs
- APP Leaders

Financial Positions:

Based on specific financial pressures imposed on the health care industry due to the postponement and cancellation of elective procedures and other impacted revenue streams, three financial ratios were selected to assess financial susceptibility/sustainability prior to the COVID-19 outbreak:

- **Cash Ratio:** Measures an organization's ability to repay its short-term debt obligations with cash and cash equivalents. Calculated as cash and cash equivalents divided by current liabilities.
- **Total Debt-to-Capitalization:** Measures the total amount of outstanding debt as a percentage of the organization's total capitalization (total debt plus total unrestricted net assets). Calculated as the three-year average of total debt divided by total debt plus total unrestricted net assets.
- **Earnings Before Interest, Depreciation, and Amortization (EBIDA) Margin:** Measures how much profit a company makes on a dollar of sales after paying for variable costs of production, such as wages, but before paying depreciation, amortization, interest and nonoperating costs. Calculated as the three-year average of EBIDA divided by net operating revenue.

Data reflect a three-year average (2016, 2017, 2018). Organizations are broken into top third, middle third and bottom third for this ranking.

APPENDIX C: ABOUT SULLIVANCOTTER

SullivanCotter partners with health care and other not-for-profit organizations to drive performance and improve outcomes through the development and implementation of integrated workforce strategies. Using our time-tested methodologies and industry-leading research and information, we provide data-driven insights and expertise to help organizations align business strategy and performance objectives – enabling our clients to deliver on their mission, vision and values.

For more information, visit www.sullivancotter.com or call 888.739.7039.