

**RECRUITING, REVITALIZING & DIVERSIFYING:  
EXAMINING THE HEALTH CARE WORKFORCE  
SHORTAGE**

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**HEARING**  
BEFORE THE  
SUBCOMMITTEE ON EMPLOYMENT AND WORKPLACE  
SAFETY  
OF THE  
COMMITTEE ON HEALTH, EDUCATION,  
LABOR, AND PENSIONS  
UNITED STATES SENATE  
ONE HUNDRED SEVENTEENTH CONGRESS  
SECOND SESSION  
ON  
EXAMINING THE HEALTH CARE WORKFORCE SHORTAGE, FOCUSING ON  
RECRUITING, REVITALIZING AND DIVERSIFYING

—————  
FEBRUARY 10, 2022  
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Printed for the use of the Committee on Health, Education, Labor, and Pensions



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U.S. GOVERNMENT PUBLISHING OFFICE

48-900 PDF

WASHINGTON : 2023

Available via the World Wide Web: <http://www.govinfo.gov>

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# **RECRUITING, REVITALIZING & DIVERSIFYING: EXAMINING THE HEALTH CARE WORKFORCE SHORTAGE**

**Thursday, February 10, 2022**

U.S. SENATE,  
SUBCOMMITTEE ON EMPLOYMENT AND WORKPLACE SAFETY,  
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,  
*Washington, DC.*

The Subcommittee met, pursuant to notice, at 10:03 a.m., in room 430, Dirksen Senate Office Building, Hon. John Hickenlooper, Chairman of the Subcommittee, presiding.

Present: Senators Hickenlooper [presiding], Murray, Baldwin, Rosen, Braun, Cassidy, Tuberville, and Romney.

## **OPENING STATEMENT OF SENATOR HICKENLOOPER**

Senator HICKENLOOPER. The Subcommittee on Employment and Workplace Safety will come to order. Today we are discussing health care workforce, specifically how we can revitalize and reinvigorate the workforce we will need for the next several decades.

Ranking Member Braun, who is even more of an expert than some of our panelists in his own way as an employer, Ranking Member Braun and I will each have an opening statement, then we will introduce the witnesses. After the witnesses have given their testimony, Senators will have 5 minutes each for a round of questions.

While we were unable to have the hearing fully opened to the public or media for in-person attendance, live video is available on our Committee website, *help.senate.gov*. Senator Braun and I have invited Members outside the Subcommittee to participate in today's hearing, and we will look forward to them being a part of this conversation as well.

There is no doubt that during the pandemic, health care workers have worked tirelessly on the front lines and faced, in many circumstances, unimaginative—unimaginable challenges. However, the critical needs of the health care workforce were here before, and we will extend well beyond COVID unless we act.

The Association of American Medical Colleges estimates that we will face a shortage of up to 124,000 physicians by 2034. We will also need to hire at least 200,000 nurses per year to meet the increased need. Just in Colorado, we are facing an estimated shortage of 10,000 nurses over the next 5 years.

We are also facing a critical shortage of medical support staff, like medical assistance and nursing assistants. If we are going to make a dent in these daunting estimates, we need to get started now. I am glad to welcome our excellent witness panel, who are themselves working tirelessly to make progress in creating a pipeline of talent to take us into the future. We need to improve the recruitment, retention, and upskilling opportunities of our health care workers.

If they are—if we are serious about growing the field, we should make it easier for those without college degrees, for working parents, and for those without previous experience to break into early stage health care jobs. For those who are in mid-career or wanting a change, we should allow more opportunities to upskill and progress forward. And we need to recognize the importance of having a health care workforce that looks like America and brings diverse experiences to the medical field.

We need to increase diversity of representation among health care workforce to reflect the communities that they serve. One way is to invest early in expanding STEM education and mentorship opportunities for students in the health professions, particularly students of color. Health care can be a vibrant, rewarding profession, but we have to give today's health care workers and future health care workers opportunities to learn and thrive and grow at every level.

If we want to combat the current burnout and build a robust, diverse workforce in the future, this has to be a priority. I can't think of a topic more important, and I look forward to hearing our witnesses' testimony about how we can make progress in the weeks and years ahead.

We have got so much outreach and interest in this hearing, which really does show what a pressing issue it is. I would like to ask unanimous consent at this point to enter 13 letters into the hearing record from various organizations, including letters from the American Academy of Family Physicians, National Nurses United, and the University of Colorado, among others. No objections. Good.

[The following information can be found on pages 59 through 85 in Additional Material:]

Now, I will recognize Ranking Member Braun for his opening statement.

#### OPENING STATEMENT OF SENATOR BRAUN

Senator BRAUN. Thank you, Chairman Hickenlooper. This is an interesting discussion for me because since I have come to the Senate, the high cost of health care, especially from the point of view of an employer.

I had my own business for 37 years and it was so small for so long, shared it with some earlier, that it wasn't really a concern. It got to be as we grew from 15 employees into that next and most recent 20 years, 300, and now 1,250. Three of my four kids, along with a good young executive team run that business. I stay closely in touch with it.

Health care has been navigating through a lot of challenges. When you look across the world, we spend about 18 to 20 percent of our GDP on health care. The rest of the world has similar, if not better outcomes, in some cases for half that cost. We were in the throes of that challenge and then you get hit by the biggest pandemic health care challenge, it really shows a system where its weaknesses are.

I can't talk about it today, but I think beyond what we are going to try to focus on today, health care has got to be a priority for the health care consumer. When I changed my plan 15 years ago, most individuals weren't interested in prevention and wellness, they were interested in remediation at whatever the cost was. I flipped the paradigm upside down.

I think the industry has catered to mostly remediation, and I think it needs to focus as we get through shortages in workforce in offering the health care consumer more information about how you avoid the system by staying healthy and prevention. It is the underpinning of what I did, in addition to making my employees health care consumers. Let us look at where we are now.

In December 2021, 10.9 million job openings. About 15 percent of these openings were in the health care industry. On the front line, had to put up with this formidable foe that we had no idea where it was going to take us. In October 2021, a report by Morning Consult found that 18 percent of health care workers, imagine that, quit their jobs. You can see why. They were there having to put up with the uncertainty of how this was going to work out, 31 percent thinking about leaving.

I mean, most businesses can't take abruptly a 5 percent exit, let alone this. You know, when you look at shortages like this, it is always worse in some places. And I come from a State like Indiana, many of our States have a rural component. We found out we don't even have rural broadband in most places when you need to have it, when you are working away from home, or even in—as it relates to health care.

It involves other issues as well. How do we get through it and how do we get workforce in the place that has been most ravaged by the events, the health care industry itself? I think it is going to take an interesting combination of the health care industry, hospitals, practitioners, insurance companies, even pharma to know that you are going to have to take some of the burden yourselves. That you can't rely on Government to do this.

When it comes to how we educate our health care workforce, we have got to look at that in the same way as we are in many other areas. In my home State of Indiana, pre-COVID, we had probably 60,000 to 80,000 jobs that couldn't be filled because we weren't guiding our kids in middle school and high school to maybe look at the opportunities.

We were stigmatizing many of these pathways that don't require a 4-year degree. In my experience in my own business is when we have a 4-year degree opening, we get flooded with applicants. We need better life skills, better guidance in those most formative years, and I think parents would buy into that. They have had enough issues of a kid gone after a 4-year degree, ending back in

the basement, when maybe they would have needed just other common sense options put out there.

I think that across the board we spent a lot of money, \$178 billion to the provider relief fund. It will take more than just spending money. And that is what we do best here. We borrow 23 now, up close to 30 percent of it. We have to have better ideas that are hard to arrive at a solution.

Most of us in the real world don't have a printing press in the basement, and we have got to do it with limited resources in the rigor of competition. I think Government is got to take some of those cues in terms of what we need to do better. So I am glad we are having this hearing. Workforce is an issue across all States.

It is now the biggest deal, the biggest issue in the biggest sector in our economy. And when you look at the percentages of how many have left, how many are considering leaving, we have got to make sure we are at least coming up with some good ideas and not necessarily just spending money on the problem.

Senator HICKENLOOPER. Thank you, Ranking Member Braun. I appreciate that. I appreciate that perspective. Now what we will do is allow each of our witnesses to have 5 minutes, and at some point Chair Murray will be here and we will let her do her opening statement when she gets here as well.

Senator CASSIDY. Senator Hickenlooper, we will have the opportunity to introduce the witness?

Senator HICKENLOOPER. You will certainly will. And you probably have a busy schedule, so I will even let you go first with Senator Cassidy. So why don't I turn it to you for that Member privilege.

#### OPENING STATEMENT OF SENATOR CASSIDY

Senator CASSIDY. I appreciate that consideration. Thank you, Chairman Hickenlooper and Ranking Member Braun. It is my honor to introduce Reynold Verret, the sixth President of Louisiana Xavier University, one of Louisiana is historically black colleges and universities.

Dr. Verret is a proven leader in higher education, fostering an innovative university environment to address underrepresentation in medicine and other fields, and to respond to the workforce needs of today. Dr. Verret is also an accomplished biochemist and immunologist. And if you look at his tie, I think that is the periodic table, which I know that Senator Hickenlooper would recognize.

He participated in the COVID-19 vaccine trials and has been a vocal advocate in my State for folks to take the vaccine. From the start of the pandemic, Dr. Verret and Xavier have worked with local health agencies and hospitals to host mobile testing centers and to set up a fully operational COVID-19 testing lab to serve local communities and Xavier's campus.

Before being President of Xavier, Dr. Verret was Provost at Savannah State and Wilkes University, a Dean at the University of the Sciences in Philadelphia, Faculty and Department Chair at the Chemistry Departments of Tulane University and Clark Atlanta University, and an Adjunct Professor of Immunology at the Tulane

and Morehouse School of Medicine and has conducted cancer research at MIT.

As a former academician, I am impressed with that resume. But I would say that Dr. Verret's leadership throughout the pandemic has been equally or more impressive. Dr. Verret clearly understands the challenges facing HBCUs in today's environment and the urgent need to address underrepresentation of racial minorities in the medical and health science fields.

I am pleased to have worked with Dr. Verret on my bill with Senator Schatz, the John Lewis National Institute on Minority Health and Health Disparities Research Endowment Revitalization Act that would provide additional funding to HBCUs to research health disparities and to promote the diversity and strength of the science workforce.

We need leaders like Dr. Verret that speak to the challenges to plot the way forward, and to help find solutions in recruiting a larger and more diverse health care workforce. With that, I yield.

Senator HICKENLOOPER. Thank you. Appreciate that—that warm introduction. Now I will take over again for two introductions and then we will revert to Senator Braun for the last introduction. First, I would like to introduce Dr. Margaret Flinter from Middletown, Connecticut. She is the Senior Vice President and Clinical Director of the Community Health Center, Inc..

She Chairs the Board of Directors, National Nurse Practitioner, Residency and Fellowship Training Consortium. I think it is fair to say that over these many decades, she has helped transform the Community Health Center, Inc. not only into one of the Nation's largest federally qualified health centers, but one of the most innovative health system networks of any category in the country.

I know, I remember firsthand when they first began doing telemedicine back in the 1990's, before it was common, and certainly it was difficult to be able to do any billing for it at all. Anyway, thank you so much for being here, Dr. Flinter.

Next, I am going to introduce Norman Quinones. She is a Nursing Services Manager for Clinica Family Health in Lafayette, not Lafayette, Louisiana, but Lafayette, Colorado. She is a Site Coordinator for the National Institute of Medical Assistant—Medical Assistant Advancement, NIMAA.

Ms. Quinones started working at Clinica in 1992 as a Medical Assistant and has served in a variety of leadership roles, and I know for a fact that she is one of the people that holds Clinica together and helps them succeed in one of the most challenging and diverse, geographically diverse, as well as diverse among people, health care systems in the West and certainly in Colorado by a long measure.

As I've said, she is from Lafayette, Colorado. I love the fact that she is next to Dr. Verret. We have the Lafayette kind of group together. We are delighted to have you here, Ms. Quinones. And now I am going to turn the last introduction over to my friend from Indiana, Senator Braun.

Senator BRAUN. Thank you. You will also be hearing from Rachel Greszler, a Research Fellow in the Economics, Budget and Entitle-

ment Center at the Heritage Foundation. Her area of focus is on labor and retirement policies. And previously served as a Senior Economist on the staff of the Joint Economic Committee of Congress for 7 years. Thanks for joining us today, Rachel. I look forward to hearing from you.

Senator HICKENLOOPER. Perfect. Alright, so we will then start. Dr. Flinter, why don't you start and then we will go right down, right down along the table.

**STATEMENT OF MARGARET FLINTER, PH.D., APRN, SENIOR VICE PRESIDENT AND CLINICAL DIRECTOR, COMMUNITY HEALTH CENTER, INC., AND CHAIR, BOARD OF DIRECTORS, NATIONAL NURSE PRACTITIONER RESIDENCY AND FELLOWSHIP TRAINING CONSORTIUM, MIDDLETOWN, CT**

Ms. FLINTER. Perfect. Can you hear me?

Senator HICKENLOOPER. Yes.

Ms. FLINTER. Perfect. Well, good morning, Chairman Hickenlooper and Members of the Senate HELP Committee, and Members of the Employment and Workplace Safety Subcommittee. Thank you so much for having me here today. I hope to convey to you in my few minutes the urgency of the health care situation and to identify strategies that are working and that we can build upon.

Primary care is in a crisis, as you have already alluded, between burnout, early retirement, an aging workforce, and competition with other medical specialties. As Senator Hickenlooper said, we are headed for a predicted shortage of almost 130,000 physicians by 2030.

At the same time, the aging of the U.S. population, the impact of complex and multi chronic illness, and the persistent health disparities that we are also aware of all combined to make the need for every individual, every family, every community to have access to high quality primary care ever more important.

The National Institute of Science, Engineering and Medicine's landmark 2021 report, issued just a few months ago, has laid out a blueprint of what needs to be done. Where is the next generation of primary care providers going to come from? I answered, it is already here.

Nurse practitioners are here in number, and they are focused on primary care, but they want, need, and deserve the opportunity for post-graduate residency or fellowship training, similar to what their colleagues in medicine, dentistry, and other health professions have enjoyed in order to prepare for, practice, and settings in which the nurse practitioner is the bedrock, the core, and the foundation of primary care.

Today I want to speak to what we are doing to address this and what remains to be done. I am going to focus on primary care providers today, but my comments are also relevant to psychiatric mental health nurse practitioners and to these specialty care and hospital outpatient setting and inpatient setting.

15 years ago, based on both research and experience, I recognized it was a time for a major innovation and training for new nurse practitioners who are committed to being primary care pro-

viders and particularly in our safety net settings like community health centers, like rural health centers.

We were asking them to embrace the full scope of primary care practice from the start. But we saw firsthand what one new nurse practitioner called the shock and awe of seeing just how sick people can be in primary care and how complex the care was in our settings like community health centers. And while all new nurse practitioners are prepared and competent for entry level practice, what we say is there are very few entry level patients in our settings and community health centers and in rural health.

This gap between preparation and practice quickly gives rise to burnout, frustration, and too often we saw early departure by nurse practitioners from full scope primary care roles and the practices that so need them. And so, in 2007, the Community Health Center developed and piloted the country's first formal post-graduate residency training program for new nurse practitioners.

We did it with four new nurse practitioner residents, but with a commitment to building a model that others could replicate across the country. This intensive yearlong training has given rise to a national movement. There are now 250 postgraduate NP residency and fellowship training programs specializing just in primary care in the United States and many more in this specialty and acute care settings as well.

Just in community health centers, there are now 75 programs, some are joint nurse practitioner MPA programs. These programs are very carefully designed and structured to ensure intensive clinical training with expert preceptors, the development of mastery and caring for highly challenging conditions such as opioid use disorder, multi-chronic illness.

But the training also includes the skills to improve practice as well as deliver care to provide the most effective prevention and health promotion care, and the resilience to thrive as primary care providers and members of a high performing team, which must of course, include our medical assistance, our nurses, our community health workers, and our behavioral health clinicians.

What started as a model has grown into a movement and research indicates that nurse practitioner graduates of post-graduate training programs remain in primary care and underserved practices at higher rates compared to national averages. They are also more likely to mirror their patient populations. They are more diverse, and they serve more underserved populations.

An initial concern that creating such programs implied that nurse practitioners were somehow lacking has given way to a recognition that this is simply what new nurse practitioners want and deserve, and 77 percent of newly graduated NPs report that they would like to do a post-graduate residency program, if one were available. In 2019, HRSA's Bureau of Workforce funded 36 of these programs that is only 36 of the 250 in the country. They required that they be accredited in order to assure rigor in their program, rigor and quality.

We are happy to say to a Consortium, of which I serve as chair, is recognized by the Department of Education as an accrediting or-

ganization. I want to say that in my work with the Consortium, I have had the pleasure of visiting NPR residency programs across the country, from the State of Washington to Maine, from Hawaii to Alabama, and many points in between, including Indiana.

I am deeply impressed by the commitment of the boards, the executive and clinical leaders, and the frontline clinicians and staff to this model because it works. It works in attracting those for whom the desire to serve and care for people as a primary care provider is both a profession and a calling.

It works in retaining them in our most challenging practices as primary care providers and as future leaders in health care. But these programs need Federal support to continue this work and for new programs to start. As I have said, HRSA has stepped up with a small program for 36, but we need more.

Today, I focused on the nurse practitioner as a primary care provider, but I know firsthand we need to devote our attention to every member of the team. I am so glad that Norma Quinones is speaking to you today about medical assistance.

Thank you for your concern, for your commitment to our health care workforce, and to our people and communities that rely on us for this primary care. Thank you so much.

[The prepared statement of Ms. Flinter follows:]

PREPARED STATEMENT OF MARGARET FLINTER

Good Morning Chairman Hickenlooper, and Members of the Senate Health, Education, Labor and Pensions Employment Subcommittee. Thank you for the opportunity to speak to this Committee.

We need to ensure that every person and every family in every community has the opportunity to get high quality primary care. Thus, we have a vital need to ensure that we are training the next generation of primary care providers to make that possible. Today, I will speak not just to the need, but to what is being done to meet that need. I am going to focus primarily today on primary care providers and the primary care setting but my comments are also relevant to psychiatric/mental health care and specialty care.

We know the United States has an urgent short and long term need for expert primary care providers. The National Academy of Sciences, Engineering and Medicine's landmark 2021 report, *Achieving High Quality Primary Care*, (Phillips et al., 2021) has laid out a blueprint of what must be done to achieve high quality primary care for all people but it does this against a backdrop of a projected shortage of 130,000 physicians. (Zhang et al., 2020) This comes at a time when the healthcare needs of the population have never been more intense due to an aging population, the burden of chronic illnesses, and persistent health disparities by race, income and ethnicity. And of course, COVID has left its mark everywhere.

Where will the next generation of primary care providers come from? I answer: they are already here. They are nurse practitioners. But we have to give them the opportunity to train and prepare for practice and settings in which they are the bedrock, core, and foundation of primary care in the U.S.

Nothing is static in life or health care. Fifteen years ago, based on research and decades of experience, I recognized that it was time for a major innovation in training for NPs committed to being primary care providers, particularly in community health centers and rural and underserved areas. We needed them to be ready and able to embrace the full scope of primary care practice when they entered practice right from the start. We saw firsthand the "shock and awe", as one new NP described it, at just how sick the patients are, and how complex the care is. While all new NPs are prepared and competent for entry level practice, we recognized that there are few "entry level" patients in our very busy and stressed underserved communities and settings. This gap quickly gives rise to burnout and frustration. Too often we witnessed early departure of nurse practitioners from the very settings that needed them the most. The solution we proposed was formal postgraduate residency or fellowship training. This intensive yearlong training in the practice setting

gives new NPs the opportunity to develop the confidence, competence, and mastery to undertake full scope practice in settings both rural and urban, and to embrace the full range of primary care services.

In 2007, my colleagues and I designed and launched the first postgraduate residency program to support this level of intensive hands-on NP preparation at Community Health Center, Inc. (Flinter, 2011) We did it with 4 NP residents and a commitment to designing a model that could be replicated nationally. Today, there are 250 postgraduate NP residency and fellowship training programs specializing in primary care in the U.S. Seventy five are sponsored by FQHCs and an additional 20 six are sponsored by academic partners but carried out in an FQHC. The programs are carefully constructed to ensure progressive, intensive clinical training with expert preceptors, development of mastery in caring for highly challenging conditions such as substance use disorder, HIV, multiple chronic illnesses, and all intertwined with adverse social determinants of health and all while promoting wellness, prevention, and health promotion. The NP Residents are trained in the science of improving practice as well as delivering care. The programs provide the experience and skills for new NPs to practice as part of a high performing team, which leverages the contributions of medical assistants, RNs, behavioral health clinicians and, increasingly, community health workers.

What started as a model has grown into a movement because it works. Research indicates that graduates of postgraduate training programs remain in primary care and underserved practices at high rates compared to national averages. In a nationally representative study conducted last year, primary care NPs with residency training were also more likely to mirror their patient populations (were more diverse) and also saw more underserved populations (minority populations with limited English proficiency. (Park et al., 2022)

An initial concern of some that the creation of postgraduate training implied that NPs were somehow lacking has given way to recognition that this is what new NPs want and deserve. In a recent national survey, 77.5 percent of newly graduated NPs reported they were either “willing” or “very willing” to participate in a postgraduate training program. (Faraz, 2015) We are asking them to be the backbone of primary care, and they deserve the opportunity to choose intensive postgraduate primary care training, appropriate in length and content to today’s primary care practice models.

Pragmatically, the model addresses the most urgent need for primary care organizations: recruiting and retaining an expert primary care workforce. Today, we recognize that this must include training psychiatric/mental health NPs as a vital part of the primary care team to address behavioral health and substance use disorders. Many of the original NP Residency programs are expanding to include tracts for psychiatric/mental health NPs. And while today’s testimony is focused on primary care, I want to stress that our colleagues in in-patient and specialty outpatient settings have identified the same needs, and concluded that postgraduate residency and fellowship training is essential for new NPs and PAs in their settings as well.

In 2019, HRSA’s Bureau of Health Workforce recognized the value and impact of postgraduate training for new NPs with a new program, ANE-NPR, and funded a combination of 36 new and established programs. HRSA added requirements that programs seek and obtain accreditation, and also establish academic practice partnerships. It subsequently received modest appropriations in 2019 and 2020 to further support the program. In 2020–2021, 368 NP residents were supported by the program according to HRSA’s data warehouse.

The National Nurse Practitioner Residency and Fellowship Training Consortium (NNPRFTC or simply, “the Consortium”) was created to ensure quality and rigor in postgraduate NP training through formal accreditation. It has earned recognition by the U.S. Department of Education as a federally recognized accrediting organization. The Consortium also works with new and existing programs to design their programs from the start using accreditation standards to provide a roadmap to a rigorous, successful program.

How much impact can we have on the goal of ensuring that every person and every family have access to great primary care and a primary care provider? The Consortium’s accredited programs plus a group of programs with whom CHC has formally collaborated can document 550 alumni. With 250 programs nationally and a conservative estimate of four postgraduate trainees per program, we can assume up to 1,000 new NPs may now be able to choose a program—far more than just a few years ago, but far less than is needed. We are able to track where alumni of the Consortium’s accredited programs practice upon completion of the program. The vast majority are practicing as primary care providers, mostly in community health

centers and underserved areas. We need to continue to support the currently funded programs, expand access to new programs, and support those that have devoted scarce resources to standing up a program on their own.

In my work with the Consortium, I have visited many programs: from the Yakima Valley Farmworkers Clinic and CHAS in the State of Washington, to Cahaba Medical Care in Alabama, from Waianae Coast Comprehensive Health Center in Hawaii to Thundermist Health Center in Rhode Island and many points in between. I am deeply impressed by the top to bottom commitment of boards, executive leadership, and front line clinicians and staff to this model because it addresses and resolves much of their highest priority: Recruiting and retaining expert primary care providers who are deeply committed to their practice and communities.

Thank you.

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Senator HICKENLOOPER. Thank you.

Dr. Verret.

**STATEMENT OF REYNOLD VERRET, PH.D., PRESIDENT, XAVIER  
UNIVERSITY OF LOUISIANA, NEW ORLEANS, LA**

Mr. VERRET. Chairman, thank you for having me today. Chairman Hickenlooper and Members of the Committee, thank you for the opportunity to address you today. My name—sorry. Chairman Hickenlooper and Members of the Committee thank you for the opportunity to testify today.

My name is Reynolds Verret, C. Reynolds Verret. I serve as sixth President of Xavier University of Louisiana. My institution is historically a black university, an HBCU. It is also a Catholic institution. The ultimate purpose of Xavier is to contribute to the promotion of a just—a more just and humane society by preparing its students to assume roles of leadership and of service in a global society.

I was asked testify before the Committee about how Xavier has employed innovative strategies to address in critical underrepresentation of blacks in health and other science—health care and other sciences. I will speak for my institution, but you may extend many of my comments to the other 100 accredited HBCUs across the Nation.

Xavier is renowned for its work as a leading institution in training African-American undergraduates to complete and go on to complete the MD across the Nation, and also PhDs in the physical and life sciences. Our considerations when developing new programs, especially the graduate and professional levels, includes special criteria. One, whether the programs reflect a growing demand.

Two, will degrees lead to positions of—with possibilities for personal growth and flexibility, will degrees earn salaries that allow students to repay their loans, if the proposed degrees are of service to the larger society, and especially underrepresented communities, and most importantly, whether these degrees offered at Xavier help diversify professions and increase representation.

Our new programs target professions in which only 1 to 3.5 percent of practitioners identify as African-Americans. The diversity is critical to provide equitable health care outcomes. Xavier started this approach many years ago. However, the challenges of care, of

health care equity was highlighted in the recent disparities demonstrated by the COVID pandemic.

To provide an overall perspective of what we do in Xavier, since 2016, we have started 23 new programs. New undergraduate programs include from Bioinformatics, Data Science, Medical Laboratory Science, Neuroscience, Robotics, and Mechanical Engineering, and Statistics. At the graduate levels, programs include Masters of Health Science, Physician Assistant Studies, Masters of Public Health and Health Equity, Speech and Language Pathology, and Masters in Pharmaceutical Sciences.

Three upcoming programs that are the MS in Health Informatics, and also MS in Genetic Counseling, and the Doctorate in Physical Therapy. While we are proud of the work we do at Xavier, we and the Nation are challenged to address the staggering numbers of black doctors and scientists nationally. Much more must be done to develop a representative community of health care providers and scientists, physicians to reduce and eliminate health disparities.

To fully address this need, the pipeline of sending undergraduate students into schools such as Xavier must be vastly expanded. This will require providing pathways to all but most importantly to our first generation students, including information to families on pathways to college, the application financially processes, all to make the journey achievable without the burden of lifelong debt.

America cannot afford to develop only a subset of its talent, forsaking many whose contributions are needed, losing them due to socioeconomic barriers. With this being said, I would like to firmly think Congress for most recent investments in funding to HBCUs, tribal colleges and universities, minority serving institutions.

I am also grateful for funding which benefits our student population directly. Last, may I make a few suggestion recommendations? We need to double the Pell Grant. Embracing the only national program that helps low income students achieve higher education would serve the Nation and ease the path to needy professions. Revive subsidies for first 2 year education—for the first 2 years of education at HBCUs. Still more than 50 percent of all students at HBCUs are first generation learners. Removing financial impediments will expand the talent pool to the United States.

Investing in an additional \$5 billion to expand the Title III grant, institutional grant programs at HBCUs will go a long way to strengthen our institutions. A few historically black institutions produce a great percentage of the diversity in health and STEM. Acknowledge this work with more robust resources to expand their impact and capacity.

Fully fund the HCOP, the Health Careers Opportunities Program and similar programs. Too few black institutions also have capacity—too few black institutions have capacity and resources to function as major research institutions. Why don't we speak of the R01 status, even though they are actively nearing that point? More Federal investment, developing and building capacity at a few HBCUs, Xavier included, will allow us to continue to expand our work in response to national need.

In President Biden’s Joint Families and Infrastructure plans, HBCUs, tribal colleges, and MSIs, will slate to receive \$90 billion in investment in research related infrastructures. This is needed and essential. Another point I would say is to forgive the balance of the HBCU Capital Finance Program debt for the remaining HBCUs who were excluded from that forgiveness.

We at Xavier understand that this really should not be routine. However, there are numerous opportunities in the Ignite HBCU Excellence Act. Unburden these institutions, including Xavier. Last but not least, we as a committee of institutions are still processing the cowardly acts of terror, which have disrupted so many HBCUs.

I anticipate representations at UNCF and other representatives of our universities will put forward funding and policy recommendations for—to the appropriate committees in the coming weeks. I hope the members of this community will support these recommendations, mitigating threat and safeguarding our Nation is most precious assets, which are our students.

Mr. Chairman, I thank you and I look forward to answer the questions of the Members of the Committee.

[The prepared statement of Mr. Verret follows:]

PREPARED STATEMENT OF REYNOLD VERRET

Subcommittee Chairman John Hickenlooper and Members of the Subcommittee, thank you for the opportunity to testify today.

My name is C. Reynold Verret, and I serve as the 6 President of Xavier University of Louisiana (Xavier). Xavier was founded by Saint Katharine Drexel of the Sisters of the Blessed Sacrament. My institution is Catholic and considered a historically Black college and university (HBCU).

The ultimate purpose of Xavier is to contribute to the promotion of a more just and humane society by preparing its students to assume roles of leadership and service in a global society. This preparation takes place in a diverse learning and teaching environment that incorporates all relevant educational means, including research and community service.

I was asked to testify before the Subcommittee today to share how our institution is addressing issues of underrepresentation of Blacks in medical and health sciences fields, how this nation can increase the numbers of Black students achieving advanced and terminal degrees, share information on the workforce development and new programs we are launching, and address shortages of practitioners of color in existing and emerging health science and medical fields.

**HBCU History and Statistics**

Before I share how Xavier is impacting representation in Health and Science fields in the Nation with development of innovative academic programs at the undergraduate and graduate levels and preparing students to pursue and persist to graduate and terminal degrees, let me share some general statistics about HBCUs and their performance.

HBCUs were created as early as 1837 to provide African Americans access to higher education. Noted for their contributions in educating Black, low-income, and educationally disadvantaged Americans, the 101 accredited HBCUs today constitute the class of institutions that satisfy the statutory definition of the term “HBCU” as defined in the *Higher Education Act of 1965* (HEA).<sup>1</sup>

HBCUs disproportionately enroll low-income, first-generation and academically underprepared college students—precisely the students that the country most needs to obtain college degrees. In 2018:

<sup>1</sup> The definition of an HBCU can be found in Section 322(2) of the HEA.

- Nearly 300,000 students attended HBCUs;<sup>2</sup>
- More than 75 percent of HBCU students were African Americans; and
- Over 60 percent of undergraduate students at HBCUs received Federal Pell Grants, and over 60 percent of these students received Federal loans.<sup>3</sup>

HBCUs comprised 3 percent of all two-and 4-year non-profit colleges and universities, yet they:

- Enroll 10 percent of African American undergraduates;
- Produce 17 percent of all African American college graduates with bachelor's degrees; and
- Graduate 24 percent of African Americans with bachelor's degrees in STEM fields.<sup>4</sup>

A 2015 Gallup survey confirms that HBCUs are providing African American students with a better college experience than African American students at other colleges and universities.

- 55 percent of African American HBCU graduates say their college prepared them well for post-college life versus 29 percent for African American graduates of other institutions.<sup>5</sup>

HBCUs attained these results at an affordable price for students—that is, the cost of attendance at HBCUs is about 30 percent lower, on average, than other colleges—despite limited operating budgets and endowments that are roughly half the typical size of other 4-year public and private non-profit colleges and universities.

Since our founding, HBCUs have been, and continue to be, under-resourced institutions. An issue brief produced by ACE (American Council on Education) and UNCF (United Negro College Fund, Inc.) revealed the following:

- Public HBCUs rely more heavily on Federal, state, and local funding in comparison with their non-HBCU counterparts (54 percent of overall revenue vs 38 percent);
- Private HBCUs depend a little bit more on tuition dollars than their non-HBCUs counterparts (45 percent compared with 37 percent);
- Private gifts, grants, and contracts constitute a smaller portion of overall revenue at private HBCUs compared to their non-HBCU counterparts (17 percent vs 25 percent);
- Public and Private HBCUs experienced the largest declines in Federal funding per full-time equivalent student between 2003–2015; and
- In both the public and private sectors, HBCU endowments lag behind those of non-HBCUs by at least 70 percent.<sup>6</sup>

Despite being under-resourced institutions, HBCUs have a large economic impact that often goes unnoticed by most. In 2017, UNCF released a report detailing the economic impact of HBCUs. The report revealed that in 2014, the impact of HBCUs on their regional economies included:

- \$10.3 billion in initial spending, which includes spending by the institution for personnel services, spending by the institution for operating expenses, and spending by students;
- An employment impact of 134,090 jobs, which approximately 43 percent were on-campus jobs and 57 percent were off-campus jobs;

<sup>2</sup> U.S. Department of Education, National Center for Education Statistics. (2020). Digest of education statistics 2019 [Table 313.20]. Retrieved from <https://nces.ed.gov/programs/digest/d19/tables/dt19-313.20.asp>

<sup>3</sup> UNCF Public Policy and Government Affairs calculations using 2018 data from the U.S. Department of Education, National Center for Education Statistics, Integrated Postsecondary Education Data System. Data shows that out of 257,451 total undergraduate students at HBCUs, 159,101 students were receiving Pell Grants and 162,179 students were receiving Federal loans.

<sup>4</sup> UNCF Patterson calculations using U.S. Department of Education, National Center for Education Statistics, Integrated Postsecondary Education Data System.

<sup>5</sup> Gallup, Inc. (2015). Gallup-USA funds minority college graduates report. Retrieved from UNCF Website: <https://www.uncf.org/wp-content/uploads/PDFs/USA-Funds-Minority-Report-GALLUP-2.pdf>

<sup>6</sup> Williams, K.L. & Davis, B.L. (2019). Public and private investments and divestments in Historically Black Colleges and Universities. Retrieved from American Council on Education Website: <https://www.acenet.edu/news-room/Pages/Public-and-Private-Investments-and-Divestments-in-HBCUs.aspx>

- \$10.1 billion in terms of gross regional product, which is a measure of the value of production of all industries;
- A work-life earnings of \$130 billion for the Class of 2014, which is 56 percent more than they could expect to earn without their 2014 certificates or degrees; and
- A total economic impact of \$14.8 billion.<sup>7</sup>

Regarding Xavier University of Louisiana specifically, my institution had the following economic impact on its regional economy according to the UNCF report:

- \$200,000,000 in annual economic impact;
- 1,715 jobs supported annually; and
- \$1.7 billion in lifetime earnings for one graduating class.

In addition to the positive impact HBCUs make on the overall economy, HBCUs also have a strong impact academically when observed at the State and local level. An upcoming report to be released by UNCF shows that:

- HBCUs comprised 8.5 percent of the 4-year institutions across the 21 states and territories in the analysis;
- Across the 21 states and territories in the analysis, HBCUs enrolled, on average, 24 percent of all Black undergraduates pursuing a bachelor's degree in a college or university in 2016;
- Across the 21 states and territories in the analysis, on average, 26 percent of all Black bachelor's degree recipients graduated from an HBCU in 2016; and
- In North Carolina, HBCUs are 16 percent of the 4-year institutions, but enroll 45 percent of all Black undergraduates and award 43 percent of all Black bachelor's degrees in the state.<sup>8</sup>

### History of Xavier

Xavier University of Louisiana is the only historically Black and Catholic institution in the Nation, and is nationally recognized for its science, technology, engineering, and mathematics (STEM) curriculum, while remaining close to its liberal arts roots. Xavier's mission is to create a more just and humane society by preparing its students to assume roles of leadership and service in a global society. This preparation takes place in a diverse learning and teaching environment that incorporates all relevant educational means, including research and community service.

As of Fall 2021, the University has 245 full-time faculty members who offer courses in over 50 majors on the undergraduate, graduate, doctoral, and first-professional degree levels. Xavier's current enrollment is 3,604. Of these, 2,749 are undergraduates and 236 are graduate students enrolled in the College of Arts and Sciences. In addition, there are 613 students enrolled in the College of Pharmacy, which offers the Master of Health Science in Physician Assistant Studies, the Master of Science in Pharmaceutical Sciences, and the Doctor of Pharmacy, and 236 students are enrolled in Master's and Doctoral programs in the College of Arts and Sciences. Xavier's student body is 77 percent African American, with approximately 39 percent from Louisiana, primarily from the New Orleans area. The balance comes from 41 other states, the District of Columbia, Puerto Rico, the Virgin Islands, and several countries. 50 percent of our students have an expected family contribution of below \$2,500. 30 percent of our students are first generation students. (1st generation students have lower retention and graduation rates). Xavier welcomes students who are spread out across the academic profile spectrum and has a proven track record of meeting students where they are and filling educational gaps to assist in their perseverance to degree and beyond.

### How Xavier Overcomes Obstacles to Student Success

Xavier achieves this student success despite the many obstacles posed through a strong support system for students through: Intensive advising by faculty and staff

<sup>7</sup> Humphreys, J.M. (2017). HBCUs make America strong: The positive economic impact of Historically Black Colleges and Universities. Retrieved from UNCF Website: <https://www.uncf.org/programs/hbcu-impact>

<sup>8</sup> Saunders, K. & Nagle, B.T. (2018). HBCUs punching above their weight: A state-level analysis of historically Black college and university enrollment and graduation. Washington, DC: UNCF Frederick D. Patterson Research Institute

that includes Pre-Health advisors, career advisors, and graduate school advisors; Workshops and presentations to assist students on their pathway; Academic Resource Centers—provide tutoring and supplemental instruction; Early alert system that notifies key faculty and staff when students need intervention to put them back on track to success; Residential education program and co-curricular programs to develop the whole student and grapple with the socio-economic challenges many of our students face.

According to the U.S. Department of Education, during the past decade, Xavier has ranked first nationally in the number of African American students earning undergraduate degrees in Chemistry and the Physical Sciences overall, and in the top five in Biology. Many well-prepared, highly motivated students are attracted by Xavier's reputation in this regard. Conversely, academically disadvantaged students also are drawn to Xavier because of its track record in "leveling the playing field," especially in the first year of college. The New York Times Selective Guide to Colleges observes, "Xavier is a school where achievement has been the rule and beating the odds against success a routine occurrence."

According to the Flexner report data for the 13 historically Black medical schools that were closed and 4 historically Black medical schools that remained open after the 1910 Flexner report,<sup>9</sup> an extrapolation based on data from the medical schools that remained open indicated that 5 of the closed medical schools might have collectively provided training to more than 35,000 graduates by 2019. If these 5 closed schools had remained open, they could have produced a 29 percent increase in the number of graduating African American physicians in 2019 alone.<sup>10</sup> While this may seem to many a question purely of "what if," I posit it is an alarming look at how the U.S. could have had a more diverse mixture in the health professions, because the percentages of African-American U.S. doctors has remained unchanged largely throughout my adult life. According to the Association of American Medical Colleges (AAMC), only 5 percent of all U.S. doctors are Black or African American. A new UCLA study finds that the proportion of physicians who are Black in the U.S. has increased by only 4 percentage points over the past 120 years, and that Xavier has a long-standing national reputation in producing Black health professionals. The University has consistently been the No. 1 undergraduate source of African Americans who persist to complete their MDs. Xavier is nationally ranked as one of the top institution's whose undergraduates achieve PhDs in the life and social sciences. The College of Pharmacy has also consistently been among the nation's leaders in awarding Doctor of Pharmacy degrees to African Americans.

Since 2002, graduates have gone on to receive 2,755 master's degrees, 241 PhD degrees, and 1,529 First Professional degrees since matriculating at Xavier.

Xavier is committed to ensuring that entering first year students persist and complete their educational goals and recognizes the value of reaching out to students well before their college years to enhance skills and habits that will lead to academic success. For over thirty years, Xavier has coordinated summer programs for high school students through its Summer Science Academy (SSA). Approximately 500 students participate each summer in an array of STEM programs including MathStar, BioStar, ChemStar and analytical reasoning programs.

Xavier also has several programs that support minority student achievement for its undergraduates, including the LS-LAMP (Louis Stokes Louisiana Alliance for Minority Participation), BUILD (Building Infrastructure Leading to Diversity) Program, MICHESS (Materials and Interfaces Center for High Energy Storage and Sensing) Program, the Ronald E. McNair Program, HBCU-UP (Historically Black Colleges and Universities Undergraduate Programs) programs, Upward Bound Math and Sciences and McNair programs.

Xavier's goal is to provide students the highest level of learning possible in all areas of the liberal arts and sciences, to help them develop their own commitment to life-long learning, and to prepare them for opportunities to enter and succeed in emerging as well as time-honored careers that require a high level of talent, drive for excellence, and commitment to service.

<sup>9</sup> Abraham Flexner and Herman Gates Weiskotten. *The Flexner Report on Medical Education in the United States and Canada* (1910).

<sup>10</sup> Campbell KM, Corral I, Infante Linares JL, Tumin D. Projected Estimates of African American Medical Graduates of Closed Historically Black Medical Schools. Retrieved from <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2769573>

### **Developing Graduate Programs to increase Representation of Blacks in Careers of Today and Tomorrow**

At Xavier we continue to innovate in what programs we will invest in to better the success opportunities for our students. Our considerations when developing new programs, especially at the graduate and professional level include whether the program reflects a growing demand, if earning this degree will lead to positions that call upon personal judgment and to possibilities for continued personal growth and flexibility needed for rapidly changing markets, whether students who earn the degree will earn salaries that allow them to pay back their student loans and serve as economic generators for the communities in which they live, if the proposed degree make possible personal improvement while being of service to society and most especially to underserved communities of color.

One of our biggest considerations in development of programs is whether the degrees offered at Xavier help diversify a profession and increase representation. Our recently launched programs and planned programs target professions in which only 1–3.5 percent of practitioners identify as African Americans. This is critical to providing equitable healthcare outcomes. While Xavier started this innovative method of considering programs for development many years ago, the challenge of health care equity was highlighted by the recent disparities demonstrated by COVID outcomes in Black communities.

To provide an overall perspective, since 2016, we have started 23 programs: 6 certificate programs, 9 bachelor's degree programs, 6 minors, 4 master's programs, 1 dual degree program.

New undergraduate programs include Bioinformatics, Data Science, Medical Laboratory Science, Neuroscience, Robotics and Mechatronics Engineering, Statistics.

New graduate programs include Master of Health Sciences, Physician Assistant Studies; Master of Public Health, Health Equity; Master of Science, Speech-Language Pathology; Master of Science, Pharmaceutical Sciences. Three more in development include Master of Science, Health Informatics (start Fall 2022); Master of Science, Genetic Counseling (start Fall 2024); Doctor of Physical Therapy is in its early planning stages.

### **Challenges to Our Work**

Our greatest challenges to this work are the cost to develop the programs, space limitations that we and many HBCUs face as we deal with aging infrastructure and remain undersourced for capital improvement and expansion projects. The socio-economic challenges that face our students and efforts that we must make for them to succeed despite these challenges. This includes lack of funding for entrance exams, travel for interviews, need to go directly into career field to alleviate the debt of achieving undergraduate degrees, and the cost of the graduate programs.

Mr. Chairman, now that I have informed the Committee on what makes Xavier perform well at the production of health professionals, I want to leave you with some recommendations:

1. Double the current Pell Grant. Embracing the only national program that helps low-income students achieve higher education would help ease the avenue to graduate and health professions studies. One of the biggest impediments of Black and low-income students is finances. Students with aptitude and no resources all too often stop out of college, and that is a national tragedy. Doubling Pell, immediately, can immediately increase the odds of students to stay enrolled despite their circumstances.
2. To that end, every effort to provide subsidies to the first 2 years of education at an HBCU should be revived. Still in 2022, above 50 percent of HBCU students are first generation learners. Allowing financial impediments to be diminished will allow those learners to choose the institution which has a proven track record of producing minority health professionals. These financial impediments prevent much of our talent pool from ever pursuing a graduate degree.
3. HBCUs' institutional funding is so often in jeopardy. The institutions are more reliant on tuition, room, and board. An additional \$5 billion to expand the Title III institutional aid grants to HBCUs would go a long way to strengthen their academic, administrative and fiscal capabilities, such as creating or expanding educational programs in high-demand fields like the health professions, STEM, computer sciences, nursing and allied health. We are limited and delayed by financial restrictions as we

attempt to launch new and innovative programs. Limited by space restrictions, infrastructure restrictions, seed funding to hire talented faculty and staff.

4. There are only a few historically Black institutions which produce a great percentage of the diversity in health and research. Those institutions should receive more robust resources for being excellent at what they do. I know there are programs like the Department of Health and Human Services' (HHS) "Centers of Excellence" and National Institutes of Health's (NIH) "Research Endowment" programs, but if you look at persistent health disparities and the national inability to grow the number and percentage of African American health professionals, more robust funding is needed. If you are interested, we can share proposed funding numbers with you, such as an additional \$2 billion directed toward building a pipeline of skilled health care workers with graduate degrees.

5. I also mentioned that part of Xavier's success has been various programs to prepare our students for the rigors of a health professions education. Those programs have never been fully funded, including the "Health Careers Opportunities Program" (HCOP). HCOP and similar programs, and what Xavier has learned from administering them, has allowed our institution to excel and do as much as possible to increase national diversity across the health sector.

6. Too few Black institutions have capacity and resources to function as major research institutions, often described as R01 status. We at Xavier and many other Black institutions are creating huge results in the production of Black scientists and contributing to research at the leading without the Federal investments needed to attain this status that allows more laboratory time for our faculty who are stressed with heavy teaching loads and their institutions fiscal limitations to release them for research. Investing in developing a few key HBCUs, starting with Xavier, will allow us to continue and expand our work and advance development of talent and ability in response to national need. This investment will multiply the number of Black students who go on to serve the physical and life sciences (STEM), the health sciences, social sciences, and research and innovation needs of the Nation. Xavier has been historically proven by its success in this work. We urge you to make investments in us and similar institutions now to build capacity of our institutions to achieve R01 status.

7. While historically Black colleges have always done "more with less," the year 2022 should be the year that changes. In President Biden's joint families and infrastructure plans, HBCUs, tribal colleges, and minority serving institutions (MSIs) were slated to receive over \$90 billion in investments in research related infrastructure. This is essential. An influx of funding is a recognition that HBCUs have systematically been underfunded; and despite that, HBCUs have excelled beyond the expectation. However, if the playing field is leveled, with a backlog of deferred maintenance transformed into the laboratories necessary to attract and educate the next generation of health professionals, our production level can increase.

8. Forgive balance of HBCU Capital Finance Program debt for remaining HBCUs: The long-term impact of the Federal Government providing permanent relief the HBCU Capital Finance institutions in December 2020 will be felt for generations. Xavier knows this impact having survived the impact Hurricane Katrina. We continue our recovery from the recent Hurricane Ida However, the provisions of the Consolidated Appropriations Act of 2020 State that only obligated funds borrowed from the Department of Education's program were eligible for relief. When Xavier, undertaking an opportunity to finally tackle a backlog of deferred maintenance, borrowed \$100,000,000 from the HBCU Capital Finance Program, the subsequent permanent relief proved to have little to no institutional impact. As an issue of fairness for similarly situated institutions, the remaining (and existing) HBCU Capital Finance Program loans should also undergo permanent relief. We at Xavier understand that this relief should not be routine; however, there are numerous measures in the 117th Congress which include this permanent relief, including the Institutional Grants for New Infrastructure, Technology, and Education for (IGNITE) HBCU Excellence Act.

9. Last, but not least, we as a community of institutions are still processing the cowardly acts of terror which have disrupted so many HBCUs. I expect our representation at UNCF will put forth funding and policy recommendations to the appropriate appropriations subcommittees in the coming weeks. I hope the Members of this Committee will support those recommendations.

Mr. Chairman, thank you. I look forward to answering the questions of the Members of the Committee.

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Senator HICKENLOOPER. Thank you.

Ms. Quinones.

**STATEMENT OF NORMA QUINONES, LPN, NURSING SERVICES MANAGER AND NATIONAL, INSTITUTE FOR MEDICAL ASSISTANT ADVANCEMENT (NIMAA) SITE COORDINATOR, CLINICAL FAMILY HEALTH, LAFAYETTE, CO**

Ms. QUINONES. Good morning. What an honor for me to be here. My name is Norma Quinones, and I am the Nursing Services Manager at Clinica Family Health, a community health center in Lafayette, Colorado, that serves low income individuals.

I applied to Clinica Family Health as a Medical Assistant in 1992, when our organization just had one clinic with six exam rooms and about 25 employees. I have been able to grow with Clinica over the past 30 years, and we will never forget being given the opportunity to start my career as an MA. Within Clinica's support, I became an LPN and worked as a nurse team manager for several years.

I am now the Nursing Services Manager for Clinica. I love what I do. I get to dedicate my time to staff and students as they deliver medical, dental, mental health care to thousands of patients. Part of my job is helping coordinate the NIMAA program at Clinica, which means I get to support future MAs on their own educational journey.

The National Institute for Medical Assistance Advancement is unique, nationally accredited non for-profit post-secondary program formed in 2016 by two leading FQHCs, Salud Family Health Center in Fort Lupton, Colorado, and Community Health Center, Inc. in Middletown, Connecticut. NIMAA is a model for addressing primary care health workforce shortages, creating an accessible entry point for long term health care careers and diversifying the U.S. workforce.

Before working with NIMAA, we had trouble finding qualified medical assistance prepared to work in our demanding environment. Some who graduated from expensive programs incurred a lot of debt, making it hard for them to resist higher paying jobs in the for-profit sector. It was hard to find good MAs and harder to keep them.

NIMAA's program has helped us build a workforce pipeline within our community and reflective of our community. It provides an affordable option that allows students to work part time while they are completing the program. It prepares graduates well for demanding primary care settings that—where MAs are desperately needed.

It is true—it is a true roll your own model that provides opportunity for nontraditional students, single parents, recent immigrants, first generation high school graduates, or those of us that enter the workforce at an older age.

Nationally, 90 percent of medical assistance are female, and the majority are black, indigenous, or people of color. NIMAA's program allows us to help participants begin a health care career that would otherwise be out of reach for them and earn a livable wage. Over the past 3 years, Clinica has hosted 18 NIMAA externs. We hired 15 of those 18 upon graduation.

Most are still with our organization. This is a valuable workforce pipeline for Clinica, and it is extremely rewarding to watch the students grow in their careers as I did. MAs can enjoy a rewarding career, whether they stay in the MA role or move to management, nursing, administration, or other roles. For example, one of the early NIMAA graduates is applying to become a Nursing Team Manager—or, I am sorry, a Medical Assistant Team Manager.

NIMAA is an excellent program with student retention of 89 percent, a graduation rate at 84 percent, and national credential and exam pass rate of 89 percent, and a job—and a verified job placement at 81 percent. NIMAA's Program has already graduated more than 250 students, and it is growing rapidly.

NIMAA has 48 active clinical partners across 14 States, including community health centers, hospital systems, and other safety net providers. This successful program could be scaled to reach thousands more students each year and to help address critical workforce shortages in diverse urban and rural communities across the country.

Thank you for the opportunity to share Clinica and our students' perspective on NIMAA, what it has meant for Clinica, and how it can serve as a model for health care pipeline and pathway efforts.

[The prepared statement of Ms. Quinones follows:]

PREPARED STATEMENT OF NORMA QUINONES

Good morning, what an honor for me to be here. My name is Norma Quinones and I am the nursing services manager at Clinica Family Health, a community health center in Lafayette, Colorado that serves low-income individuals.

I applied to Clinica Family Health as a Medical Assistant in 1992, when our organization had just one clinic with six exam rooms and about 25 employees. I have been able to grow with Clinica over the past 30 years and will never forget being given the opportunity to start my career as an MA. With Clinica's support, I became an LPN and worked as a nurse manager for several years. I am now the Nursing Services Manager for Clinica. I love what I do. I get to dedicate my time to staff and students as they deliver medical, dental and mental health care to thousands of patients. Part of my job is helping coordinate the NIMAA program at Clinica, which means I get to support future MAs on their own educational journeys.

The National Institute for Medical Assistant Advancement (NIMAA) is a unique, nationally accredited, nonprofit post-secondary program formed in 2016 by two leading FQHCs—Salud Family Health Center from Fort Lupton Colorado and Community Health Center, Inc. in Middletown Connecticut. NIMAA is a model for addressing primary care health workforce shortages, creating an accessible entry point for long-term health careers, and diversifying the U.S. workforce.

Before working with NIMAA, we had trouble finding qualified medical assistants prepared to work in our demanding environment. Some who graduated from expensive programs incurred a lot of debt, making it hard for them to resist higher paying jobs in the for-profit sector. It was hard to find good MAs and also hard to keep them.

NIMAA's program has helped us build a workforce pipeline within our own community, and reflective of our community. It provides an affordable option that allows students to work part-time while completing the program. It prepares graduates well for demanding primary care settings that desperately need MAs. It is a true "grow your own" model that provides opportunities for non-traditional students, single parents, recent immigrants, first generation high school graduates, or those re-entering the workforce at an older age. Nationally, ninety percent of medical assistants are female, and the majority are Black, Indigenous, or People of Color. NIMAA's program allows us to help participants begin a health career that would otherwise be out of reach for them, and earn a livable wage.

Over the past 3 years, Clinica has hosted 18 NIMAA externs. We hired 15 of those 18 upon graduation, and most are still with our organization. This is a very valuable workforce pipeline for Clinica, and it is extremely rewarding to watch these students growing into their careers, as I did.

MAs can enjoy a rewarding career, whether they stay in the MA role or move into management, nursing, administration or other roles. For example, one of our early NIMAA graduates at Clinica is applying to be a Medical Assistant Team Manager.

NIMAA is an excellent program with a student retention rate of 89 percent, a graduation rate of 84 percent, a national credentialing exam pass rate of 89 percent, and a verified job placement rate of 81 percent.<sup>1</sup>

NIMAA's program has already graduated more than 250 students and is growing rapidly. NIMAA has 48 active clinical partners across 14 states, including community health centers, hospital systems and other safety net providers.

This successful program could be scaled to reach thousands more students each year and help to address critical workforce shortages in diverse urban and rural communities across the country.

Thank you for the opportunity to share Clinica's and our students' perspective on NIMAA, what it has meant for Clinica, and how it can serve as a model for health career pipeline and pathway efforts.

### **Further Description of NIMAA and Medical Assistant Workforce Needs and Opportunities**

Medical assisting provides an accessible entry-point to a health career and is a critical support role in advanced primary care practices.

The National Institute for Medical Assistant Advancement (NIMAA) offers a unique workforce solution that leverages partnerships with local healthcare providers to provide both a high-quality educational program and extensive in-clinic experience. This approach results in a workforce pipeline from within and representative of the partner clinic's community.

NIMAA and programs like it have the potential to increase rapidly the medical assistant (MA) workforce across the United States, and to create a pool of candidates for advancement to other high-demand health care jobs.

This written statement provides further detail on the demand for and role of medical assistants, aspects of NIMAA's model that can inform workforce pipeline efforts, and opportunities and challenges for maximizing the reach of programs like NIMAA in the current workforce and educational environment.

Federal support can serve to ensure the availability of effective programs in rural and medically underserved communities.

#### **The National Institute for Medical Assistant Advancement (NIMAA)**

NIMAA grew out of a need identified by Community Health Center, Inc., of Connecticut, one of the nation's largest federally Qualified Health Centers, which was spending months providing extensive retraining for newly hired medical assistants lacking competency in core skills and education in comprehensive, team-based care. In consultation with two noted leaders in the field, Thomas Bodenheimer, MD, MPH, and Edward Wagner, MD, MPH, CHC's President and CEO Mark Masselli formed a team and invested initial resources in developing a new way of providing MA training and education. After a period of incubation, NIMAA was formed in partnership with Salad Family Health Centers of Colorado. The Colorado Health Foundation recognized NIMAA's importance as a critical element in the redesign of primary health care and workforce development, and thanks to the Foundation's vision and support, NIMAA was established in Colorado. NIMAA remains an affiliate

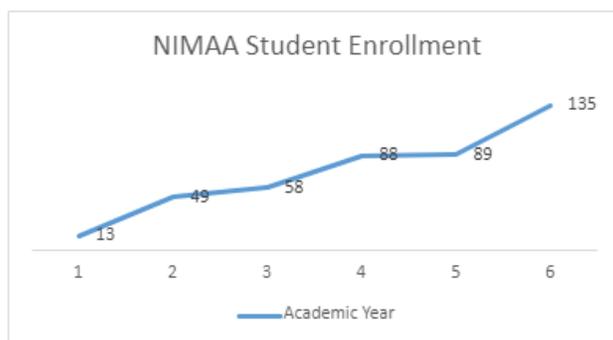
<sup>1</sup> 2020–2021 Rates as reported to the Accrediting Bureau of Health Education Schools.

of Community Health Center, Inc., which provides operational support for this program and has facilitated its national growth.

CHC was the first FQHC in the Nation to form its own research and education center, the Weitzman Institute. Founded in 2007, Weitzman is grounded in community health, and committed to improving healthcare for the vulnerable and underserved through research, education, and policy. The Institute is an incubator for programs such as NIMAA, and its experts and faculty conduct training and education through the on-line Project ECHO platform, hosting programs for thousands of providers in the U.S. and abroad annually.

NIMAA enrolled its first class of 13 students in 2016, with its two founding partners as clinical externship sites. Since then NIMAA has grown substantially, and in the 2021–2022 calendar year will enroll over 135 students, with clinical externships offered in 40 organizations across 14 states.

NIMAA's growth to date, illustrated in the chart below, has been organic, as word of the program continues to spread and additional clinical practices learn about NIMAA and decide to participate.



A focused investment in NIMAA and similar programs will greatly accelerate the rate at which the current health care workforce shortage is addressed while providing access to meaningful jobs and career advancement in communities economically impacted by the COVID 19-pandemic in particular.

#### NIMAA Student Outcomes

NIMAA collects and reports performance (outcome) data that meets the standards of its accrediting body, the Accrediting Bureau of Health Education Schools (ABHES). NIMAA's graduation, retention and placement rates all exceed ABHES standards and are considerably higher than those of many vocational education programs.

For the 2020–21 school year, NIMAA reported an 89 percent retention, 84 percent graduation, 89 percent credentialing exam pass rate and 81 percent verified job-placement of graduates.

Several unique characteristics of NIMAA's model contribute to these strong outcomes:

- NIMAA's extensive externship requirement (10 hours per week, beginning in the first week of the program) is consistent with the needs of adult learners, and ensures that students are confident in their hands-on skills and have a full understanding of the practice environment upon graduation.
- NIMAA's curriculum is tailored to the needs of primary health care providers and is regularly updated to reflect emerging needs and practices.

As discussed above, NIMAA's program structure is accessible to and affordable for residents of medically underserved communities, resulting in strong retention and graduation rates.

### Scalability of the NIMAA Model

NIMAA's distance (on-line) education model allows NIMAA to grow rapidly. School operations are supported from NIMAA's Colorado-based office and do not require the establishment of a local physical campus to deliver the program. NIMAA instructors work from four US time zones, allowing them to be accessible to students when students need help.

NIMAA is able to offer its program in any community where an appropriate primary care practice is interested in serving as an externship site, and where NIMAA has completed the required regulatory process to offer its educational program to State residents.<sup>2</sup>

### Reach in Rural Communities

Distance learning models, like NIMAA's, are available to rural and other underserved communities without the investment of capital infrastructure; they also eliminate the need for students to travel long distances to attend classes in person.

Key resources need to be in place for models like NIMAA to be successful in rural communities:

- Broadband internet access is critical for students to use advanced on-line learning tools, such as simulation software and interactive learning modules.
- Rural clinical partners must have the human resources to bring the program into their communities and to support the extensive externship hours that are a key component of the learner experience.

Smaller practices, which includes many rural providers, are usually able to host only two or three student externs. However, the training provider expends the same resources on relationship management, program infrastructure, and support as it would for partners who host two or three times as many students. Thus, the per-student training cost is higher in rural areas.

### UpSkilling the MA Workforce

The critical role of Medical Assistants in the delivery of primary care is borne out by the projected growth of Medical Assistants over the next 10 years. The Bureau of Labor Statistics, Occupational Handbook projects a growth in MA jobs of 18 percent from 2020–2030, higher growth than for health care jobs overall. The BLS projects 104,400 medical assisting openings annually, and a net growth of 132,600 jobs over 10 years.<sup>3</sup>

While NIMAA's curriculum includes knowledge and skill-building specific to the medical assistant's role in a team-based primary care setting, the majority of Medical Assistants entering the workforce will be trained in traditional programs. These graduates will need upskilling in skills and competencies related to team-based care to be effective team members in the emerging primary care environment. Medical assistants already in the field will need continuing education to maintain their national credentials and ensure their skills are evolving along with the practice environment.

NIMAA clinical partners requested that NIMAA develop UpSkilling courses in team-based care topics to support traditionally trained MAs to be successful in an advanced primary care setting where the medical assistant has an expanded role within the team.

NIMAA has developed a set of UpSkill NIMAA courses, offered through the Weitzman Institute, and continues to add courses in response to industry demand. For example, the immunization course has been updated to include topics related to COVID19. UpSkill NIMAA courses have been used by both individual practices and accountable care organizations wishing to support implementation of an advanced primary care model in their practices.

The UpSkill NIMAA courses are delivered on-line, and can count toward the continuing education hours needed to maintain a medical assisting certificate. UpSkill

<sup>2</sup> Bodenheimer T, Willard-Grace R, Ghorob A. Expanding the Roles of Medical Assistants: Who Does What in Primary Care? *JAMA Intern Med.* 2014;174(7):1025–1026. doi:10.1001/jamainternmed.2014.1319

<sup>3</sup> Bureau of Labor Statistics, U.S. Department of Labor, Occupational Outlook Handbook, Medical Assistants, at <https://www.bls.gov/ooh/healthcare/medical-assistants.htm> (Visited February 3, 2022).

NIMAA courses can also support the advancement of medical assistants along an MA career ladder that meets the health care practice's needs. For example, an MA may be required to complete the Inter Professional Team-Based Care, Quality Improvement and Making the Data Count, and Professionalism and Communication courses, and demonstrate related competencies, to move from MA1 to MA2.

### Funding Opportunities

Authorization of national programmatic appropriations funding by the U.S. Congress in support of NIMAA would allow the nonprofit to scale its operations to meet primary care workforce needs nationwide, provide robust support to students, and reduce barriers to participation of small and rural primary care practices.

### About Medical Assistants and Medical Assistant Workforce

#### The Role of Medical Assistants in Primary Care

Well-trained medical assistants are essential to the delivery of effective and efficient care in advanced primary care settings, and to provider retention and satisfaction.

Primary care practices are increasingly adopting a delivery model that requires integrated team-based care in which all members—behavioral, oral and physical health providers; care coordinators; health educators; front office staff; and medical assistants—work together to meet individual patients' needs and manage population-based health prevention and screening efforts.

Medical assistants serve as the “choreographer” in this model, ensuring that team members are prepared, facilitating the flow of the visit, coordinating follow-up care and ensuring screening, referral and other relevant data are documented and shared appropriately. The medical assistant's preparedness has a tremendous impact on the team's functioning and on the quality of care provided.

The Center for Excellence in Primary Care at the University of California, San Francisco argues that medical assistants can be utilized in expanded roles such as health coaching, team documentation and panel management under the direction of a provider. This improves patient access while reducing the demands on primary care clinicians, positively affecting the work life of clinicians.

Dr. Tillman Farley, Chief Medical Officer of Salud Family Health Center and member of NIMAA's Board of Directors says of Medical Assistants in his practice:

*“I am in awe every day of the amazing individuals that do our MA work. We put an incredible amount of work and responsibility on them, and they carry that burden every day with smiles on their faces . . . They are truly the lynchpins of our organizations. We all need a superpower, and our superpower is our MAs.”*

#### Medical Assistant Workforce Diversity and Equity

The medical assistant workforce in the U.S. is diverse: 90 percent are women, 19 percent Latino and 42 percent Black. The median age of medical assistants is 37.

**NIMAA students are recruited from health center service areas, and they reflect the diversity of their communities in race and age.** NIMAA's student body over the past 2 years was 64 percent Hispanic/Latino (of any race); 7 percent American Indian/Native American; 9.6 percent Asian; 6 percent Black or African American; and 4 percent Native Hawaiian/Pacific Islander. Fifty-four percent of NIMAA students were 25 years old or older, and approximately one third were single parents.

- NIMAA's program is deliberately structured to be accessible to low-income students and non-traditional learners.
- NIMAA's tuition of \$6,000 is much less expensive than the \$15,000 to \$40,000 often charged by for-profit schools, making it more accessible to low-income students.
- NIMAA's **8-month program** is shorter than most, which reduces students' opportunity costs to participate, and permits the program's graduates to move more quickly to paid employment.
- The NIMAA distance-learning educational model allows students to complete their coursework at times that are convenient for them, and lets them balance their education with their part-time employment and/or other responsibilities.

- NIMAA’s student services and instructional staff build one-on-one relationships with students and support them in addressing personal and academic challenges.
- NIMAA applicants are interested in advancing their health careers over time, and NIMAA’s training in team-based care provides students with a strong foundation they can build upon with additional education and training.

### **Career Pathways for Medical Assistants**

Medical assistant training is unique in that it encompasses a broad range of skills, including front-office administrative functions, billing and coding, patient communication, and medical (back office) skills. NIMAA’s program includes curriculum and skills related to the team-based care model and empowers students to acquire knowledge and experience foundational to a number of career pathways.

NIMAA’s clinical partners report that staff who began their careers as medical assistants now work in many different roles, including as clinic managers, immunization program coordinators, care coordinators, operations managers and directors, billing managers, nurses, chief nursing officers and physician assistants, to name a few.

Ms. Quinone’s testimony delivered before the Senate HELP Subcommittee on February 10, 2022, illustrates this opportunity for advancement. A NIMAA graduate in the first group of students hosted by Clinica shared this with Ms. Quinones about her experience in NIMAA and as a medical assistant:

*“I am writing to express my sincere gratitude to you for making the NIMAA program here at Clinica possible. Three years ago I was thrilled to learn I had been chosen as one of the first candidates to participate in the NIMAA program. Clinica and NIMAA gave me the opportunity to become a medical assistant and I can honestly say I love what I do. My job gives me a sense of accomplishment when I’m able to help patients and my fellow co-workers. I’ve had the privilege of training two NIMAA students by sharing my vision, experiences and also mistakes. NIMAA has given me the knowledge, skills and courage to apply for a leadership position. I will always be grateful for this opportunity.”*

Medical assistant training and experience provide a foundation for many career pathways. However, those pathways and the related education needed to pursue them are not well documented. Thus, it is often up to the individual to identify and navigate these pathways, and for individual employers to provide the combination of experience and additional training or education that supports career advancement. Better documentation of “organic” career pathways that build upon medical assisting skills can create a pipeline for in-demand administrative, managerial and clinical roles in primary care settings. NIMAA is passionate about contributing to the delineation and further development of these pathways in collaboration with the health care industry and higher education partners.

Most national health professions training initiatives, such as the National Health Service Corps, and the Teaching Health Center Graduate Medical Education (THCGME) Program, are focused on encouraging entry into health careers at the bachelor’s or advanced degree levels, and bringing health professions into medically underserved areas. NIMAA, and other programs like it, create an additional workforce development strategy that facilitates entry into a health career for residents of medically underserved areas who need to maintain an income stream while starting a career, and for whom a 4-year course of study is not immediately feasible.

### **Demand for Medical Assistants and other Allied Health Workers Nationally and in Colorado**

The Bureau of Labor Statistics Employment Projections Program estimates medical assistant job growth from 2020–2030 will be 18 percent, much faster than the average for all occupations (8 percent) and, faster than other healthcare support occupations (16 percent).

The Bureau of Labor Statistics Reports describes the demand for Medical Assistants as follows:

About 104,400 openings for medical assistants are projected each year, on average, over the decade. Many of those openings are expected to result from the need to replace workers who transfer to different occupations or exit the labor force, such as to retire.

The growth of the aging baby-boom population will continue to increase demand for preventive medical services, which are often provided by physicians. As a result, physicians will hire more assistants to perform routine administrative and clinical duties, allowing the physicians to see more patients.

An increasing number of group practices, clinics, and other healthcare facilities will also need support workers, particularly medical assistants, to complete both administrative and clinical duties. Medical assistants work mostly in primary care, a steadily growing sector of the healthcare industry.

In Colorado there are an estimated 1,890 MA openings annually, with MA positions expected to grow by 36 percent with 4,110 jobs added by 2028.<sup>4</sup> The Colorado 2021 Talent Pipeline Report identifies medical assisting as one of Colorado's top jobs statewide, and in five of the state's eight regions, with 10-year growth rates in those regions of between 23 and 43 percent.<sup>5</sup>

While medical assistant wages and cost of living vary regionally, **medical assisting jobs in the US generally pay a livable wage.** The living wage for a family of four in the US in 2019 was \$16.54/hour, while the median wage for medical assistants in the US in 2020 was \$17.23 per hour. Many health care providers require medical assistants be certified through one of the national credentialing bodies, and provide a higher wage to medical assistants who have passed a national certification exam.

## Reducing Barriers to Innovative Training Approaches

### Regulatory Considerations

The primary barrier that limits NIMAA's ability to expand nationwide is the lack of regulatory reciprocity across states for full-distance vocational programs, like that which exists among 4-year colleges with SARA (State Authority Reciprocity Agreements). NIMAA is regulated by the Colorado Department of Higher Education, Division of Private and Occupational Schools, and complies with all relevant Colorado regulations. However, some states still require that NIMAA go through the same application process as a school physically located in their State would, which can take months or even years. Other states do not regulate full-distance schools, or have a separate set of requirements for such schools. As a result, NIMAA must comply with multiple sets of regulations and requirements. The fees charged by State regulatory bodies (in addition to the fees NIMAA pays in Colorado, which cover all enrolled students regardless of residence), and the administrative burden of tracking and reporting on these regulations, is extremely costly. In several cases, it is not feasible for NIMAA to offer its program in a State even where it has willing clinical partners because the cost of the regulatory processes and barriers is too high.

NIMAA fully understands and supports the importance of protecting students from predatory practices. However, many of the regulatory hurdles placed in front of NIMAA seem redundant for a non-profit school that has national accreditation and is in full regulatory compliance in its home state.

### Apprenticeship and Health Workforce Needs

Apprenticeship, and other models that allow students to earn a salary while participating in training, can facilitate engagement of low-income and non-traditional students in training programs.

Several of NIMAA's clinical partners have medical assistant apprenticeships in which NIMAA's on-line didactics fulfill the related instructional requirement, and where completion of the NIMAA program is one of the requirements of the apprenticeship, which then continues beyond graduation from NIMAA.

NIMAA has encouraged its clinical partners to explore the apprenticeship model, and has facilitated conversations with local workforce offices to that end. Several aspects of apprenticeship limit participation by NIMAA partners, including:

<sup>4</sup> Projections Central <https://www.projectionscentral.com/Projections/LongTerm>

<sup>5</sup> 2021 Colorado Talent Pipeline Report. Colorado Workforce Development Council and Talent Found. Accessed at <https://cwdc.colorado.gov/blog-post/2020-talent-pipeline-report-released>, 2.3.2022.

- The 2,000-hour requirement of federally registered apprenticeships is considerably longer than the 960 hours of NIMAA's program.
- The industry-recognized credential for medical assisting is a national credentialing exam, while an apprenticeship completion certificate is not.
- The uncertainty regarding which or how many students will qualify for apprenticeship support.
- The administrative tasks required to establish and maintain registered apprenticeship programs.
- The lack of financial support for participation of non-profit health care employers in apprenticeship.

In addition, states sometimes limit the availability of apprenticeship programs or funds for training provided by specific types of training providers, such as Community Colleges. This restricts the participation of non-profit training providers like NIMAA.

### **Workforce Resources and Health Workforce Needs**

Many workforce efforts are delivered through the workforce infrastructure, including local workforce boards. A strength of the workforce system is that local workforce boards prioritize programs according to local needs. Such a system, however, is challenging for a national distance-education solution like NIMAA, as it requires making connections and maintaining relationships with dozens of local workforce offices.

NIMAA is very interested in engaging workforce program clients in its program, and has had success doing so. NIMAA has also facilitated introductions between its clinical partners and local workforce boards, as many are unaware of the role of workforce boards and are not familiar with the boards in their region.

The Department of Labor in each State maintains lists of eligible training providers from which workforce participants may receive training and obtain support while doing so. NIMAA is on the Eligible Training Provider List (ETPL) in most states where it enrolls students.

However, in some states there are challenges to ETPL participation. Some states require that a training provider be regulated by the State department of higher education to be on the ETPL, but does not regulate distance-only programs. Others require that a training participant themselves request that a school be added. Some local workforce boards will not support training by distance-education providers, regardless of whether that training entity is on the list.

### **Recommendations for Expanding Access to Health Careers through Medical Assisting**

Career pathways for medical assistants should be better documented within career pipeline and pathway efforts to:

- Identify paraprofessional or non-clinical roles (such as certified nursing assistant, front desk staff, patient care technician) for which medical assisting is a natural next step.
- Assist medical assistants with their long-term goal of becoming a nurse or provider, and ensure they are aware of the educational and career steps and that will allow them to do so.
- Provide information to medical assistant students regarding the many career pathways that stem from medical assisting outside of provider roles.
- Assist health care employers in developing employee retention and advancement initiatives and partnerships.
- Facilitate the development of stackable credentials and articulation agreements in educational systems that reflect and support the career pathways that exist organically in the health care industry.
- Workforce funding should be available to facilitate the participation of non-profit community-based health care providers, including small and rural clinics as host sites for students, and support pipeline development and internal career advancement efforts.
- State and local efforts to expand healthcare apprenticeships should include funding to support participation by non-profit health care providers and should support training provided by non-profit vocational schools in addition to community college programs.

- Ensure that distance-education (on-line) training providers are eligible to be included on Eligible Training Provider Lists in all states, and streamline the process for inclusion on State lists.

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Senator HICKENLOOPER. Thank you.

Ms. Greszler.

**STATEMENT OF RACHEL GRESZLER, RESEARCH FELLOW IN ECONOMICS, BUDGET AND ENTITLEMENTS, INSTITUTE FOR ECONOMIC FREEDOM AND OPPORTUNITY, THE HERITAGE FOUNDATION, WASHINGTON, DC**

Ms. GRESZLER. Good morning and thank you for the opportunity to testify today. As an economist who focuses on labor policy, I would like to first discuss the current labor force shortage across the U.S. and then look specifically within the health care sector.

The current labor shortage is unlike any before in U.S. history. We have an unemployment gap of at least 4 to 5 million workers. Job openings, which are currently at 10.9 million, are 40 percent above their pre-pandemic record, and they are more than double the prior 10 year average. And employers are struggling, as 49 percent of businesses have positions that they are unable to fill.

Nearly half of all businesses have increased compensation in December alone and 32 percent plan to increase over the next 3 months. Those higher wages are a great thing when they come from workers becoming more productive, but when it is simply employers having to pay people more to do the exact same thing, that translates into higher prices.

We have seen today with a 40-year record high inflation that those wage gains have been entirely erased and real wages are actually dipped down. Resignations are also at record highs, with nearly one in three workers quitting their jobs in 2021. Replacing workers is extremely costly and this adds to burdens and creates higher costs. COVID-19 is not the main cause of the labor crisis, but rather bad policies that have restricted the labor supply and \$6.6 trillion in deficit finance spending has artificially increased demand for goods and services.

Instead of spending more Federal money and imposing more labor market distortions, policymakers should remove the employment barriers that they have created. That includes eliminating welfare without work policies, reducing tax burdens that are prohibiting higher wage and productivity gains, letting people pursue the work that they want, and expanding childcare options by allowing parents to use Federal head start funding dollars at a provider of their choice.

The health care workforce shortage includes both long standing issues as well as pandemic related ones. So prior to the pandemic, health care employment had been growing faster than overall employment, but that has since reversed, and especially so since the implementation of COVID-19 vaccine mandates. If health care employment had grown at the same rate as total employment over just the past 3 months, we would have 73,000 more health care workers today.

It is one thing if we are frustrated by long waits at restaurants, it is certainly a major disruption to have canceled flights or school busses that don't show up. But when hospital units close or people have delays and surgeries and simply can't access health care that significantly impacts people's health and even their lives. The CMS vaccine mandate could remove 70,000 or more health care workers from their jobs.

Congress should prevent this by protecting medical providers' right to set their own vaccine policies. The longer term health care workforce is primarily a State issue. State Governments need to eliminate unnecessary licensure, scope of practice, and certificate of need laws that limit the health care workforce. Doctors and nurses should be able to practice their professions where the need is greatest and not simply within the geographic confines of their license.

It is particularly ludicrous when a provider can't have a telehealth visit with a regular patient simply because they are out of the State at that time. Also needlessly restricting nurse practitioners from performing services that they were trained to provide limits care and drives up costs, and certificate of need laws have consistently proven anti-competitive and harmful.

While States are the primary gatekeepers of the health care workforce, the Federal Government can renew unnecessary burdens and promote competition and flexibility to better meet America's health care needs.

Some specific actions include adjusting Federal and State health care payments to shift the burden of bad policies like certificate of need laws onto the States that impose them. Expanding the use of telemedicine. Improving the graduate medical education system to meet more communities' needs. Not shortchanging home health care workers by sending part of their paychecks to unions without their consent. And reducing the regulatory burdens required by Federal health care programs.

The time is spent on paperwork and regulatory compliance is time that is not spent treating patients. 58 percent of doctors list paperwork and regulatory burdens as their biggest complaints, and nearly half of all physicians say that they are considering retiring earlier than planned because of changes in the health care system.

Lives are literally at stake because of the health care workforce shortage, and many regulations are needlessly making this worse. Congress should immediately stipulate the vaccine mandates are decisions for health care providers, and State and Federal policymakers should reduce barriers and burdens to better respond to Americans' increasing health care needs. Thank you.

[The prepared statement of Ms. Greszler follows:]

PREPARED STATEMENT OF RACHEL GRESZLER

My name is Rachel Greszler. I am a Research Fellow in Economics, Budgets, and Entitlements at The Heritage Foundation. The views I express in this testimony are my own and should not be construed as representing any official position of The Heritage Foundation.

My area of expertise is in economics and labor policies, so I would like to focus first on the unprecedented labor shortage in the U.S. today, including why it exists and how policymakers can help alleviate it.

I will then discuss recent trends in health care employment and provide recommendations for State and Federal policymakers to allow the health care workforce to more freely expand to meet growing health care demands.

It is important to note that since State licensing laws serve as the gatekeepers to the health care workforce, the Federal Government has limited the ability to increase the supply of health care workers. Federal policymakers must take these limits into account to avoid wasting taxpayer dollars.

### The Labor Shortage

The U.S. is in the midst of a labor shortage unlike any other in U.S. history. This is affecting every sector of the economy and exists across all levels of jobs. Total employment today is between 4.1 million<sup>1</sup> and 5.3 million<sup>2</sup> below where it might have been without the pandemic and absent other changes in economic conditions.<sup>3</sup> This employment gap is entirely a labor-supply problem. Without the shortage of willing workers, employment would likely be above trend right now, with an employment surplus instead of a gap.

This is the opposite of what was expected at the start of the pandemic, and in many ways is the result of bad policies that have restricted the supply of willing workers while simultaneously pumping large amounts of deficit-financed Federal spending into the economy with the effect of increasing the demand for workers.

**Labor Shortage Demographics.** Throughout the pandemic, different groups of workers have been affected differently. For example, at the beginning of the pandemic, lower-wage workers and women who were caregivers were more likely to have lost or dropped out of employment, and older workers who were at greater risk from COVID-19 were more likely to stop working.

Table 1 provides a breakdown of the employment gaps for various groups of workers, as measured by the percentage difference between current employment (December 2021) and where it would have been if, absent the pandemic, employment had followed steady-State employment growth.<sup>4</sup> (All tables and charts are also provided in full-size graphics at the end of this testimony).

Survey of the BLS. According to the BLS, these data are based on a very small number of observations and should be interpreted with extra caution. For further information on the CPS, see BLS, “Labor Force Statistics from the Current Population Survey: Technical Documentation,” <http://www.bls.gov/cps/documentation.htm> (accessed January 31, 2022).

Employment gaps are widespread. Women’s employment gap is slightly higher than men’s, and parents’ gap is significantly higher than non-parents. Notable, however, is that the parental employment gap is entirely the result of lower employment among parents of school-aged children (ages 6–17) as opposed to younger children (under 6). In fact, the 1.9 percent employment gap of workers with young children is lower than the 2.1 percent employment gap of workers without children, and significantly lower than the overall 2.6 percent employment gap. This implies that while parents struggle with finding accessible and affordable childcare, this is not unique to the COVID-19 pandemic and is not a cause of the recent labor shortage.

The rationale for large employment gaps of both men (5.1 percent) and women (5.2 percent) with school-aged children is unclear.

Initially, parents consistently experienced lower employment gaps than non-parents. That changed in late spring 2021. One factor that could have been weighing on parents’ employment in the latter half of 2021 was Congress’s passage of the American Rescue Plan including monthly child payments (beginning in July 2021) that were not conditioned on work.

<sup>1</sup> The 4.1 million estimated gap relies on total employment figures from unpublished tabulations from the Current Population Survey (CPS) of the U.S. Bureau of Labor Statistics (BLS).

<sup>2</sup> The 5.3 million estimated gap relies on total payroll employment figures from the Current Employment Statistics of the BLS. Payroll employment figures are lower than total employment figures in the Current Population Survey because they do not include some workers such as the self-employed.

<sup>3</sup> For methodology of the employment gap, see Rachel Greszler, “What Is Happening in This Unprecedented U.S. Labor Market?”, February 2022 Update,” Heritage Foundation Backgrounder No. 3684, forthcoming, <http://report.heritage.org/bg3684>

<sup>4</sup> All demographic employment data comes from unpublished tabulations from the Current Population Survey of the BLS. According to the BLS, these data are based on a very small number of observations and should be interpreted with extra caution. For further information on the CPS, see BLS, “Labor Force Statistics from the Current Population Survey:

A study by researchers at the University of Chicago estimated that making the child payments permanent would reduce the labor-force participation and employment of parents by 2.6 percent, which is 1.5 million workers.<sup>5</sup> With these payments now expired, future economic studies may help reveal the impact of unconditional child payments on parents' work decisions.

### **Labor Shortage Creating Tremendous Struggles for Employers, Consumers**

Businesses across nearly every industry in the United States are desperate for workers and have expanded their pay and benefit packages in response to the shortage of willing workers. Yet the number of job openings in the United States remains at record levels, with 10.9 million job openings in December 2021—the equivalent of 1.7 jobs available for each of the 6.3 million unemployed workers.

The current 10.9 million job openings are 3.4 million above the pre-pandemic high (November 2018) and reveal how difficult it is for employers to find the workers they need.<sup>6</sup> Simultaneously, workers are quitting their jobs at record-high rates. In 2021, 47 million workers quit their jobs, requiring employers to replace 11 million more workers than they had to in 2020, and 14 million more than the average between 2011 and 2020.<sup>7</sup>

With 4.3 million or 2.9 percent of workers quitting their jobs each month over the past 6 months, this pace translates into employers having to replace 35 percent of their workers (more than one of three) over the course of a year.

According to the National Federation of Independent Businesses, 49 percent of businesses had job openings that they were unable to fill in December 2021, with 95 percent of those businesses saying that they had no or few qualified applicants.<sup>8</sup>

**Adding to Inflation.** The labor shortage has caused employers to raise compensation, with a record-high 48 percent of businesses reporting that they increased compensation in December, and another 32 percent saying that they plan to raise compensation over the next 3 months.<sup>9</sup> Although hourly pay increased by an above-average 4.7 percent over the past year (December 2020 to December 2021), real average earnings (taking into account the effect of inflation) were down 2.4 percent.<sup>10</sup> for all employees on private nonfarm payrolls, seasonally adjusted, December 10, 2021, <https://www.bls.gov/news.release/realer.htm> (accessed January 13, 2022).

When employers have to pay workers more to perform the same jobs, they have to raise their prices, which has contributed to a four-decade high in annual inflation of 7.0 percent in December 2021.<sup>11</sup>

### **Causes of the Current U.S. Labor Shortage**

While some factors related to COVID-19 may be affecting certain workers' employment, it does not appear that the pandemic itself is weighing significantly on employment. Rather, some of the policies enacted in response to the pandemic have reduced workers' willingness and capacity to work. Maximum employment requires not only that it pay to work, but also that it not pay to not work.

**Compensation Is Rising.** Wages have been rising and workplace benefits have expanded (though high levels of inflation have reduced the value of wage gains). Over the past decade, average hourly earnings of all employees in the U.S. increased by 35.3 percent while average hourly earnings in health care increased 32.5 percent. Within the health care sector, average hourly earnings at hospitals rose 34.7 percent and earnings at nursing care facilities increased 39.5 percent.

<sup>5</sup> Kevin Corinth, Bruce D. Meyer, Matthew Stadnicki, and Derek Wu, "The Anti-Poverty, Targeting, and Labor Supply Effects of the Proposed Child Tax Credit Expansion," Becker Friedman Institute for Economics at the University of Chicago, October, 2021, <https://bfi.uchicago.edu/wp-content/uploads/2021/10/BFI-WP-2021-115-1.pdf> (accessed February 4, 2022).

<sup>6</sup> BLS, "Job Openings and Labor Turnover Survey," <https://www.bls.gov/jlt/> (accessed February 2, 2022).

<sup>7</sup> Ibid.

<sup>8</sup> National Federation of Independent Businesses, "Labor Market Challenges Breaks 48-Year Record as Biggest Issue Impacting Small Businesses," November 2021, <https://assets.nfib.com/nfibcom/2021-Nov-Jobs-Report-FINAL.pdf> (accessed date January 12, 2022).

<sup>9</sup> Ibid.

<sup>10</sup> BLS, "Real Earnings News Release," Table A-1: Current and real (constant 1982-1984 dollars) earnings for all employees on private nonfarm payrolls, seasonally adjusted, December 10, 2021, <https://www.bls.gov/news.release/realer.htm> (accessed January 13, 2022).

<sup>11</sup> BLS, U.S. Department of Labor, Consumer Price Index Summary, December 2021, <https://www.bls.gov/news.release/cpi.nr0.htm> (accessed January 12, 2022).

Since the start of the pandemic, in February 2020, overall average earnings in the U.S. have increased 9.9 percent (through December 2021), but health care has experienced significantly larger wage gains of 11.6 percent across all health care, 12.4 percent within hospitals, and 16.1 percent in nursing care facilities.

**Welfare-without-work Policies.** Various government programs and policies enacted in the name of COVID-19 have made it easier for people to not work, and almost certainly continue to play a role in weak employment, particularly among lower-and middle-wage workers. Those include \$600 weekly bonus unemployment insurance benefits, a 21 percent increase in food stamps, massive expansion in Obamacare subsidies, and an eviction moratorium and rental assistance.

A measure called the reservation wage, which is the lowest wage at which individuals will accept a job, surged 26.4 percent between March 2020 and March 2021 for workers making less than \$60,000 (from \$40,197 to \$50,825). It has since declined significantly as the bonus unemployment insurance benefits ended.

Evidence from past studies of welfare—without-work benefits find that they tend to reduce the supply of work, and a recent National Bureau of Economic Research study on the effects of the pandemic unemployment insurance benefits found that they significantly restricted employment.<sup>12</sup>

**Federal Spending Spree.** The Federal Government has spent \$6.6 trillion on COVID-19 packages—the equivalent of \$51,600 for every U.S. household. All this deficit-financed spending—over half of which has been purchased by the Federal Reserve—increases the demand for goods and services, which requires more workers to meet those demands.

**Vaccine Mandates.** Various states, private businesses, and medical facilities began implementing COVID-19 vaccine, or vaccine-and-testing, mandates in the late summer and fall of 2021. The Federal Reserve’s October 2021 Beige Book noted that vaccine mandates were contributing to high turnover and production slowdowns, and that impending “Federal vaccine mandates were expected to exacerbate labor problems.”<sup>13</sup>

Comprehensive data does not exist on how many health care workers have lost their jobs because of the vaccine mandate, but employment growth in health care between September 2021 and December 2021 was more than 60 percent below total U.S. employment growth over the same period. Had the health care sector experienced the same growth rate as total employment over just those 3 months, there would be 72,900 more health care workers today.<sup>14</sup>

This was during a time in which only some states had imposed vaccine mandates on the health care sector, and the legality of the Center for Medicaid and Medicare Services (CMS) vaccine mandate was still in question. With the CMS mandate going into effect across 25 states and the District of Columbia between now and February 28th, the health care worker shortage will almost certainly increase.

The experience thus far of health care providers subject to vaccine mandates shows that they have had a significant impact on employment and operations. While some providers have been able to keep terminations over vaccine requirements down to 0.5 percent or less of its workforce, some providers have had to terminate 2 percent or more of their employees. A sampling of news reports documenting significant effects include:

New York State’s largest health care provider, Northwell Health, had to lay off 1,400 workers—nearly 2 percent of its workforce.<sup>15</sup>

The Mayo Clinic fired roughly 700 workers—about 1 percent of its staff—due to the vaccine mandate.<sup>16</sup>

<sup>12</sup> Harry J. Holzer, R. Glen Hubbard, and Michael R. Strain, “Did Pandemic Unemployment Benefits Reduce Employment? Evidence from Early State-Level Expirations in June 2021,” National Bureau of Economic Research Working Paper No. 29575, December 2021, <https://www.nber.org/papers/w29575> (accessed February 5, 2022).

<sup>13</sup> U.S. Federal Reserve, The Beige Book, October 20, 2021, <https://www.Federalreserve.gov/monetarypolicy/files/BeigeBook-20211020.pdf> (accessed October 22, 2021).

<sup>14</sup> BLS, “Employment, Hours, and Earnings from the Current Employment Statistics Survey,” available for download at <https://www.bls.gov/data/> (accessed February 2, 2022).

<sup>15</sup> Joseph Choi, “Largest New York Health Care Provider Fires 1,400 Employees over Vaccine Refusal,” The Hill, October 4, 2021 <https://thehill.com/homenews/state-watch/575283-largest-new-york-healthcare-provider-fires-1400-employee-over-vaccine> (accessed February 5, 2022).

<sup>16</sup> Chantal Da Silva, “Mayo Clinic Fires 700 Workers Who Failed to Comply with Covid Vaccine Mandate,” NBC News, January 5, 2022, <https://www.nbcnews.com/news/us-news/mayo-clinic-fires-700-workers-failed-comply-covid-vaccinemandate-rcna11004> (accessed February 7, 2022).

UVM Health Networks in New York reported that, “vaccination mandate for healthcare workers has brought long-standing healthcares staffing shortage into sharper focus.”<sup>17</sup> With 55 employees voluntarily resigning for a variety of reasons since the mandate went into effect and another 30 leaving or being terminated as a result of the mandate, UVM has had to temporarily close units and delay inpatient surgeries by a week.

Mowhawk Valley Health System (MVHS) in New York State had to fire nearly 5 percent of its employees—180 in total—which increased the system’s vacancy rate from 13.7 percent to 17.5 percent, meaning the hospital had only about four employees for every five positions.<sup>18</sup>

When vaccine mandates leave hospitals and health care providers short-staffed, this reduces patients’ access to care and can diminish the quality of care they receive. One of my own family members had to take her 4-year-old daughter to a hospital in another state, 160 miles away, for emergency diagnosis and surgery because the nearest Children’s Hospital was experiencing significant staffing shortages due to the vaccine mandate.

As a labor policy economist, I have focused this Causes section on the current widespread labor shortage. I include some longer-term causes of health-care-specific labor shortages in the Solutions section.

### Health Care Labor Shortage

Shortages of health care workers—especially primary care doctors—existed before the pandemic and are projected to grow drastically

as the population of people ages 65 and older is expected to increase by 50 percent with the aging of the baby boomer population. Older people have more medical problems and more complex problems that result in higher medical utilization and costs.

A 2018 analysis by the Association of American Medical Colleges predicted that by 2030, there will be a shortage of between 42,600 and 121,300 physicians in both primary and specialty care.<sup>19</sup> There are also current and rising shortages in other health care positions such as nurses, home health care workers, and nursing home health aides. Too few health care providers translates into limited access to health care and worse health outcomes.

Prior to the pandemic, health care employment had been growing faster than overall employment, but not fast enough to keep pace with growth in the aging population that consumes the most medical care. Between December 2011 and the start of the pandemic in February 2020, total employment grew by 14.8 percent while health care employment grew 16.7 percent.

Since the start of the pandemic (February 2020 through December 2021), health care employment has been particularly hard-hit, experiencing a 2.7 percent employment decline compared to the overall 2.3 percent workforce decline.

Factoring in where employment would otherwise have been if the economy had experienced steady-State employment growth since February 2020, the overall employment gap is 3.5 percent<sup>20</sup> and the health care employment gap is 3.9 percent, or 644,000 fewer health care workers than might otherwise have existed absent the employment changes that occurred since the pandemic.

<sup>17</sup> The University of Vermont Health Network, “UMV Health Network NNY Affiliates Continue to Provide Care Despite Mandate,” Champlain Valley Physicians Hospital, September 28, 2021, <https://www.cvph.org/News/Detail/297> (accessed February 8, 2022).

<sup>18</sup> “MVHS Outlines COVID-19 Vaccine Mandate Impact on Health System,” September 28, 2021, <https://www.mvhealthsystem.org/news/2021-09-28/mvhs-outlines-covid-19-vaccine-mandate-impact-on-health-system> (accessed February 5, 2022).

<sup>19</sup> Tim Dall et al., The Complexities of Physician Supply and Demand: Projections from 2016 to 2030 (2018 Update), IHS Markit Ltd., for the Association of American Medical Colleges, March 2018, <https://aamcblack.global.ssl.fastly.net/production/media/filer-public/85/d7/85d7b689-f417-4ef0-97becc129836829/aamc-2018-workforce-projections-update-april-11-2018.pdf> (accessed August 24, 2018)

<sup>20</sup> This employment gap is based on the BLS’s Current Employment Statistics Survey. This is larger than the 2.6 percent gap reported in the demographic data because they include different populations and sample sizes. The demographic data is a survey of workers (not employers), and it has a smaller sample size and also a different method of measuring employment. (The demographic data can include self-reported employment whereas the health care and total employment figures mentioned above are based on firms’ payroll employment).

### Federal Government's Role in Health Care Workforce

The Federal Government has a limited ability to affect the supply of health care workers because State licensing boards regulate who can obtain professional licenses and what medical services they can perform. Nonetheless, the Federal Government's role in health care through federally funded health care programs has created barriers to the health care workforce. Many of the rules and regulations of these Federal programs affect the supply of the health care workforce.

**Significant Control of the Graduate Medical Education (GME) System.** The Federal Government currently spends billions of dollars each year on GME, or residency programs. Prior to the mid-20th century, hospitals usually absorbed the cost of GME without government subsidies, but in the 1960's, Federal funding for GME became part of Medicare spending. These Federal subsidies were supposed to be temporary, but have become the primary source of GME funding. By providing about \$15 billion in funding per year, it is likely that the Federal Government has crowded out financing that might otherwise have come from various other stakeholders.

The U.S. GME system fails to produce a sufficient number and adequate allocation of doctors to meet Americans' health care needs. Factors such as a 25-year-old cap on the number of Medicare-funded residency slots and the direct payment of GME funds to hospitals instead of being tied to students' results is a focus on teaching hospitals' needs instead of the health care needs of the American population as a whole.

**Recent Federal Investments in Health Care and the Health Care Workforce.** Pandemic legislation, including the Coronavirus Aid, Relief, and Economic Security (CARES) Act of 2020 and the American Rescue Plan (ARP) of 2021 provided huge investments in the U.S. health care workforce. Some of those investments include \$12.7 billion of increased Federal Medicaid matching funds to increase the workforce for home-and community-based services; \$8.5 billion for rural health providers; \$7.0 billion to invest in the public health care workforce; \$1.55 billion to address unmet health care needs and expand health care workforce programs in underserved communities; and about \$250 million for behavioral health workforce expansions.<sup>21</sup>

These recent funds are an enormous investment and will take significant time for their potential benefits to accrue. Congress should focus on ensuring the efficacy and accountability of these funds to meet their designated needs.

Instead of jumping to spend more Federal money to increase the health care workforce, policymakers should allow time (with proper oversight) for the existing tens of billions of dollars in investments in the health care workforce to play out. Moreover, Federal lawmakers should not spend money in areas where existing state-imposed barriers to the expansion of the health care workforce and health care access will prevent those Federal dollars from achieving their full value.

**Veteran's Administration Not a Gold-Standard for Care.** The Federal Government's direct provision of health care through the Veteran's Health Administration (VHA) and Veterans Affairs (VA) facilities falls short in its delivery of quality, timely, and affordable care.

According to a 2016 report from The Heritage Foundation:

Since 2014, investigations of the Veterans Health Administration (VHA) have revealed glaring issues with the Administration's policies and practices, including excessively long wait times and secret waitlists for health care at hundreds of Veterans Affairs (VA) facilities. A report from a VA whistleblower<sup>22</sup> shows that as many as 238,000 veterans may have passed away before receiving care.<sup>23</sup>

<sup>21</sup> Angela J. Beck et al., "Investing in a 21st Century Health Workforce: A Call for Accountability," *Health Affairs*, September 15, 2021, <https://www.healthaffairs.org/doi/10.1377/forefront.20210913.133585/full/> (accessed February 6, 2022).

<sup>22</sup> Ryan Grim, "Leaked Document: Nearly One-Third of 847,000 Vets with Pending Applications for VA Health Care Already Died," *The Huffington Post*, July 13, 2015, <http://www.huffingtonpost.com/2015/07/13/veterans-health-care-backlogdied-n-7785920.html> (accessed June 14, 2016).

<sup>23</sup> John O'Shea, "Reforming Veterans Health Care: Now and for the Future," *Heritage Foundation Issue Brief No. 4585*, June 24, 2016, <https://www.heritage.org/health-care/reform/report/reforming-veterans-health-care-now-and-the-future>.

The VA is uniquely structured to provide care for veterans and has plenty of need to improve on access, quality, and accountability. The VA should not become a means of expanding the government's role in health care beyond veterans.

**Federal Government's Failed Track Record in Job-Training Programs Evidence It Should Not Enact Health Care Workforce Training Programs.** In light of the health care worker shortage, it may be suggested that the Federal Government embark in health workforce job-training programs. But the Federal Government has a terrible track record on job-training programs.

A gold standard evaluation of the Workforce Investment Act found that despite the Department of Labor's directive to provide training for in-demand services, only 32 percent of participants found occupations in their area of training, and the majority of participants—57 percent—did not believe that their training helped them find employment.<sup>24</sup> Moreover, individuals receiving the full workforce training were less likely to obtain health insurance or pension benefits, their households earned several thousand dollars less, and they were more likely to be on food stamps than participants who received minimal services.

Annalisa Matri, and Ronadl D'Amic, "Providing Public Workforce Services to Job Seekers: 15-Month Impact Findings on the WIA Adult and Dislocated Worker Programs," *Mathematica Policy Research*, May 30, 2016, <https://www.mathematica.org/publications/providing-public-workforce-services-to-job-seekers-15-month-impact-findings-on-the-wia-adult> (accessed February 4, 2022).

The National Job Corps Study (a youth job-training program), found that a Federal taxpayer investment of \$25,000 per Job Corps participant resulted in participants being less likely to earn a high school diploma, no more likely to attend or complete college, and to earn only \$22 more per week, on average.<sup>25</sup>

It is not surprising that Federal job-training programs are out of touch with the needs of employers in high-demand occupations because politicians and bureaucrats will never know businesses' needs better than employers themselves. Politicians are particularly ill-equipped to understand and meet the needs of the health care industry. Any training efforts they may attempt to undertake would not only be thwarted by existing government regulations, but in the fast-paced and rapid-response health care industry, Federal efforts would almost certainly come up a day late and a dollar short.

### Solutions to Increase Health Care Workforce, Health Care Access

The severe labor shortage across the U.S. has had disproportionately large effects on the health care workforce, at the same time as the pandemic has increased the demand for health care and required new health care protocols that have made the provision of health care more costly and time-consuming.

Even prior to the pandemic, however, the U.S. faced a shortage of health care professionals. According to the Health Resources and Service Administration, 88 million Americans live in areas designated to have shortages of primary care health professionals.<sup>26</sup>

Although there are some actions Federal policymakers can take to make it easier for international medical professionals to enter the U.S., most barriers to expanding the health care workforce and access to health care rely on removing state-level barriers. No matter how much money the Federal Government may spend attempting to increase employment in and access to health care, it will be of limited use so long as states continue to restrict entry into health care occupations and unnecessarily restrict the services health care workers can provide.

There are steps, however, that Federal policymakers can take to enable greater flexibility for the health care industry to respond to Americans' health care needs,

<sup>24</sup> Sheena McConnell, Kenneth Fortson, Dana Rotz, Peter Schochet, Paul Burkander, Linda Rosenberg, Annalisa Matri, and Ronald D'Amic, "Providing Public Workforce Services to Job Seekers: 15-Month Impact Findings on the WIA Adult and Dislocated Worker Programs," *Mathematica Policy Research*, May 30, 2016, <https://www.mathematica.org/publications/providing-public-workforce-services-to-job-seekers-15-month-impact-findings-on-the-wia-adult> (accessed February 4, 2022).

<sup>25</sup> David B. Muhlhausen, "Job Corps: An Unfailing Record of Failure," Heritage Foundation WebMemo No. 2423, May 5, 2009, <https://www.heritage.org/jobsandlabor/report/job-corps-unfailing-record-failure>.

<sup>26</sup> Health Resources and Services Administration, "Shortage Areas," U.S. Department of Health and Human Services, <https://data.hrsa.gov/topics/healthworkforce/shortage-areas> (accessed February 7, 2022).

as well as to remove unnecessary burdens in Federal health care programs that limit health care access and prevent more innovative and cost-effective care.

It is also important for the Federal Government to ensure proper accountability and effectiveness of the tens of billions of Federal dollars recently allocated to expanding the health care workforce. This may require the Federal Government working with states to encourage them to remove barriers to that funding to achieve its intended purposes.

### **First, Ensure a Well-Functioning U.S. Labor Market**

Foundational to expanding the health care workforce—or any sector’s workforce—is a well-functioning U.S. labor market with ample participants. For individuals, that requires that it pays to work and does not pay to not work. To help encourage more people to pursue their productive capabilities, policymakers should:

**Limit Taxes and Reduce Regulations** so that individuals and employers can enjoy higher returns to work (such as greater pay, higher productivity, and increased opportunities).<sup>27</sup>

**Enable Greater Natural Wage Increases** by making it easier and less expensive for people to obtain income-enhancing education and skills, and by eliminating the double tax in investments that boost productivity and wages.<sup>28</sup>

**Make Welfare Work Better Through Work-Oriented Programs** that help people achieve independence (and also help break cycles of poverty).

**Let People Pursue the Work They Want** by not forcing workers into unions, by not enacting laws that prohibit companies from doing business with independent workers, and by clarifying the definition of “employee” across Federal laws based on the level of control the individual maintains over his work.

**Expand Accessible, Affordable Childcare** by allowing parents to use Federal childcare subsidies and Head Start funds at a provider of their choice.<sup>29</sup>

**Do Not Increase Government Spending.** Passing big spending bills with new unfunded entitlement programs in addition to the recent \$6.6 trillion in COVID-19 spending and atop the \$30 trillion U.S. Federal debt would be reckless and further interfere in the already troubled labor market.

### **Second, Remove Barriers that Restrict the Healthcare Workforce**

**Abandon Federal Vaccine Mandates.** The Federal Government’s vaccine mandate for Medicare and Medicaid providers extends to about 14 million workers. An October 2021 “Vaccine Monitor” survey from the Kaiser Family Foundation reported that 5 percent of adults say they would leave their job if their employer required them to get a vaccine or get tested weekly, and that figure jumped to 9 percent if weekly testing was not an option.<sup>30</sup>

While health care workers may be less likely than the general population to quit their jobs over a vaccine mandate, if even 0.5 percent of the 14 million workers subject to the CMS COVID-19 mandate quit, this would result in a loss of 70,000 health care workers.

The Federal Government should abandon the CMS mandate and instead allow health care providers to set their own vaccination policies, based on their simultaneous goals of providing safe environments and ensuring access to quality care.

### **Third, State and Federal Lawmakers Need to Remove Barriers to Entry and Eliminate Unnecessary Burdens in Health Care Delivery**

**Reform the Graduate Medical Education System.** Becoming a practicing physician in the U.S. requires between seven and 10 years of education that involves the cer-

<sup>27</sup> Adam N. Michel, “The Tax Cuts and Jobs Act: 12 Myths Debunked,” Heritage Foundation Backgrounder No. 3600, March 23, 2021, <https://www.heritage.org/taxes/report/the-tax-cuts-and-jobs-act-12-myths-debunked>.

<sup>28</sup> Jamie Bryan Hall and Mary Clare Amselem, “Time to Reform Higher Education Financing and Accreditation,” Heritage Foundation Issue Brief No. 4668, March 28, 2017, <https://www.heritage.org/education/report/time-reform-higher-education-financing-and-accreditation>.

<sup>29</sup> Rachel Greszler and Lindsey M. Burke, “Rethinking Early Childhood Education and Childcare in the COVID-19 Era,” Heritage Foundation Backgrounder No. 3533, September 30, 2020, <https://www.heritage.org/sites/default/files/2020-09/BG3533.pdf>.

<sup>30</sup> Liz Hamel et al., “KFF COVID-19 Vaccine Monitor: October 2021,” Kaiser Family Foundation, October 28, 2021, <https://www.kff.org/coronavirus-covid-19/pollfinding/kff-vid-19-vaccine-monitor-october-2021/> (accessed October 31, 2021).

tification of at least four different medical accreditation boards and councils.<sup>31</sup> Dr. Kevin Pham explains that while these organizations originally arose “to weed out sham schools and shoddy practitioners,” their safeguards have become a bottleneck, and the “organizations are becoming monopolistic.”<sup>32</sup>

These barriers and the GME system’s reliance on Federal funding makes it extremely difficult for smaller and rural community hospitals to sponsor residency programs, which results in a shortage of residency spaces and a misallocation of physicians across the U.S.

Policymakers should improve the GME system by consolidating GME financing into a single funding stream based on the cost of training residents; allocating GME funding management to the states based on agreed-upon criteria; having funds follow the residents rather than the training programs; and by including all stakeholders—not just governments—in GME financing.<sup>33</sup>

Moreover, policymakers should break the accreditation monopoly to encourage the development of additional and innovative GME programs.

**Allow Provisional Licensing for Medical School Graduates Who Do Not Receive a Residency Position.** Completing a residency program is generally necessary for medical school graduates to begin practicing medicine on their own. Yet, between 2014 and 2018, an average of 8,444 medical school graduates per year did not find a position in a residency program (which operates through a monopoly matching system).<sup>34</sup> States could potentially utilize the talent of these highly educated individuals by allowing for provisional licensing of medical graduates to work under the supervision of qualified physicians. A publication by Kevin Dayaratna, Paul Larkin and John O’Shea recommends that such provisional licenses, issued by state licensing boards, should include “earning a medical degree from an accredited medical school, passing the USMLE, and collaborating with a supervising licensed physician.”<sup>35</sup>

**Accelerate Visas for International Medical Graduates (IMGs).** According to the Council on Graduate Medical Education, IMGs make up about 20–25 percent of the physician workforce, but visa restrictions and delays limit their ability to come to the U.S. and help fill unmet health care needs. According to the American Medical Association, “The proportion of residency programs sponsoring H–1B visas for training has gradually decreased in the last few years as the immigration requirements are multistep, costly (for the employer), and often complicated with bureaucratic immigration nuances.”<sup>36</sup> U.S. immigration laws should make it easier for the U.S. to fill unmet physician needs through International Medical Graduates.

**Streamline Entry for Experienced Medical Professionals from Abroad.** To obtain a license to practice medicine in the U.S., many experienced doctors from foreign countries have to spend years completing the same type of internship and residency program as U.S. medical school graduates, even though many of those foreign doctors have already completed similar education and have years of practical experience.<sup>37</sup> American medical licensing boards should streamline the process for experienced foreign doctors to practice in the U.S., potentially utilizing a provisional licensing system.<sup>38</sup>

<sup>31</sup> Kevin Pham, MD, “America’s Looming Doctor Shortage: What Policymakers Should Do,” Heritage Foundation Backgrounder No. 3343, September 5, 2018, <https://www.heritage.org/sites/default/files/2018-09/BG3343-1.pdf>.

<sup>32</sup> *Ibid.*

<sup>33</sup> John O’Shea, MD, “Reforming Graduate Medical Education in the U.S.,” Heritage Foundation Backgrounder No. 2983, December 29, 2014, <http://thf-media.s3.amazonaws.com/2014/pdf/BG2983.pdf>.

<sup>34</sup> Kevin Dayaratna, Paul J. Larkin, Jr., and John O’Shea, MD, “Reforming American Medical Licensure,” *Harvard Journal of Law and Public Policy*, Vol. 42, No. 1, <http://www.harvard-jlpp.com/wplicensingcontent/uploads/sites/21/2019/02/Larkin-Final.pdf> (accessed February 7, 2022).

<sup>35</sup> *Ibid.*

<sup>36</sup> American Medical Association, “International Medical Graduates (IMG) Toolkit: Types of Visas and FAQs,” International Medical Education, <https://www.ama-assn.org/education/international-medical-education/international-medical-graduatesimg-toolkit-types-visas> (accessed February 6, 2022).

<sup>37</sup> Dayaratna, Larkin, Jr., and O’Shea, “Reforming American Medical Licensure.”

<sup>38</sup> Australia’s Medical Board provides a promising example whereby foreign medical professionals that are licensed in their own country and have passed the Australian licensing exam or similar equivalent can obtain a provisional license. Provisionally licensed doctors are granted one of four different levels of practitioner supervision, based on their qualifications. After proving their competence, foreign practitioners are eligible to obtain a full medical license.

American medical boards could also establish reciprocity agreements with other countries, so that the U.S. could accept certain levels of education and experience in other countries toward American licensure. Both of these policies would help reduce the shortage of spots in America's Graduate Medical Education system.

**Reduce Administrative and Regulatory Burdens.** According to Dr. Kevin Pham, "The essential health care interaction occurs between the physician and the patient, and anything that interferes with that relationship makes the best practice of medicine harder."<sup>39</sup> The more time that doctors and medical professionals have to spend complying with administrative and regulatory burdens, the less time they can spend doing what they were trained and desire to do—treating patients.

Excessive regulatory burdens that make it less desirable to work in health care can cause workers to prematurely leave their professions. According to a Physicians Foundation survey,

49 percent of doctors feel often or always burned out, and 58.3 percent of doctors' primary complaints are the paperwork and regulatory burden.<sup>40</sup> Moreover, almost half of physicians are considering retiring earlier than planned because of reasons related to changes in the health care system. This includes 41.2 percent of physicians younger than 45, and 50 percent of those 46 and older.<sup>41</sup>

Some of the most significant administrative burdens include quality-reporting measures, prior authorization requirements, and excessive documentation of details in clinical encounters. For example, an American Medical Association study found that a small, three-physician practice will complete an average of 100 prior authorizations per week. And Medicare requires doctors to recertify durable medical equipment every year for patients with chronic medical conditions, such as insulin pumps for individuals with type 1 diabetes.<sup>42</sup> The Federal Government, through the CMS should reduce and eliminate unnecessary administrative burdens.<sup>43</sup>

**Do Not Reduce Home Healthcare Workers Paychecks Through "Dues Skimming."** The Biden Administration seeks to force more workers into unions by extracting union dues from home healthcare workers' Medicare and Medicaid payments, without their consent.

Docking the paychecks of home healthcare workers'—or any workers'—paychecks and requiring them to cede control over their work to union officials will make healthcare work less attractive. The fact that only 6.1 percent of private sector workers are union members<sup>44</sup> shows that unions do not benefit all workers, and they would likely prevent some would-be healthcare workers from continuing in their jobs due to the higher costs and restricted autonomy that comes with union membership. No government—Federal nor state—should ever require workers to join a union as a condition of performing their desired jobs.

**Reform State Licensure Laws and Accreditation Rules.** State licensing laws determine who can perform various health care professions within a state. In many instances, State licensure boards function as political monopolies to prevent new entrants into the market, as opposed to public safety protectors. There are many ways states can and should prevent unnecessary licensure barriers, including by taking power away from monopolistic licensing boards, by reducing and eliminating unnecessary licensing requirements, by expanding options for individuals to obtain health care education, and by enacting reciprocity agreements with other states.

**Reform State Scope of Practice Laws.** Scope of practice laws act as a second barrier to the delivery of health care by restricting the range of health care services and procedures that already licensed professionals can provide, and by requiring varying levels of supervision for these professionals to practice in their field.

Most often, scope of practice laws apply to nonphysician providers such as nurse practitioners, or Advanced Practice Registered Nurses (APRNs). Currently, 25 states

<sup>39</sup> Pham, MD, "America's Looming Doctor Shortage: What Policymakers Should Do."

<sup>40</sup> The Physicians Foundation, 2016 Survey of America's Physicians, Practice Patterns & Perspectives, 2016, pp. 7–17, <https://physiciansfoundation.org/wp-content/uploads/2018/01/Biennial-Physician-Survey-2016.pdf> (accessed February 8, 2022).

<sup>41</sup> The Physicians Foundation, 2016 Survey of America's Physicians, Practice Patterns & Perspectives, pp. 29–33.

<sup>42</sup> Pham, MD, "America's Looming Doctor Shortage: What Policymakers Should Do."

<sup>43</sup> *Ibid.* This report includes the following recommendations: "Ease policies driving administrative burdens in the form of paperwork requirements; ease documentation requirements for clinical visits; rescind the mandate to use EHRs in order to receive full compensation by Medicare; and respect and support the role the private sector has to play in developing products that meet doctors' needs."

<sup>44</sup> BLS, "Union Members—2021," News Release, January 20, 2022, <https://www.bls.gov/news.release/pdf/union2.pdf> (accessed February 8, 2022).

plus the District of Columbia provide Full Practice Authority (FPA) for nurse practitioners to perform all of the services and procedures they were trained to perform.<sup>45</sup> The other 25 states reduce or restrict the ability of nurse practitioners to engage in one or more element of their practice and require career-long collaboration or supervision.

A Federal Trade Commission explains how scope of practice laws can limit the supply of primary health services and restrict competition between different types of practitioners:

Physician supervision requirements may raise competition concerns because they effectively give one group of health care professionals the ability to restrict access to the market by another, competing group of health care professionals, thereby denying health care consumers the benefits of greater competition. In addition, APRNs play a critical role in alleviating provider shortages and expanding access to health care services for medically underserved populations. For these reasons, the FTC [Federal Trade Commission] staff has consistently urged State legislators to avoid imposing restrictions on APRN scope of practice unless those restrictions are necessary to address well-founded patient safety concerns. Based on substantial evidence and experience, expert bodies have concluded that APRNs are safe and effective as independent providers of many health care services within the scope of their training, licensure, certification, and current practice.<sup>46</sup>

**Eliminate State Certificate-of-Need (CON) Laws or Require States to Bear Financial Burden.** Imagine if opening a business required procuring detailed analysis and projections, hiring lawyers, lobbyists, and consultants, and convincing existing competitors to not oppose your entry into the market. This is what hospital offices and medical providers must do to prove to a State agency that there is a “need” for the new or expanded facility they want to build. Academic studies show that Certificate-of-Need (CON) laws that exist in 35 states and the District of Columbia lead to lower quality, reduced access, and higher costs, including 30 percent fewer hospitals and 11 percent higher healthcare costs.<sup>47</sup> The FTC and the Anti-Trust Division of the Department of Justice (DOJ) have consistently come to the same conclusion under both Democratic and Republican Administrations.<sup>48</sup>

States should eliminate CON laws and Congress should consider evaluating the extent to which CON laws are driving up Federal healthcare costs and adjust payments to the states accordingly, to prevent Federal taxpayers from bearing the financial burden of states’ bad policies.<sup>49</sup>

**Expand the Use of Telemedicine.** Access to telemedicine can be extremely beneficial for all populations, and especially those in rural areas and older people or individuals with disabilities for whom it can be more difficult to travel to appointments. Ongoing private investments along with a recent \$48 billion in Federal investments in broadband services will greatly expand broadband access. Federal lawmakers should provide parity of payments within Federal programs for telehealth and in-person visits. And State lawmakers should remove barriers that prevent healthcare practitioners in one State from providing telehealth services to patients in another state.

<sup>45</sup> American Association of Nurse Practitioners, “State Practice Environment,” <https://www.aanp.org/advocacy/state/state-practiceenvironment> (accessed February 7, 2022).

<sup>46</sup> Federal Trade Commission, “Competition and the Regulation of Advanced Practice Nurses,” Policy Perspectives, March 2014, <https://www.ftc.gov/system/files/documents/reports/policy-perspectives-competition-regulation-advancedpractice-nurses/140307aprnpolicypaper.pdf> (accessed February 8, 2022).

<sup>47</sup> See State Policy Network, “Certificate-Of-Need Laws: Why They Exist and Who They Hurt,” SPN Blog, April 1, 2021, <https://spn.org/blog/certificate-ofneedlaws/text—The-percent20Kaiser-percent20Family-percent20Foundation-percent20found,residents-percent20across-percent20the-percent20entire-percent20State> (accessed February 8, 2022).

<sup>48</sup> Maureen K. Ohlhausen, “Certificate of Need Laws: A Prescription for Higher Costs,” *Anti-trust*, Vol. 30, No. 1, Fall 2015, c 2015 by the American Bar Association, available at: <https://www.ftc.gov/system/files/documents/public-statements/896453/1512fall15-ohlhausenc.pdf> (accessed February 8, 2022).

<sup>49</sup> Robert E. Moffit, “State Certificate-of-Need Laws Deserve a Federal Response,” *Real Clear Health*, January 10, 2022, <https://www.realclearhealth.com/articles/2022/01/10/state-certificate-of-need-laws-deserve-a-federal-response-111288.html> (accessed February 8, 2022).

### Summary

The U.S. is experiencing a labor shortage unlike any before in U.S. history, and the health care sector has been particularly hard-hit.

The Federal Government has limited availability to affect the supply of the health care workforce and it should not be in the business of directly training health care workers.

Ultimately, states control the entry gates to the health care workforce. States need to eliminate unnecessary licensing and scope of practice restrictions. Unless or until they do so, any

Federal funding aimed at expanding the health care workforce will be of limited value.

Federal policymakers should immediately focus on removing barriers that are contributing to the nationwide labor shortage, such as vaccine mandates, welfare-without-work programs, and restrictions on individuals' ability to work in the ways that work best for them. Moreover, policymakers should refrain from enacting further massive Federal spending bills that would artificially and unsustainably pump up the demand for workers.

Within existing Federal funding and health care programs, policymakers should enable greater flexibility to respond to America's health care needs, and remove unnecessary burdens in Federal health care programs that limit health care access and that prevent more innovative and cost-effective care.

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**Employment Gaps by Gender, Presence of Children, and Age**Difference Between Actual Employment Levels and Counterfactual Employment Trend,<sup>1</sup> February 2020 To October 2021<sup>2</sup>

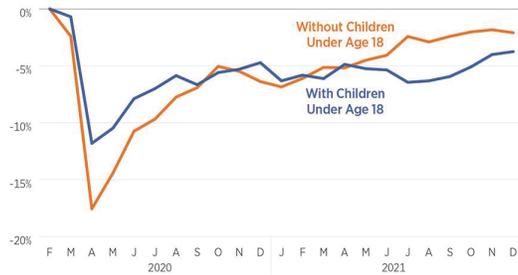
| Group                                       | Employment Gap,<br>Individuals | Employment Gap,<br>Percentage | Share of Total<br>Employment Gap |
|---|--------------------------------|-------------------------------|----------------------------------|
| All Workers                                 | -4,137,893                     | -2.6 percent                  | 100 percent                      |
| Men   | -1,996,801                     | -2.4 percent                  | 48.3 percent                     |
| Women                                       | -2,141,091                     | -2.9 percent                  | 51.7 percent                     |
| Workers with children                       | -1,889,868                     | -3.8 percent                  | 45.7 percent                     |
| Workers without children                    | -2,248,024                     | -2.1 percent                  | 54.3 percent                     |
| Men with children under 18                  | -823,138                       | -3.2 percent                  | 19.9 percent                     |
| Women with children under 18                | -1,066,730                     | -4.3 percent                  | 25.8 percent                     |
| Men without children under 18               | -1,173,663                     | -2.1 percent                  | 28.4 percent                     |
| Women without children under 18             | -1,074,361                     | -2.1 percent                  | 26.0 percent                     |
| Workers with children 6 to 17, none younger | -1,490,634                     | -5.1 percent                  | 36.0 percent                     |
| Workers with children under 6               | -399,234                       | -1.9 percent                  | 9.6 percent                      |
| Men with children 6 to 17, none younger     | -731,803                       | -5.1 percent                  | 17.7 percent                     |
| Women with children 6 to 17, none younger   | -758,831                       | -5.2 percent                  | 18.3 percent                     |
| Men with children under 6                   | -91,335                        | -0.8 percent                  | 2.2 percent                      |
| Women with children under 6                 | -307,899                       | -3.1 percent                  | 7.4 percent                      |

<sup>1</sup> Counterfactual trend is based on a definition of steady-state employment growth from the Federal Reserve, equal to monthly growth of about 84,000 (0.053 percent)

<sup>2</sup> **SOURCE:** Unpublished tabulations from the U.S. Bureau of Labor Statistics' Current Population Survey. Data should be interpreted with caution as they are based on small sample sizes

### Pandemic Employment Gap by Presence of Children

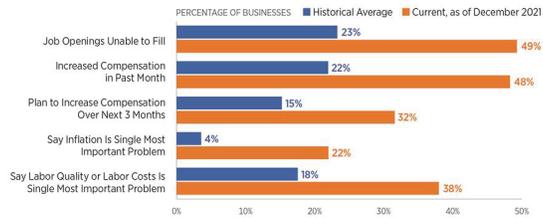
DIFFERENCE BETWEEN ACTUAL EMPLOYMENT AND COUNTERFACTUAL TREND\* SINCE FEBRUARY 2020



\* Counterfactual trend is based on a definition of steady-state employment growth from the Federal Reserve, equal to monthly growth of about 84,000 (0.053 percent).  
**SOURCE:** Unpublished tabulations from the U.S. Bureau of Labor Statistics' Current Population Survey. Data should be interpreted with caution as they are based on small sample sizes.

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### Businesses Struggle Amidst Labor Shortages, Rising Costs



**SOURCES:** National Federation of Independent Businesses, "Small Business Economic Trends Survey," <https://www.nfib.com/survey/small-business-economic-trends/> (accessed February 1, 2022), and National Federation of Independent Businesses, "Small Business Jobs Report," <https://www.nfib.com/foundations/research-center/monthly-reports/jobs-report/> (accessed February 1, 2022).

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Senator HICKENLOOPER. Great. Thank you very much. Thank all of you. I look forward to beginning the question. And I before we get to that, I would like to turn the microphone over to the Chair of the overall HELP Committee. This is the Subcommittee on Employment and Workplace Safety. But Chair Murray is here, so I would like her opening statement.

#### OPENING STATEMENT OF SENATOR MURRAY

The CHAIR. Thank you very much, Senator Hickenlooper, for organizing this hearing to talk about how we can support our health care workforce. And thank you to all of our witnesses for offering your insights on this really important topic. The discussion about how we can diversify our health care workforce is so important to improving health care for communities of color and increasing health equity.

I am really glad to be able to join for a few minutes today and really highlight the challenges I have been hearing about from health care workers in particular, something I know is a big priority for all of us. I have heard from so many nurses and doctors and other health care workers back in Washington State about how hard this pandemic has been, and I know there are similar stories across the country.

Health care workers have handled long hours, overcrowded facilities, fighting a deadly new virus, often while receiving low pay. They have worried about whether they have the equipment they need, or whether they are safe at work, or would get sick, or bring a deadly virus home to their family, and whether they could make ends meet on the wages they were paid, let alone if they had to stay home to care for themselves or for a loved one.

They have had to patiently deal, and compassionately deal with patients and family members who may have been afraid they may never see their loved ones again, frustrated by steps required to keep everyone safe, or even skeptical about the threat of this virus due to misinformation and angry with health care professionals who are just trying to help. They have seen the pain of this pandemic up close and personal, and it is taken a real toll.

Far too many health care workers have been killed by this virus, and many more are dealing with the trauma, mental health challenges, and burnout in its wake. That is why I pushed for historic investments in the American Rescue Plan to further support our health care workforce, including robust funding for workplace safety and health protections from COVID-19, as well as address some of the personal challenges facing these workers.

This pandemic has really made it clearer than ever how important it is that our health care workers are paid what they deserve, that they have a voice in the decisions about how we should recruit and train and retain health care workers, have safe workplaces which are adequately stocked and staffed, and are protected from infectious diseases and workplace violence.

We also need to make sure that all workers have paid leave for when they need to care for themselves and their own families so they can get mental health care when they need it and can choose

to join a union and collectively bargain for better wages and working conditions.

After all they have done for our communities, we owe it to our health care workers and everyone on the front lines of this pandemic to listen to their experiences and respond to the challenges they are dealing with. As we work to improve recruiting, retaining, and training for health care workers, one critical aspect of this is ensuring we improve the working conditions.

I am glad we are having this discussion today on ways we can support our health care workforce. And I am committed to making sure we include health care workers in this important conversation as it continues. And before I finish, I would just like to know we will have letters I plan to submit for the record and ask consent to do so.

Senator HICKENLOOPER. Without objection.

[The following information can be found on pages 59 through 85 in Additional Material:]

The CHAIR. Thank you, Mr. Chairman.

Senator HICKENLOOPER. Terrific, thank you very much. I know we will start our questioning and I—my only guidance, I usually instruct witnesses to keep your answers concise because there is I think you will be amazed how many questions we have, and we will get two more questions if we can be concise.

I realize I always hold that 45 seconds or 30 to 45 seconds is a goal. I realize that is usually not always possible. Let me start with Dr. Verret. Your university led the way in producing students and alumni who excel in various health professions. In particular, the Xavier is focused on intensive faculty advising, academic research centers, and co-curricular programs appears to have been critical to the success exhibited by your—achieved by your students.

I mean, this is a clearly a successful model. Xavier has been consistently for a number of years the No. 1 university and as a source for African-American students who go on to become doctors. Now you described certain additional investments that the Federal Government could make.

How else at the Federal level can we replicate, I mean, really tried to take the success that you have achieved with Xavier's programs and replicate it in schools across the country?

Mr. VERRET. Well, I would say that—to begin first is that clearly what we do in the pipelines before, in the pre-collegiate experience is an important piece. I would add that. Because what are—in preparing students who may not be aware of the access, the opportunities themselves because in many cases they have not—they are only hearing of college toward the end of their high school years.

It is a crucial piece in getting that type of pipeline. The other piece is that we also—it is important that we help students discover their weaknesses, because all students come with weaknesses, early in the education, so that what we do in providing academic support is first in the discovery process for students to discover what they know, where they are strong and where they are weak, and what support they would need.

The other piece that is a difficult one to replicate easily is actually the intentionality of forming a faculty that is committed to that kind of work. And how the faculty reflect—is committed to actually recognizing that not all students come with the education that they fully deserve. Not—most children do not choose the schools that they attend, at least not yet, in this country.

Students come with different—with different deficits. And the important thing is that deficit does not mean a lack of talent, ability. It is important that we remedy those deficits early in the experience, not later. It is important because what we discover in the first or second year, we can repair. In the third or fourth year is more difficult.

It is important that we confront that, and I use the expression of one of our students in understanding that even though they may complain that the faculty—of the staff or other things at Xavier, they will say that the faculty has our back because they know that commitment and that, and faculty committed is an important element.

Senator HICKENLOOPER. Excellent. And I just learned last week that the College Board, now known—is not just AP, advanced placement tests that they give, there are enough high schools all across the country recognizing the need for health care professionals that they are going to have an AC test so kids in high school will have it, it will be an advanced career opportunity and allow them to get some recognition and credit for taking these early, and during high school preparations for a health care career.

Dr. Flinter, during the COVID-19 pandemic, obviously burnout reached an apex. Millions of workers are reevaluating what they value in their job or their career. I mean, even before the pandemic, burnout in the health care workers was a major challenge given the nature of the work, the intensity.

Dr. Flinter, how can upskilling opportunities like nurse practitioner training programs help reduce burnout and address long term retention among the health care workers?

Ms. FLINTER. Well, thank you for the question. And let me say it was our honor to serve in the COVID pandemic.

I think in my organization, we often felt like we were on the frontlines of a battle, unlike anything we had ever seen, and whether we were outside in the freezing cold or the burning heat of July, people were very grateful to serve and to make a contribution through first testing and then vaccine.

But the work is very difficult, inherently. People sign up for the difficult work of health care, right to meet humanity sometimes at its most vulnerable moments, and to also work to keep them well. If in addition to that, you don't have the skills to provide the level of care that is needed by the population you care for, and again, I speak to our safety net settings in our rural areas where primary care is where everybody comes, they don't go off to a specialist on the first pass, you significantly increase the difficulty.

If you don't have behavioral health clinicians as part of your primary care team, you significantly increase that difficulty. If you don't have the MAs who can help manage and make automatic,

what should be automatic in prevention and screening, you increase the difficulties.

Training is a big piece of it, making sure that we have the whole team and not just part of the team to have the most effective primary care, I think is another piece. And then the third, of course, is its every organization's responsibility to ensure that they are providing both the safe workforce, as Senator Murray alluded, but also providing the ongoing training.

We participate in the NIMAA program. We welcome students, more than 200 a year, from all the disciplines and all the health care institutions in Connecticut to make sure that we are building that pipeline that can continue to increase that skill level.

Senator HICKENLOOPER. Great. Thank you very much. I have more questions and hopefully we will have time for a second round. If not, I will make sure I submit them in writing. I now turn over to Senator Braun for his questions.

Senator BRAUN. Thank you, Mr. Chairman. Touched on it earlier in my opening statement that I feel a lot of what we are navigating through currently addressing COVID, it was a feisty foe. None of us knew much about it. I know in my own company which in discussing what we were going to do when I touched base weekly, it was about treating it with respect.

It was about doing those things that we all know now that the science is saying what did work and what didn't work. And so often you get the political science involved in the discussion and it keeps us off the mark. I was going to ask Ms. Greszler about vaccine mandates. I led the charge in the Senate with the Congressional Review Act about why that didn't make sense.

Life is not fixed ever from the top down. It would be different if we were knocking it out of the park here at the Federal level. And in my 3 years, I have so many people come here wanting more of it, heard some from the panel that we need to spend more money.

The reality check is we borrow almost 25 percent of everything that we spend here, and that is up close to 30 percent. It is a bad business plan to probably look for more of that. I agree, on the other hand, that these are real issues. But do we keep shoveling more into a broken system or do we take a more entrepreneurial, a different approach?

The results say do something different. It is 20 percent of our GDP. It is 10 percent elsewhere. Ms. , you, tell me what you think about vaccine mandates. That was going to be my first question. Being an economist—my degree was in economics after I thought I was going to be a biology major. And when I found out it took 9 years to become a surgeon, I didn't get into the field.

That is part of the issue too, how long it takes, how costly it is for practitioners, for doctors on the firing line. How much of what we struggle with is due to the fact that I am a one of a lonely voice of Republicans that says the industry itself, no competition, no transparency, it is a business of remediation not prevention, increasingly dominated by large corporations that do not want to do the things that before you start throwing more Federal dollars at it, how do you fix the system itself?

Is the health care industry broken in the fact that it doesn't embrace competition, transparency, all kinds of barriers to entry, not to mention that we have a health care consumer that really isn't interested in her or his own well-being other than fix it when it is broke?

Ms. GRESZLER. Yes, let me start there with the immediate—and you mentioned the vaccine mandates, and that is where I think that you know what it is like as an employer. The medical facilities that are out there know the needs of their communities, they know the needs of their workers, and they are the ones that are better able to make the decision to balance the safety needs and the needs of actually having people there to treat their patients that come in.

That is why the decisions need to be made there. And we have seen in places that have implemented these mandates, having to lay off up to 2 percent of their workforce. That is an enormous number if you multiply that across potentially 14 million workers. And the particular problem is for more rural areas. I know a lot of you are from rural areas and those are smaller facilities.

If they lose 2 percent of their workforce, that is really difficult for them. I know I had a family member myself that had a pediatric emergency and was told, you need to travel to another State 160 miles away to that hospital because the nearby Children is Hospital is having shortage because of the vaccine mandates.

That is an immediate problem, but there are many long standing issues here. Ultimately, the States are the gatekeepers of who gets to practice medicine within their State. And so a lot of it comes down to that. And certainly, it doesn't make sense to be throwing Federal money at a gate that is not going to be opened up. We have seen more than \$10 billion invested recently.

I think it will take time to—for that money to play out. You can't increase the workforce overnight. And so we need to wait and see what happens there. But there are also things immediately that don't even cost any money, just removing those regulatory burdens that are out there. Part of the burnout issue is you want to have more time—

Senator BRAUN. Ms. Greszler, before we run out of time, and I will come back and ask it again, removing regulations, all of that. What about the industry itself? You are an economist. Does it embrace competition, transparency, and does it have barriers to entry? Give me your quick kind of pass on that, and if I need more, I will ask it on a second round.

Ms. GRESZLER. Yes, there are absolutely barriers to entry out there, and there are interests that are fighting against the competition that could lower costs and that could improve the quality of care. And part of that has to do with, I would say, an excessive level of Federal money and Federal rules and regulations that kind of dictate the system.

Senator BRAUN. Thank you.

Senator HICKENLOOPER. Thank you.

Alright, Senator Baldwin.

Senator BALDWIN. Thank you, Chair Hickenlooper. Thank you, panelists, for your testimony today. I really appreciate your focus

on this critical issue. Certainly what you have been discussing as a parent in the State of Wisconsin, in my discussions with health care leaders and advocacy groups for the health professions.

One thing I want to hear thoughts about is it in terms of preparation, especially in nursing. We have an urgent nursing shortage in the State of Wisconsin, in hospital settings, in clinical settings, in nursing home settings.

Although at the same time, there are eligible students who are turned away from potential training because of the shortage of nursing faculty. And the aging of that workforce only suggests it is going to get worse rather than better. I wonder if Dr. Flinter and Dr. Verret, if you could both speak to those issues as you see them.

Ms. FLINTER. Excuse me. Thank you for the question. I think it is multi factorial, right, in terms of the issue. Certainly of the aging of the nursing workforce, including faculty, maybe one that is also a compression, often in clinical training sites.

That is part of why I think nationally, community health centers have really tried to step forward and say, remember, training in primary care is very critical for our ends as well and really stepped forward to welcome more students, and that is one way we contribute in that setting to it.

Beyond that, we need to recognize that nursing is a broad profession, and that people may find their place where they can make the greatest contribution as faculty people, they may find it in private settings, they may find it in our safety net settings and to support people and having opportunities for really good preparation for those roles at the graduate level, as well as at the entry practice level.

We have just initiated a program with universities in Connecticut to make sure that their fourth year students actually have a capstone experience in a high-performing community health center to remind them that is an option as well. And we need to emphasize all of those pathways, research, practice, education.

Mr. VERRET. I would just want to add—I would just want to add that also we have, as Dr. Flinter mentioned, there are many factors, the shortage on the number of nursing programs, faculty and all that drives the issue. But also the other factor is the pipeline of students.

That we have—the number of barriers to students, especially our students who are of modest means, who are making decisions based upon, can I afford it? Can my family afford it? What is the impact and how we actually create pathways where the barriers are not as high to access those fields because there is a lot of talent in our second, third, fourth and fifth grades? But I don't think we have also all the talent that we have on the table as a Nation.

Senator BALDWIN. We have been talking a lot about primary care, but the complexity, Dr. Flinter, of primary care, it doesn't suggest necessarily a healthy population, etcetera. I have been focusing in on some of the urgent shortage issues, whether it is the infectious disease area of practice or the palliative and hospice care workforce or the perinatal workforce.

I wonder if you can talk about why it is important to fully build out the workforce and training pipeline when we think about shortages in these areas. And then Dr. Verret, if you can speak to particularly the necessity for a diverse workforce in all of these areas, but I think so strongly about the perinatal workforce.

I am involved in the Perinatal Workforce Act because even before the pandemic, black women in Wisconsin faced significantly higher rates of maternal complications and deaths than white women.

The Perinatal Workforce Act, which I sponsored with my colleague, Congresswoman Gwen Moore, to improve access to maternity care and grow diversity of the perinatal workforce, it is—this is critical to addressing some of the staggering maternal health inequities that we face as a country. So if you could start, Dr. Flinter.

Ms. FLINTER. I will, and I want to thank you for your comments about the critical issue of maternal infant morbidity and mortality. And I want to tell you that is front and center, I think, of all of our efforts wherever we are. You know, when it comes to the specialties and the pipeline, every specialty is critical.

You speak to your passion of speaking to primary care today. But we could not do what we do without those specialties when the time comes. I think the most effective thing we can do in primary care is to make sure that we are practicing to the maximum competence that we can within primary care and then sending on the people that really need that specialist.

If I may, one innovation that has been proven to reduce costs overall and to increase access and improve outcomes, is something called an e-consult. And we are used to in safety net settings in particular, you would wait months, months to get an appointment with an endocrinologist, with an allergist of just about any kind.

We developed a model, we call it e-consults now through a group called ComfortMed, where we can get, a primary care provider can get an excellent, in-depth consultation within 2 days and decide. And then it turns out about 75 percent of the time they don't need to follow-up in person. They can give guidance to the primary care provider.

That means there is room in that specialist practice to see the people who really need to be seen, and I think that is absolutely critical. I know others that may decide what those numbers are, how many in each specialty. We need the right care from the right people at the right time.

I think that is part of avoiding the kind of excess cost that people talk about. You need to see the right person at the right time. HIV used to be a disease of specialists. We trained all of our primary care providers to be HIV specialists, just as an example.

Mr. VERRET. What I would add to the diversity question, why diversity? I would first begin by that it does create an essential element of trust in the health care system, that is a barrier. It is not so much about having a physician—it is not so much about having your physician as the someone of the same sex, race, ethnicity as you are.

But the presence within the health care system of people who resemble you creates trust in the system and that is one social factor.

And as we mention in medicine often, the social factors are as important as the technical and clinical factors as well.

The other piece that I would say is that we have to actually understand that our most precious resource as a Nation, as any nation, are our children and the brains that they have, and that we have in the last 100 years that we have dependent upon assuming that we could rely upon only a fraction of the resource of our population for talent.

We do know that there is genius that is available to us, whether it is in architecture, construction, in medicine, or in science or wherever. That by not educating students who actually can become and aspire to join us in many of the professions we need, teaching, nursing, medicine wherever, we are driving this workforce shortage that we have—the talent need.

I would even elevate the talk to talk to a high question that if the U.S., like any nation, aspires to lead internationally, globally on any dimensions as economically, from a geopolitical point of view, it needs to have the brains that—it needs to cultivate its own brains. And that begins in K-through-12.

We have to funnel them to whatever level of education allows for them to refine those skills. And that is where we are seeing in health care that we need that presence, but we need those numbers. Those numbers are scary because as you and I are all getting old, we will need care, and that care may not be there.

Senator HICKENLOOPER. Thank you.

Now, I will turn it over to Senator Tuberville.

Senator TUBERVILLE. Thank you, Mr. Chair. Thank you very much. Thanks for being here. I continue to hear from hospitals in my home State of Alabama that our nursing shortage has reached a State of emergency. We have so few nurses to go around that hospitals have resorted to contracting with nurse staffing agencies to fill empty slots.

These agencies pair nurses who are willing to travel with hospitals facing large vacancies, and in many cases, they fill a very important need. I am concerned, however, that these agencies might be taking advantage of a very dangerous situation. They are able to charge a high percentage cut for their services, and hospitals have no choice but to pay their prices. It is huge in our State of Alabama.

I want to be clear, nurses with the backbone of our health care system and they have been on the front line heroes, our frontline heroes throughout COVID-19 pandemic. Every nurse should have the right to take the high salary available. I do not want my question to be interpreted as undervaluing nurses worth in our health care system, but I am concerned, however, that these staffing agencies might be exploiting are already overwhelmed health care system.

I would like for all four of you to say something about this briefly. This question is for everybody. What do we currently know about these agencies, and the cut they get from our lucrative contracts with struggling hospitals, and what can be done to address this issue?

Ms. GRESZLER. I will start. I don't know a lot about the agencies themselves, but the fact that so many are going to those agencies and needing that, and two things there is just the burdens that are placed on the nurses and those burdens were increased because of COVID-19, and some of them were necessary, some of them weren't and a lot of underlying things before them were, and so how can we reduce the amount of time that nurses and the doctors need to spend on needless paperwork and regulatory burdens so that they can have more time to be treating patients.

That effectively gives you more workers because it is more work-er time. And then also just addressing the State laws so that you can, the demand can go where it is needed most, and we don't have those barriers that are needlessly preventing people from practicing where they should be.

Senator TUBERVILLE. Thank you.

Ms. QUINONES. I am sorry, I don't know enough about nursing. That is out of my scope where I work, so I have no comment.

Senator TUBERVILLE. Thank you.

Mr. VERRET. I too don't know much about the agencies, but I am aware of—but there is, we have effectively a shortage of nurses. And so there is a supply issue, but also clearly it is becoming a compensation issue for many of our hospitals as well, how we compensate them will be an issue. But clearly that problem has to do with basically a shortage of nurses that hospitals are competing among themselves for nurses, even within the same city.

Senator TUBERVILLE. Thank you.

Ms. FLINTER. Thank you, Senator. May I say I just had a chance to visit Cahaba Medical Care in Alabama and a nurse practitioner residency program. There, you all are doing a great job down there and meeting the needs of your rural population. You know, the travel agencies have always been with us, I think, for decades so this is not new. I think they fulfill a certain role most of the time.

There is a portion of people who like that lifestyle. Wouldn't work for me as a nurse, but they like the lifestyle of traveling to different organizations, and they play probably a vital role when, not in COVID times in the same way, when there is a shortage of people in one area or another of a hospital. Where we have an issue, where I have an issue is when we are losing valuable experienced nurses from positions because that position is no longer attainable. And often that position is no longer attainable because it is been understaffed for a long time or under-resourced and people are just frustrated.

I think the issue is to support our host organizations and making the environment for nursing practice, whether that is thinking about the patient workload so you can give safe care, the other people on team to make that organization a place that nurses want to commit to and stay. I don't think people lightly give up a satisfying practice as a nurse to do travel nursing. But I think the travel agencies also play some role on an ongoing basis. Again, COVID threw everything to the wind. State policy, I think, can sometimes aggravate or help this.

I will say my State of Connecticut took broad action to credential a whole group of people is what they called Tier 2 vaccinators during the COVID pandemic in order to not have to rely only on nurses or physicians, PAs to give vaccines.

Our dentists, our dental hygienist, podiatrists were able to come and get trained and get an additional certification. So we need to, I think, always look at these things from a variety of perspectives. But the core is to make practice satisfying where nurses are in their communities, I think.

Senator TUBERVILLE. Thank you very much. Thank you.

Senator HICKENLOOPER. That was an instructive row of answers to a good question. Now, and I am sure you are aware—I should have said this earlier. We do have this virtual hearing, it is a bilateral hearing, so we have now Senator Rosen from Nevada on virtual. So, she is next.

Senator ROSEN. Well, thank you, Chair Hickenlooper, and of course, Ranking Member Braun for holding this really important to me hearing today. And of course, the witnesses, for everything you do and for being here with us. And of course, it is so important that we lower those barriers for providers.

We all know that because health care providers with advanced training, such as physicians or some of you just mentioned dentists, they have to complete residency trainings in order to care for patients. They often exit the training with significant student loan debt. The debt is made far worse by the fact that interest accrues while they are still in residency training. They are not actually in practice.

That creates additional financial barriers for providers otherwise interested in serving patients in rural areas or underserved areas, of course, all across this country. All 17 counties in Nevada, unfortunately, are designated as health professional shortage areas, and our health outcomes are especially likely to be worse among rural and minority residents than those in more urban centers.

In order to improve health outcomes, to address our Nation's doctor shortage, we have to do more not only to encourage providers to serve in rural and underserved communities, but also to reduce those existing barriers. And that is why I am working on bipartisan legislation with Senator Boozman that would allow medical and dental residents interest free deferment on their student loans while serving medical, dental, internship or residency programs Dr. Flinter, someone who found America's first nurse practitioner residency program, how could pausing student loan interest accruing during residency help provide flexibility for providers who opt to serve patients in rural and underserved areas?

What other incentives do you think the Federal Government should be looking at to make it easier for us to get the really good quality health care we need all across this Nation?

Ms. FLINTER. Well, thank you for that question. I will tell you that facing that mountain of debt, as you are coming into your residency program, those mandatory payments, is a daunting challenge for providers who are still in their training phase.

I think that what you have proposed, Senator Rosen, pausing student loan interest accrual during residency is what I would call a very pragmatic, reasonable thing that probably makes a big difference for people. I think the issue is that debt influences people is choice of where they are going to practice, as you have used the example of the State of Nevada, so I think that is a very pragmatic and useful idea.

I want to point out that is part of a constellation of strategies that we have here in the United States that all could be expanded to make it easier for people to tackle the training and then to choose the practice setting based on where they want to serve and where their passion is.

I will tell you that when I was an undergraduate student earning my Bachelor's degree in nursing long time ago, I worked off my student loans through a Federal loan repayment program as a rural public health nurse.

When I chose to go back to the school, to the Yale School of Nursing and become a nurse practitioner, I was fortunate enough to be taken into the National Health Service Corps, which had an obligated period of service afterwards. They sent me to what was then a small community health center that Senator Hickenlooper knows on Main Street in Middletown.

I think 47 years of practice is a pretty good return on the Federal Government's investment in those loans. This is what we see in my own organization. There are many people with decades of experience who started in community health service in underserved areas because they had help from something like Federal loan repayment or the National Health Service Corps. So this would be one more tool, I think, in the toolkit to help people.

Senator ROSEN. Well, that is great, because I want to build on exactly this because we not only have this area of just in overall physicians and dentists, nurse practitioners, and the like.

We have, especially in my State, shortage of certain medical specialties. And so we have our urban, our underserved communities, and particularly our rural, our far frontier communities, they have to go with that specialty care at all. And so I am currently working on some legislation to create a loan forgiveness program for specialists who care for patients in rural areas.

Can you speak about maybe the challenges that primary care providers have in trying to bring specialists either in-person, maybe even virtually through telehealth? We have to ask people to refer them to. And what do you think we can do to help with that and just building on what you said before.

Ms. FLINTER. Great. Well, thank you. I think a few months ago, I addressed the issue of what we can do with e-consult access from primary care to specialists so that which can be done by primary care, often in consultation with the specialist, so not the specialists necessarily directly seeing the patient, is a very important piece of that.

We have done the research on that. It is clear that is now becoming a national best practice. And the people seeing the specialist are the people who really need to see the specialists and others can

be done in management between specialists and primary care providers. Telehealth has certainly been a huge benefit to us, I think we would say.

It certainly is true of rural areas, but even in urban areas, I think we have all seen how difficult it can be to connect primary care providers and specialists. And how much additional double work you can eliminate if you can connect with people virtually as opposed to in-person. But beyond that, we need the training programs. We need the training programs for our specialists.

They should have experience in caring for people in rural and underserved communities and for care and for all populations. One of the things that we know about training, and I think Dr. Verret would agree with me, that where you train has an awful lot to do with where you practice. If you can even have a part of your training experience in a rural area, in underserved communities with underserved populations, there is a much greater chance, I think we call it imprinting, and you are continuing to care for that population and remaining in that area.

Like everything we are talking about today, there is not one strategy that is an answer. There are multiple strategies, and we need to embrace all of them. Technically, in terms of training, in terms of financial support for trainees, and in making sure that we get the right people to the right kind of provider at the right time.

Senator ROSEN. Well, I couldn't agree more. Addressing the medical workforce shortage across the spectrum, having a broad, good strong broadband base to potentiate care through telehealth and qualified professionals all along the way, all of it makes a difference.

All of that matters, and I am trying to work on and getting us all there. So appreciate you all for being here today. Thank you, Mr. Chair. I see my time is up.

Ms. FLINTER. Thank you.

Senator HICKENLOOPER. Thank you, Senator Rosen.

Senator Cassidy.

Senator CASSIDY. Yes. Dr. Flinter, you call it imprinting, I call it marrying a local.

[Laughter.]

Ms. FLINTER. That works, too, I guess.

Senator CASSIDY. As a man, it is my observation that men live where either Uncle Sam or the wife tells them to, and so that is mine. I rarely start off with a personal anecdote, but I am today because it is something that is so powerful in my experience, in my professional life. As many of you may know, I am a physician who works in a public hospital for the uninsured for over 25 years or about 25 years.

There is a woman who happened to be African-American. Her nickname was Olive. She started off as an LPN, or maybe even a medical assistant, went back to school, single mom, went back to school part time, became, say the LPN. Went back to school and continued to education and became an RN. Kept going back to

school and then got her master is in nursing. And when the nurse supervisor of the clinic retired Olive took her place.

Now one, it is a great success story for her personally, but it demonstrates to her children and a community the power of education, aside from giving us a crackerjack nursing supervisor. And so although I have not seen Olive since her hospital was literally blown up, that is the kind of facility it was, you just discarded it, she did an incredible job taking care of patients who otherwise would not have received such good care.

That said, I am heartily in favor of creating this opportunity for folks who perhaps would be the first in their family, first generation in their family to go to school. But there is other issues that separate. Dr. Verret, I am the author of the John Lewis National Institute for Minority Health, Research and Endowment Revitalization Act that would revitalize the Research and Endowment Program or the REP at the National Institute on Minority Health and Health Disparities.

The REP was established to assist minority serving institutions with low endowments to develop institutional capacity to successfully compete for NIH funding with their well-endowed, non-minority school counterparts. Now, Xavier College of Pharmacy has been a beneficiary of this program.

Can you talk about the challenges that universities like Xavier face in trying to be more competitive for Federal research dollars, and why revitalizing this program would be important to Xavier, to others, and to our nation?

Mr. VERRET. Well, that endowment program, I think which was paused some years ago, as for schools like Xavier, is the resource by which we build out the quality—bring the quality of faculty that our students need to encounter, but also facilities and in order to be competitive as research—

Senator CASSIDY. So the facilities are as important as the faculty?

Mr. VERRET. As important as the faculty. Because one needs laboratories. One needs the equipment. For example, as was mentioned of putting a testing facility for HIV means that you have to have the thermal cyclers. But that the equipment and also—and the faculty.

That is faculty, for example, who are researchers in a variety of areas, have to be able to set up laboratories or their computer systems for the work they do. So that one needs to be able to compete and place those faculty with those students. And also understanding that the research that we do at schools like Xavier is not separate from the instructional program.

Our students enter as researchers with faculty in their research programs early as undergraduates in their second year. Likewise, it is about doing the practicing on the discipline. Our students do not only learn as biologists or learn as chemists, they become—they do chemistry the same way they do history, the way our musicians do music as well.

That research—because that is different between the higher-ed and what we call secondary school.

Senator CASSIDY. I think it is safe to say the role model of somebody who is successfully doing research can inspire. I have a professor that inspired me to become a hepatology, just a liver specialist, because of a couple of them. Between the two of them, they were so remarkable, I wanted to be like them.

Mr. VERRET. One becomes a junior colleague, as a researcher. And so that experience, and also it readies them for whether they go into professional school or whether they go into a PhD program. It is amazing that some of these students were actually following into the MDP speed track also.

Our pharmacy students also who are pharmacists who are not only going into the retail sector as was traditional for many pharmacists, who are taking the higher status of the pharm D and becoming part of the clinical sector or managing the therapeutics or the chemotherapy programs in some hospitals.

They are being taught to practice at the highest level of their license.

Senator CASSIDY. Yes. And of course, been a springboard. I mentioned to you earlier, a family friend, Dr. Holden, originally went to Xavier Pharmacy School from Missouri, but that was when educational opportunity was not available for African-Americans. And after going to Xavier Pharmacy School, I went to DO school in California and practiced in California, a large pediatric practice in South Central, L.A., and changed a lot of lives that way. Thank you for your mission. I yield.

Senator HICKENLOOPER. Thank you, Senator Cassidy. I think we have time to—we are going to, Senator Braun is going to be back in the second to do a, let's call it a lightning round. No, I guess that is inappropriate. But I do, I think we do have a few more questions. Ms. Quinones, I was going to ask the projections we have been hearing from everybody about the critical need to start growing our health care workforce, yesterday.

Obviously, the key there is to do it now, and we need to make it easier for those who don't have any experience to break into the field instead of creating barriers and making it possible to expand the workforce. We have heard a variety of people mention that over this last hour and a half. So you have unique experience because you came in as an entry level assistant in Clinica, to kind of begin your career in nursing.

What were some of your experiences and what are some things you think might be applicable, could be useful to other institutions, other health care providers that are looking to expand their workforce and provide, become a conduit for people coming into the profession?

Ms. QUINONES. Yes, thank you for the question. So one of the unique situations at Clinica is that I recruit within our organization, because No. 1, somebody already has made the decision that this employee is a fit for Clinica. And the other thing that we focus on is development and growth within our system. And so we recruit within Clinica, go through the process of the NIMAA program, and I facilitate and coach them and be a—how do I want to say, a connection between Clinica and NIMAA.

This is the way that we really grow our own. They are already—they are already in the system, they know our culture, they know our mission. And so we have found out through other conversation is that this model really works for us because the commitment is already there from our staff.

They go through their training and upon graduation—they are already trained, I would say greater than 85 percent. So as soon as they graduate, they pass their MA exam, they are ready to start working as soon as they complete the 8 month program through NIMAA. And so that is a huge benefit for our MA staff and nursing staff as well, because one thing that we encourage at Clinica is to work at the top of your license.

This is a way that the medical assistants that have been working with Clinica for a while can support providers, nurses, and continue on.

Senator HICKENLOOPER. Interesting. Interesting. Dr. Verret, you mentioned a little bit about the reaching out to high school students in the summer—was it Summer Science Academy, the Xavier Summer Science Academy, it is five 500 kids, to participate in, it sounds like a cross-section of sciences, biology, and math, yes let's call it STEM. How do you get, how do you reach out to find those students in the high school network? Are they from—all from within Louisiana or are they from around the country?

Mr. VERRET. The majority are from within Louisiana, but some come from around the country, a significant number, because we have a long history. The graduates of the program to a high number of go on to college. Many of them do not go to Xavier, but they go to other colleges, to us a success. It is what I call our external mission.

Funding that has been a challenge because we fund that on dollars that we have all from foundation dollars when we can. But because those are not accessible through any funding program that we normally have. That is one pipeline of getting students early in their education to consider the science and to be exposed to that.

We also—what we also do is even weekend academies. For example, the robotics academy that is done, a work that is done on weekends, is one way of capturing the imagination of young people. I like to make the point that, if we remember that for science and health, it is not like music that students develop, discover their passions very early in life before high school, or they are not musicians or decided great musicians at the age of 18 or 19.

I say the same for sciences and also clinicians as well. So catching them even before high school is fundamental so that it is about getting that imagination and seeing that I can be, and this is a possible pathway. Role models are important. Seeing older students who are not only maybe three or 4 years older or and at it is important.

That is—especially given if you are coming from families when college is a new thing, that no one in this family has ever attended college, which is a large—we are, in our campuses, it is in the high 30, 40, 50 percent of students.

Senator HICKENLOOPER. Wow, that is amazing. Alright. So thank you.

With that, I will turn it over to Senator Braun.

Senator BRAUN. Thank you, Mr. Chairman. I am going to circle back to the structure of the industry again, and my question is going to be for Dr. Flinter. Years ago, we had a lot more hospitals, especially in rural areas. Currently, when you look at the health care dollar, 30 percent give or take hospitals, 30 percent give or take practitioners, 15 to 20 percent pharma and then insurance.

As these stakeholder that pays all the bills in the country, meaning any company that does not, is other than a health care company, it would be the rest of us employers. And in the transparency issue, even when you can self-insure, has been challenging.

The other thing is you have fewer options. You get fewer and fewer hospitals that control a lot of these markets and even fewer insurance companies. Getting workforce into the nursing side of it, how difficult is it now when it comes to the fact that you end up, unless you have a clinic or you are doing your own thing, which oftentimes are rules and regulations don't make that as easy it should be, how difficult is it to be a nurse practitioner, not only with the training and the cost of that you are talking about, but in terms of the new structure with the fact that you are working for a hospital.

Doctors complain about that often. They used to have their own businesses. Would you want to comment on that a little bit?

Ms. FLINTER. Sure. Well, thanks for the opportunity. And it is actually something I have been thinking about quite a bit recently, in part because there is a whole area within nurse practitioner practice of nurse practitioners who are going into entrepreneurial practice on their own, and there is a network set up to support them.

What it reminded me is, and there probably is a right place for everybody, right. For me, the right place is a structure like a community health center. Takes all comers regardless of insurance, comprehensive care. There is a tradeoff around how much you do individually and how much is organizational policy, but if the organizational policies line up in the direction of the values that it should, that is a plus, not a minus for me.

For other people, being an independent entrepreneur or a group nurse practitioner practice, for instance, is the right structure for them. I think people really have to think very critically about their employer, and the right employer is an employer who lines up with your mission, vision, and values for your own career.

I think people are becoming much more savvy about the kind of people, the kind of organization, the kind of structure that they want to practice in, and employers beware. No matter how big your health system is, you cannot run it without expert people to care for the patients in it. The emerging legislation around transparency and billing, about no surprise billing—we are in community health centers, our patients are the most savvy consumers of all because they are often paying out of pocket as people who are fully uninsured.

This is just a part of a fairer economy in which we make it clear what those prices are. We make sure that people understand what the deal is, and I think that is true for the people who work in them, as well as the people who receive care.

Senator BRAUN. Thank you. Next question for Ms. Greszler. Indiana visited last week, and I was shocked that it was only the second one in the U.S., the other one is in Oklahoma City, and this is a group of surgeons that didn't like the idea that their only employment opportunity is now for a huge corporation. They had a vision of having their own shingle hung out there and increasingly difficult to do. Here is what caught me.

They are going to be a cash only surgical outpatient center. I said, what about inpatient? Oh, there are so many regulations. If doctors wanting to do that, you couldn't even get the first base. Listen to this on a gallbladder operation, in Indiana, to negotiated rate between insurance companies and hospitals, \$22,000.

If you come into the system and you just need it, you have no insurance, \$32,000. They will do it for \$8,000. And that is going to be the same proportionality on a lot of other surgical procedures. That is entrepreneurship. That is what we have got to do before we start spending more Federal dollars in terms of fixing the system.

What do you think when it comes to that kind of breaking the system apart, how important is that to fix health care in general?

Ms. GRESZLER. I think that is extremely important because as far as I know, the studies have shown that those smaller practices actually have better outcomes. And there is a lot of broken parts of the health care market, but this is one of them where the prices that are charged don't necessarily reflect the services that were provided, the outcome of those services, the amount of time, but they instead reflect insurance codes that they are allowed to bill.

It is in many ways broken. One thing that could be done is the Federal Government has a lot of programs, they are in charge of payment rates there, to allow for some innovation and flexibility in those ones. We have seen that doctors and other practitioners, they want to move toward having more autonomy and not just having to go by the books of what they are told they can charge and what services they can and can't provide.

But just being free to practice is, others are in the private sector not encumbered by all these burdens that are imposed on the health care sector.

Senator BRAUN. I think it is a good point. Yours as well. I view practitioners and doctors about the same way as farmers in big Ag. It is so much different from what it used to be. And whenever we get industries that get too concentrated, the consumer never ends up being in the best place.

Senator HICKENLOOPER. On that note, although I think Senator Braun and I could probably spend the next couple of hours asking you questions, but I suspect you have other schedules, other things in your schedule. So I guess I will end our hearing for today. Let me just thank you all, Dr. Flitter, Ms. Quinones, Dr. Verret, Ms. Greszler.

I can't remember a more interesting panel and with such clear translation of your experiences in your lives into, I think, really valuable testimony that we will take going forward.

If there are other Senators who are watching at home and have questions or watching from their office, I shouldn't make jokes about virtual hearings, questions for the record will be due in 10 business days, so that is on February 24th at 5 p.m.

The hearing record will also remain open until then for Members who wish to submit additional materials for the record. The HELP Committee will next meet, well actually shortly, in room S-127 at noon to mark up several pending nominations, and then again on Tuesday, February 15th at 10 a.m. for a hearing on supporting quality workforce development opportunities and innovation to address barriers to employment.

Thank you again for all your excellent work today. We stand adjourned.

## ADDITIONAL MATERIAL

### AMERICAN AMBULANCE ASSOCIATION

Chairman Hickenlooper, Ranking Member Braun, and Members of the Subcommittee on Employment and Workplace Safety, the American Ambulance Association (AAA) commends the Subcommittee for holding this critical hearing on healthcare workforce shortage issues. Our country's emergency medical services (EMS) system is facing crippling staffing challenges that threaten the provision of crucial emergency healthcare services at a time of maximum need. As we face a pandemic that waxes and wanes but does not end, our 9-1-1 infrastructure is at risk due to these severe workforce shortages. The Congress must act if we are to prevent vital ground ambulance services from disappearing in rural and underserved urban areas and from the country as a whole, which is experiencing longer and longer wait times for 9-1-1 services. We outline some potential congressional actions to address this crisis below.

The AAA is the primary association for ground ambulance service suppliers/providers, including private for-profit, private not-for-profit, governmental entities, volunteer services, and hospital-based ambulance services. Our members provide emergency and non-emergency medical transportation services to more than 75 percent of the U.S. population. AAA members serve patients in all 50 states and provide services in urban, rural, and super-rural areas.

Our paramedics and emergency medical technicians (EMTs), as well as the organizations they serve, take on substantial risk every day to treat and transport patients who call 9-1-1. Our industry's crippling workforce shortage is a long-term problem that has been building for over a decade. It threatens to undermine our emergency 9-1-1 infrastructure and deserves urgent attention by the Congress.

The most sweeping survey of its kind—involving nearly 20,000 employees working at 258 EMS organizations—found that overall turnover among paramedics and EMTs ranges from 20 to 30 percent annually. With percentages that high, ambulance services face 100 percent turnover within a 4-year period. Staffing shortages compromise our ability to respond to healthcare emergencies, especially in rural and underserved parts of the country.

The pandemic exacerbated this shortage and highlighted our need to better understand the drivers of workforce turnover. There are many factors. Chief among them is inadequate reimbursement by governmental payers. We must have a reimbursement system that matches payments with the costs of providing services and allows us to increase wages as competition for personnel intensifies.

Our ambulance crews are suffering under the grind of surging demand and burn-out. In addition, with COVID-19 interrupting clinical and in-person training for long periods of time, our training pipeline has been stretched even thinner. The challenge is to make sure that the paramedics and EMTs of the future know that EMS is a rewarding destination. Many other healthcare providers have extensive governmental professional development resources, but that simply often does not exist for EMS.

One of the most critical gaps in an adequate pipeline of trained EMS personnel results from the fact that many existing Federal training programs and other forms of assistance are not eligible for nongovernmental or for-profit ambulance service providers. We believe that all providers, regardless of organizational form, should have access to the full range of Federal and state training and retention resources that are available.

The following potential congressional actions would help mitigate the current workforce shortage by expanding and strengthening the EMS workforce:

- Provide eligibility during the current public health emergency and for at least 2 years thereafter for first responder training and staffing grant programs administered by the U.S. Department of Health and Human Services (HHS) such as SAMHSA Rural EMS Training Grants and HHS Occupational Safety and Health Training Project Grants to for-profit entities.
- Authorize the establishment of a new HHS grant program open to public and private nonprofit and for-profit ambulance service providers to fund paramedic and EMT recruitment and training, including employee education and peer-support programming to reduce and prevent suicide, burnout, mental health conditions and substance use disorders.
- Provide tax credits to companies for employee education loan repayment assistance, provisions which would encourage training and retention of personnel who are often recruited by other healthcare providers.
- Implement minority and low-income recruitment programs. The AAA is committed to increasing diversity in the ground ambulance service workforce. We are the healthcare sector with the lowest barrier to entry, given our shorter training periods. We are supportive of provisions currently pending in this Congress, such as the Health Professions Opportunity Grants, which would provide increased access to training opportunities.
- Reduce barriers that prevent veterans from becoming certified as paramedics/EMTs. The military has a highly trained EMS workforce, but bureaucratic red tape, particularly in the state certification process, can make the transition cumbersome and time-consuming.
- Access unused visas for EMS-trained individuals.

#### *Conclusion*

The AAA thanks you for your time and attention to the critical healthcare workforce shortages facing our Nation today. We stand ready to work with Subcommittee Members and staff to develop workable solutions to strengthen the vital ground ambulance service workforce. The crisis is real. Desperately needed rural and urban services are closing weekly and many more are at risk in areas of the country where EMS is often the sole provider of after-hours healthcare services.

AMERICAN AMBULANCE ASSOCIATION  
WASHINGTON, DC 20090  
*February 10, 2022*

Senator JOHN HICKENLOOPER, Chairman  
Senator MIKE BRAUN, Ranking Member  
*U.S. Senate Committee on Health, Education, Labor, and Pensions,  
Subcommittee on Employment and Workplace Safety  
428 Dirksen Senate Office Building,  
Washington, DC 20510.*

Dear Chairman HICKENLOOPER AND RANKING MEMBER BRAUN:

On behalf of the American College of Emergency Physicians (ACEP) and our 40,000 emergency physicians, and the Emergency Medicine Residents' Association (EMRA) and our 17,000 members, thank you for your attention to the issue of health care workforce shortages and efforts to improve recruitment and to revitalize and diversify the health care workforce. The health professions, especially those on the front lines of the pandemic response, have been strained like never before, and the underlying workforce challenges that existed even before the COVID-19 pandemic have been exacerbated by the overwhelming and prolonged effects of and response to this disease. Physicians, nurses, and other essential health care workers have tirelessly given their all—often at great personal cost—to provide high-quality care during this unprecedented public health crisis, and dedicated efforts are needed

to rebuild and maintain the health and well-being of the individuals who provide our health care safety net.

Workforce shortages are especially pronounced in rural and underserved areas throughout the country, and numerous barriers to providing equitable care in these communities persist. Among these are the inability to recruit qualified and sufficiently experienced, educated, and trained physicians, nurses, ancillary support staff, and other health care providers. Despite a 28 percent increase in emergency medicine residency positions over the past 10 years, there has been no corresponding increase in emergency medicine residency trained or emergency medicine board certified physicians working in rural EDs. This is a complex problem due to a variety of factors, including limited opportunities for exposure to these communities during residency training, fewer full time employment opportunities overall due to ED staffing requirements and continued rural facility closures, a lack of recruitment tools and incentives such as those provided for primary care professions, among many others. Additionally, rural EDs, compared to their urban counterparts, are resource limited, financially stressed, and experience higher interfacility transfer rates. And while the COVID-19 pandemic has increased the use of telehealth, rural areas still suffer from inconsistent availability of telehealth access and structural challenges like limited/nonexistent broadband access. Transportation issues also limit many individuals' ability to reach hospitals, and emergency medical services (EMS) in rural areas also experience significant transportation delays due to issues with crew availability.

We hope the Committee's examination of current health care workforce shortages will include a focus on the ongoing nursing shortages and the recent practices of nurse staffing agencies that have resulted in exorbitant increases in costs to already-strained health care systems. The extreme physical and mental toll of the COVID-19 pandemic response has inflicted enormous trauma and stress on physicians and nurses, resulting in increased burnout and dissatisfaction for those on the front lines and greater attrition in the health care workforce. This has left many health systems desperate to fill workforce gaps by relying on nurse staffing agencies, some of whom have imposed extreme rate hikes to supply travel nurses to hospitals.

Especially during the Omicron wave when hospitals have tried to continue providing care for COVID-19 patients and other conditions requiring hospitalization, facilities have been left with no other choice than to pay substantially inflated rates in their attempts to maintain staffing levels capable of meeting their community's needs. We appreciate the recent attention to this issue raised by some in Congress and other health care stakeholders and encourage continued investigation and oversight of potentially anticompetitive practices occurring in the health care workplace.

Such shortages also greatly exacerbate the issue of crowding and ED "boarding," a scenario where patients are kept in the ED for extended periods of time due to a lack of available inpatient beds or space in other facilities where the patient can be transferred. Empirical studies have shown boarding contributes to worse patient outcomes and increased mortality related to downstream delays of treatment for both high- and low-acuity patients. In addition to disrupting the ED workflow and creating operational inefficiencies, it often also creates additional dangers, such as ambulance diversion, increased adverse events, preventable medical errors, more walkouts by patients, lower patient satisfaction, violent episodes in the ED, and higher overall health costs. Solving ED boarding is not an isolated emergency department issue but rather a hospital-wide imperative.

Reducing boarding and mitigating its effects on all patients is critical in improving patient outcomes and their overall health, especially for those with mental or behavioral health needs. ED boarding challenges disproportionately affect patients with behavioral health needs who wait on average three times longer than medical patients because of these significant gaps in our health care system. Some research has shown that 75 percent of psychiatric emergency patients, if promptly evaluated and treated in an appropriate location—away from the active and disruptive ED setting—have their symptoms resolve to the point they can be discharged in less than 24 hours, further highlighting the need to provide timely, efficient, and appropriate mental healthcare.

Many emergency physicians report that given ongoing shortages and the influx of patients (both COVID- and non-COVID-related) that ED boarding is at an all-time high. Adding to this challenge is the fact that EDs are also not subject to the same staffing ratio requirements as other parts of the hospital often are, and as a result, the ED too often becomes the only place in which to keep many patients. While we have shared ideas and suggestions with legislators and regulators to provide both

short-and long-term solutions to reduce ED boarding (such as regulatory waivers and flexibility around documentation requirements that contribute to burnout among nurses), more fundamental efforts to address the root causes of nursing and physician shortages are needed to ensure patients have timely access to care.

Finally, as you work to address these challenges, ACEP and EMRA urge Congress to ensure that American patients have access to high-quality lifesaving emergency care. We believe the gold standard for care in an emergency department (ED) is via a physician-led emergency care team, with that care performed or supervised by a board-certified/board-eligible emergency physician. Physician Assistants (PAs) and nurse practitioners (NPs) can and do serve integral roles as members of the emergency care team, but do not replace the medical expertise provided by emergency physicians. The physician-led emergency care team is the safest care model for our patients and particularly important for Medicare beneficiaries, who are some of the most medically vulnerable patients in our population, often suffering from multiple chronic conditions or other complex medical needs and account for nearly 20 percent of ED encounters each year.

Supporting physician-led health care teams is also aligned with most state scope of practice laws. For example, over 40 states require physician supervision of or collaboration with PAs. Most states require physician supervision of or collaboration with nurse anesthetists, and 35 states require some physician supervision of or collaboration with nurse practitioners, including populous states like California, Florida, New York and Texas. These states represent more than 85 percent of the U.S. population. Moreover, despite multiple attempts, in the last 5 years no state has enacted legislation to allow nurse practitioners full-immediate independent practice.

Some have proposed expanding the scope of practice of nonphysician professionals in order to increase access to care, especially in rural and underserved communities. However, in reviewing the actual practice locations of nurse practitioners and primary care physicians, it is clear nurse practitioners and primary care physicians tend to work in the same large urban areas. There remain significant shortages of nurse practitioners in rural areas—the very problem with physician access that scope expansion has sought to address. This occurs regardless of the level of autonomy granted to nurse practitioners at the state level. We believe that the ongoing challenges in recruiting and retaining all levels of health care professionals in rural and underserved areas are more complex, and that this persistent issue requires more innovative solutions to incentivize physicians and other health care professionals to work in these communities. We would welcome the opportunity to work with you and your colleagues to find more effective and durable solutions to these longstanding workforce challenges to ensure that Americans in rural and underserved areas have access to high-quality emergency care, recognizing the level of expertise and training required for independent practice of emergency medicine and supporting the provision of physician-led team-based care.

Once again, we are grateful for the opportunity to share these comments with you and appreciate your attention to the ongoing workforce challenges facing health care professionals, especially in light of the continued response to the COVID-19 pandemic. ACEP and EMRA stand ready to work with you and your colleagues to respond to these challenges and ensure that all Americans have access to the high-quality health care they need and deserve.

Sincerely,

GILLIAN SCHMITZ,  
*ACEP President.*  
ANGELA G. CAI,  
*EMRA President.*

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AMERICAN HOSPITAL ASSOCIATION

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners—including more than 270,000 affiliated physicians, 2 million nurses and other caregivers—and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to submit this statement for the record as the Subcommittee on Employment and Workplace Safety of the Committee on Health, Education, Labor and Pensions examines America's health care workforce shortage.

As America enters the third year of the COVID-19 pandemic, health care providers are confronting a landscape deeply altered by its effects. As of Feb. 10, 2022,

there have been approximately 80 million COVID-19 cases and over 900,000 deaths in the U.S., with nearly 30 million cases and approximately 110,000 deaths in just the last 2 months.

Our nation's hospital and health system workers have been on the front lines of this crisis since the outset, caring for millions of patients, including nearly 4.4 million patients hospitalized with COVID-19. During this time, hospitals have continued to face a range of pressures, with workforce-related challenges among those most critical.

Though managing workforce pressures were a challenge for hospitals even before the pandemic, these challenges have only grown more acute. The incredible physical and emotional toll that hospital workers have endured in caring for patients during the pandemic has, among other issues, exacerbated the shortage of hospital workers. This shortage has become so critical that some states and the Federal Government have deployed military and National Guard resources to help mitigate staffing challenges at some hospitals. As this shortage has worsened and COVID-19 hospitalizations have reached record levels, labor costs for hospitals have increased dramatically. This combination of factors has been exploited by travel staffing companies and other firms that provide contract labor resources, driving up workforce costs even more for hospitals. Hospitals also have incurred significant costs in recruiting and retaining staff, which have included overtime pay, bonus pay and other incentives. This is occurring at a time when many hospitals and health systems are still facing other immense financial constraints. For many hospitals around the country this has led to an unsustainable situation that threatens their ability to care for the patients and communities they serve.

#### **Health Care Workforce Shortages**

Hospitals are facing a critical shortage of workers. Approximately, 1,130 hospitals or 27 percent of hospitals that reported data on staffing to the Federal Government indicated that they were anticipating a critical staffing shortage within the week of Feb. 8. Further, 15 states had 33 percent or more of their hospitals reporting a critical staffing shortage.

Nurses, who are critical members of the patient care team, are one of the many health care professions that are currently in shortage. In fact, a study found that the nurse turnover rate was 18.7 percent in 2020, illustrating the magnitude of the issue facing hospitals and their ability to maintain nursing staff. The same study also found that 35.8 percent of hospitals reported a nurse vacancy rate of greater than 10 percent, which is up from 23.7 percent of hospitals prior to the pandemic. In fact, two-thirds of hospitals currently have a nurse vacancy rate of 7.5 percent or more.

Almost every hospital in the country has been forced to hire temporary contract staff to maintain operations at some point during the pandemic. According to a survey by AMN Healthcare, 95 percent of health care facilities reported hiring staff from contract labor firms, with respiratory therapists being the primary need for many hospitals and a critical team member necessary for COVID-19 patient care.

As hospitals have looked to bring in more staff, job postings for both clinical and non-clinical staff have increased from pre-pandemic levels. Based on data from Liquid Compass analyzed by Proluent Health, job postings for clinical staff have increased by 45 percent for nurses and 41 percent for other allied clinical staff between January 2020 and January 2022. At the same time, non-clinical staff such as environmental service and facilities workers, who play an important role in maintaining hospital operations, have seen job postings increase nearly 40 percent.

Hospitals were already spending more money on contract labor even before the latest COVID-19 surge. According to a Definitive Healthcare study, contract labor expenses for hospitals have more than doubled over the last decade. However, the prices charged by contract labor firms during the pandemic have become exorbitant as supply is scarce and demand is at an all-time high. For example, average pay for hospital contract nurses has more than doubled compared to pre-pandemic levels. According to Proluent Health, there has been a 67 percent increase in the advertised pay rate for travel nurses from January 2020 to January 2022, and hospitals are billed an additional 28 percent-32 percent over those pay rates by staffing firms. In fact, in some areas pay rates for travel nurses have been as high as \$240/hour or more, which have contributed to the dramatic increase in hospitals' labor costs. Labor expenses are up 12.6 percent on an absolute basis, and 19.1 percent on a per patient basis compared to levels in 2019.

With COVID-19 hospitalizations reaching record highs, the staffing crisis currently plaguing our Nation's hospitals is only expected to worsen. In 2017, more than half of nurses were age 50 and older, and almost 30 percent were age 60 and older. According to Bureau of Labor Statistics data, it is anticipated that 500,000 nurses will leave the workforce in 2022, bringing the overall shortage to 1.1 million nurses. And due to significant shortages of faculty, classroom space and clinical training sites, nursing schools actually had to turn away more than 80,000 qualified applicants in 2019. These data highlight the need to develop and implement longer-term solutions to avoid the further deepening of this crisis, which includes investing in more opportunities and slots for health care workers in the pipeline.

### Supporting the Workforce

**Because our workforce is our most precious resource, hospitals and health systems are committed to supporting them.** That's why we've created programs and developed resources to promote caregiver well-being and resiliency. Examples include helping to pay back student loans, providing child care and transportation, offering tuition reimbursement and training benefits, providing referral and retention bonuses, and supporting programs that address mental and physical health.

Hospitals also are developing new team-based care models that allow health care workers from various disciplines and specialties to provide customized, patient-centered care. This allows them to manage medical and social needs across all settings to improve care and enhance professional satisfaction.

For example, in Virginia, Mary Washington Healthcare collaborated with a local community college on a clinical education model allowing student nurses to support the current nurse workforce before they had graduated, addressing the critical demand for more nurses. In Pennsylvania, Geisinger provides \$40,000 in financial support each year for up to 175 employees who want to pursue a nursing career and make a 5-year work commitment as an inpatient nurse. And in Maine, Northern Light Maine Coast Hospital invites financial support from the local community to help underwrite the cost of programs to train future nurses and medical assistants and alleviate a crucial shortage of these professionals.

### Policy Solutions

**Our workforce challenges are a national emergency that demand immediate attention from all levels of government and workable solutions.** These include recruiting, revitalizing and diversifying the health care workforce by:

- Lifting the cap on Medicare-funded physician residencies;
- Boosting support for nursing schools and faculty;
- Providing scholarships and loan forgiveness;
- Expediting visas for all highly trained foreign health care workers;
- Disbursing any remaining funds in the Provider Relief Fund, as well as replenishing the fund to help providers cope with increased staffing costs;
- Investigating reports of anticompetitive behavior from nurse-staffing agencies during the pandemic that is further exacerbating critical workforce shortages;
- Pursuing visa relief for foreign-trained nurses; and
- Supporting the health of physicians, nurses and others so they can deliver safe and high-quality care by providing additional funding and flexibility to address behavioral health needs and funding for best practices to prevent burnout.

We urge Congress to enact the Lorna Breen Health Care Provider Protection Act, which would direct resources to reduce and prevent health care professionals' suicides, burnout and behavioral health disorders. This bipartisan, bicameral legislation would authorize grants to health care providers to establish programs that offer behavioral health services for front-line workers, and require the Department of Health and Human Services (HHS) to study and develop recommendations on strategies to address provider burnout and facilitate resiliency. The bill also would direct the Centers for Disease Control and Prevention to launch a campaign encouraging health care workers to seek assistance when needed.

In addition, we must support state efforts to expand scope of practice laws to allow health care professionals to practice at the top of their license. Congress also should increase funding for the Health Resources and Services Administration's

Title VII and VIII programs, including the health professions program, the National Health Service Corps, and the nursing workforce development program, which includes loan programs for nursing faculty. Congress also should consider expanding the loan program for allied professionals and direct support for community college education to high priority shortage areas in the health care workforce.

Finally, Congress should expand and increase funding for Centers of Excellence and the Health Careers Opportunity Programs, which focus on recruiting and retaining minorities into the health professions to build a more diverse health care workforce.

### Conclusion

The AHA appreciates your recognition of the challenges ahead and the need to examine America's health care workforce shortage. We must work together to solve these issues so that our Nation's hospitals and health systems can continue to care for the patients and communities they serve.

#### AMERICAN ASSOCIATION FOR RESPIRATORY CARE

The American Association for Respiratory Care thanks Chairwoman Patty Murray, Ranking Member Richard Burr, and Members of the Health, Education, Labor and Pensions (HELP) Committee for holding this important hearing on Recruiting, Revitalizing & Diversifying: Examining the Health Care Workforce Shortage. In particular, we urge the Committee to consider the Allied Health Workforce Diversity Act as part of its work on this important topic.

The ongoing public health crisis due to COVID-19 has resulted in unexpected challenges involving the delivery of healthcare and the need for long-term recovery. We urge Congress to focus its efforts on ensuring our Nation can meet these challenges in part by working to promote a workforce adequate to meet the needs of the country, and one that reflects the diverse communities it serves. The allied health professions that include respiratory therapy, physical therapy, occupational therapy, speech-language pathology, and audiology are well positioned to assist with both the immediate care and long-term recovery and rehabilitation of those affected by COVID-19. Diversifying this workforce will help better enable these health care professionals to meet the current and future needs of this population.

As the Committee undertakes an evaluation of health workforce shortages, it is important to point out that the pandemic has resulted in regional and nationwide shortages of respiratory therapists. Given the unknown long-term respiratory needs of those individuals who were diagnosed with COVID-19 and discharged from an inpatient hospital stay, it is important now more than ever that the Committee address the market forces that can lead to decreasing enrollment in respiratory care education programs, escalating burnout in the healthcare profession, and steadily growing retirement among the baby boomer generation. According to a recent health resources survey by the American Association for Respiratory Care,<sup>1</sup> by 2030, approximately 92,000 respiratory therapists are projected to have left the profession.

As the Committee seeks to address issues around recruiting and diversifying the healthcare workforce, we strongly believe increasing diversity will lead to improved access to care, greater patient choice and satisfaction, and better education experience for health professions students, among many other benefits. In particular, a diverse health care workforce can help to both address preexisting health disparities among the population, as well as those disparities exacerbated by the COVID-19 pandemic. This is supported by the Centers for Disease Control and Prevention assessment that there is an increased "risk for severe COVID-19 illnesses and death for many people in racial and ethnic minority groups."<sup>2</sup>

We appreciate the support of HELP Committee Members Senators Casey and Murkowski, who have been strong champions for diversifying the allied health professions by introducing the Allied Health Workforce Diversity Act (S. 1679), which would create a workforce development program for rehabilitation therapy providers and audiologists to increase the percentage of individuals from underrepresented communities in these professions. We urge you to build on their efforts to create this new program to support better representation in the professions of audiology, phys-

<sup>1</sup> 2020 AARC Human Resource Study. Table 47, page 123. *aarc-hr-study-rt.pdf*

<sup>2</sup> Centers for Disease Control and Prevention. COVID Data Tracker Weekly Review, Interpretive Summary for April 2, 2021. Accessed April 4, 2021. <https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/index.html>

ical therapy, occupational therapy, respiratory therapy, and speech-language pathology as the Committee tackles a wide range of health care workforce issues. We appreciate the opportunity to provide our comments and look forward to working with you to improve the diversity of the respiratory care workforce.

### Workforce Issue Brief

Advocate Aurora Health (Advocate Aurora) has developed a diverse and inclusive workforce to support the delivery of quality, integrated inpatient, outpatient, and home-based health services. Our workforce is comprised of more than 75,000 employees, including more than 10,000 physicians and 22,000 nurses. With 27 acute care hospitals, an integrated children's hospital and a psychiatric hospital, primary and specialty physician services, outpatient centers, physician office buildings, pharmacies, rehabilitation, home health, and hospice care, Advocate Aurora provides a continuum of service at more than 500 sites of care in northern Illinois and eastern Wisconsin.

Currently, staffing shortages are the most urgent challenge facing our hospitals and other sites of care; accompanying these shortages are higher costs to recruit and retain health care workers and paying the exorbitant rates some staffing agencies are charging. According to an AHA report, current labor expenses per adjusted discharge for hospitals have increased 12.5 percent compared to 2019.<sup>1</sup> Moreover, in late January 2022, the Bureau of Labor Statistics reported that compensation for hospital workers was 4.5 percent higher in December 2021 compared to the year prior.<sup>2</sup>

### Supporting Federal Initiatives

COVID-19 has taken a heavy toll on our employees who have been on the front lines of the pandemic for 2 years, and Advocate Aurora is grappling with health care worker shortages as hospitalizations increase and ICU capacity decreases across Illinois and Wisconsin with each wave of COVID variants. Physicians, nurses, and other clinical and non-clinical health care professionals are critically needed, but ongoing COVID-19 hospitalizations have created unprecedented levels of demand that are exceeding supply. Advocate Aurora supports the efforts of Congress and the Biden-Harris Administration to address the issue of workforce shortages among health care workers, as well as the following initiatives:

- Make permanent the telehealth flexibilities permitted during the pandemic, including removing geographic restrictions on the location of the patient, allowing rural health clinics and federally qualified health centers to serve as the distant site, and allowing critical access hospitals the same ability to offer and bill for telehealth services as other providers.
- Provide resources to assist hospitals with unprecedented staffing and COVID response costs by appropriating additional dollars through the Provider Relief Fund (PRF).
- Ensure the public health emergency (PHE) period does not expire until ICU capacity has returned to pre-pandemic levels.
- Extend J1 visas for international health care workers and ensure a timely process for review, streamlining entry into the U.S. for clinical staff with approved immigrant visas.
- Plan for future workforce shortages by increasing Graduate Medical Education (GME) residency slots under Medicare and increasing funding for the Children's Hospital Graduate Medical Education program to support Federal investment in pediatric physician training.
- Invest additional resources in nursing education programs and other initiatives to support nursing school enrollment, faculty positions, educational programming, and educational and technological infrastructure.
- Consider increased and expanded tax incentives to encourage health care workers to increase their tenure at their current positions and reduce turnover rates, which can threaten patient safety and continuity of care.
- Expand and increase funding for mental health services and other programs to support current health care professionals to reduce burnout.

<sup>1</sup> <https://www.aha.org/fact-sheets/2021-11-data-brief-health-care-workforce-challenges-threaten-hospitals-ability-care>

<sup>2</sup> <https://www.bls.gov/news.release/eci.t05.htm>

- Implement student loan forgiveness or assistance, and provide increased incentives and programs to create a health care workforce pipeline with features like scholarships, training, and financial incentives.
- Address price gouging by certain nursing staffing agencies, which have been charging nearly three times the amount for nurses compared to pre-pandemic rates.
- Increase funding for nursing and allied health programs and the National Health Service Corps program, directing higher numbers of participants to serve in hospital settings.
- Advance efforts to diversify the health workforce, including grants to education programs to increase workforce diversity in the allied health professions.

### **Advocate Aurora's Workforce Development**

While we are calling on Congress and the Administration to enact policies and programs and provide increased resources to strengthen, expand, and diversify the Nation's health care workforce, we at Advocate Aurora are doing our part. Advocate Aurora is focused on recruiting and retaining a diverse array of team members to inspire creativity and innovation. We aim to cultivate an atmosphere of inclusion and compassion to create a welcoming and safe space for all team members. Specifically, we have sponsored the following initiatives to achieve positive workforce development:

- In 2021, we increased our minimum wage to \$18 an hour. The wage increase, intended to recognize Advocate Aurora team members' critical work, also reflects another major effort to create social impact that dramatically improves individuals' health and well-being. The 10,800 team members directly impacted by Advocate Aurora's new minimum wage include those in food service and environmental services positions. An additional 20,000 team members who already made more than \$18 an hour, including pharmacy technicians and licensed practical nurses (LPNs), also received raises. This \$93 million investment, which included compression adjustments, benefited more than 30,000 team members and in turn, strengthened our marketplace and most importantly, enhanced the quality of life across our communities.
- *Advocate Workforce Initiative (AWI)*: With funding from JP Morgan Chase, Advocate Aurora developed a pipeline of diverse talent from the greater Chicagoland area by seeking out individuals who are interested in entry-to mid-skill level health care careers. Since 2015, our partnership with JPMorgan Chase has allowed us to bring together stakeholders—health care systems, education providers, and community-based organizations—to connect diverse job seekers with health care career training, support services and employment opportunities. Advocate Aurora co-led the Chicagoland Healthcare Collaborative and implemented the AWI. To date, these partnerships have resulted in training more than 900 community residents. More than half of the program participants secured employment in health care, and 84 percent were persons of color. While the AWI funding sunset in 2020, it will be relaunched in mid-2022.
- *Advocate Aurora Corporate Internship Program*: For the last 7 years, we have awarded competitive summer internships to a small group of college students to support hard-to-fill corporate positions in our organization. To date we have hired interns from more than 40 colleges across the Nation, partnering with local organizations that support up to 20 underrepresented students each year. These are paid internships that focus on corporate careers, such as: Human Resources; Finance; Accounting; Diversity, Equity, and Inclusion (DE&I); and Information Technology. The apprenticeship program focuses on recruiting diverse and underrepresented talent, including people with disabilities, into these roles. Advocate Aurora had 15 virtual corporate interns in 2021 and will have 23 in 2022.
- *Earn-While-You-Learn Corporate Apprenticeship Program*: We have partnered with the Wisconsin Department of Workforce Development and the Wisconsin Technical College System to offer job seekers the opportunity to earn while they learn and expand their skills for middle-skill positions. In 2022, Advocate Aurora will be expanding the Culinary Apprenticeship program to Illinois. In partnership with the Illinois Depart-

ment of Labor and the City Colleges of Chicago's Washburn Hospitality and Culinary Institute, the Culinary Apprenticeship program will place seven new apprentices to five of our medical centers—Christ, Lutheran General, Illinois Masonic, South Suburban, and Trinity hospitals. In total, there will be 11 full-time Culinary Apprenticeships in Illinois and four in Wisconsin.

- *Community Scholarships and Education Reimbursement:* Annually, we partner with both Milwaukee and Chicago businesses to distribute scholarships—Phase 1 awards 10 community scholarships up to \$5,000 each; Phase 2 awards 20 scholarships Up to \$5,000 Each (10 to Community Members, 10 to Dependents of Team Members). Priority is given to students in STEM/health-related or corporate fields of study. Also, Advocate Aurora operates an Education Assistance Partnership with Bright Horizons for current employees to receive tuition benefits up to \$5,250 per year for non-nursing programs and up to \$7,200 per year for nursing programs.
- The Milwaukee Healthcare Workforce Initiative operates in close partnership with Employ Milwaukee (workforce investment board), bringing together five community-based organizations, including the Milwaukee Urban League, and providing them leveraged funds to help recruit and train participants for in-demand careers in health care. Advocate Aurora obtained a \$500,000 grant through the Medical College of Wisconsin's Advancing a Healthier Wisconsin (MCAHW) endowment to support this important effort. This program is similar to the AWI program described above.
- *The Medical Assistant Accelerated Pathway to Employment Training Project (MAAPET)* meets a crucial workforce need by increasing a diverse talent pool of Medical Assistants (MAs) working in ambulatory clinics across Southeast Wisconsin. Advocate Aurora Health is collaborating with our partners in the Center for Healthcare Careers of Southeast Wisconsin to launch an accelerated Medical Assistant Training Program with assistance from a generous grant provided by the Medical College of Wisconsin Advancing a Healthier Wisconsin Endowment. This grant-funded program will train 100 new Medical Assistants. In this pathway program, trainees will be paid to go through a 14-week training program. The first 10 weeks (400-hours) will be dedicated to in-class learning and laboratory demonstrations. Students will then transition into a 4-week (160-hours) clinical placement. Upon the completion of the 14-week training program (560-hours), students will sit for the CCMA (Certified Clinical Medical Assistant) exam through the National Healthcareer Association.

A key aim of the MAAPET project is to develop an MA workforce that is reflective of the community that it serves. Key to this is recruitment of participants from the community who wish to gain a career in health care. By providing an accelerated, financially supported training, low income/underrepresented individuals will be given priority opportunities to enroll. The training team will monitor overall recruitment achievements and monitor the goal of having at least 70 percent of each cohort class meet target demographic goals. To date, 23 AAH team members have enrolled in the program.

- *The Bridge Initiative Chicago* was made possible by a \$1 million dollar grant awarded by JPMorgan Chase to support workforce development efforts in the Chicagoland area through a partnership with AAH, Sinai Health and University of Chicago Medicine (UCM). It has three tracks to encourage and support individuals in pursuing a career in health care: COMMUNITY TRACK (“HEALTHCARE FORWARD”) led by Sinai Chicago incorporates community-facing strategies to increase engagement in the health care workforce at the entry-level, including fortified recruitment protocols and industry-focused training offered at accessible community venues. This track invites disenfranchised community members, particularly persons of color (POC), to seek jobs and realize a living wage. INCUMBENT ADVANCEMENT (“EVOLVE”) track led by AAH addresses disparity of opportunities for POC within health care by introducing self-directed digital skills training, cohort-based training, and career coaching. This track aims to develop new technical, discipline-specific skills (entry-level to middle skills).

EMERGING LEADERSHIP (“RISE HIGHER”) track led by UChicago Medicine incorporates a new leadership curriculum and certificate program to promote career advancement and leadership skills among incumbents. This track seeks to promote racial equity and leadership success from middle skill to management level.

- *Workplace Transition Policy and Practice*: In the fall of 2020, Advocate Aurora created guidelines to support our transgender, non-binary, and gender diverse team members who may be socially, legally, or medically transitioning during their employment with Advocate Aurora.
- *LGBTQ Cultural Awareness*: Based on feedback we received from team members participating in the Healthcare Equality Index (HEI) accreditation process, we are expanding our LGBTQ cultural awareness initiative and exploring easily accessible and trackable LGBTQ learning opportunities for our team members.
- *Inclusion Council and Core Teams*: The Advocate Aurora Inclusion Council is a newly launched, differentiated model for integrating DE&I into our health system. This model addresses the challenge of locally executing our system DE&I strategy by deploying 11 inclusion council core teams dedicated to leading DE&I action plans for our patient service areas, corporate functions, and select ancillary services.
- *Advocate Aurora Employee Wellness Support*: Advocate Aurora is committed to creating and maintaining diverse, inclusive, and engaged working environments where team members can pursue their passion and feel supported, valued, and recognized. Further, the team member well-being program at Advocate Aurora is designed to educate team members and encourage them to manage and improve their health, including offering incentives, such as discounts at its fitness centers, indoor and outdoor guided walking paths at each hospital location and a variety of physical, mental, and social programs, resources, and interventions to support team members in their well-being journey.

#### **About Advocate Aurora Health**

Advocate Aurora Health is one of the 12 largest not-for-profit, integrated health systems in the United States and a leading employer in the Midwest with 75,000 employees, including more than 22,000 nurses and the region’s largest employed medical staff and home health organization. A national leader in clinical innovation, health outcomes, consumer experience and value-based care, the system serves nearly 3 million patients annually in Illinois and Wisconsin across more than 500 sites of care. Advocate Aurora is engaged in hundreds of clinical trials and research studies and is nationally recognized for its expertise in cardiology, neurosciences, oncology and pediatrics. The organization contributed \$2.5 billion in charitable care and services to its communities in 2020. The Centers for Medicare & Medicaid Services in 2020 announced that Advocate Aurora Health’s three affiliated Accountable Care Organizations (ACOs) combined saved taxpayers \$87.5 million through the Medicare Shared Saving Program, the most of any integrated system in the country.

#### AMERICAN OCCUPATIONAL THERAPY ASSOCIATION

Dear CHAIR HICKENLOOPER, RANKING MEMBER BRAUN, AND MEMBERS OF THE SUBCOMMITTEE:

The American Occupational Therapy Association (AOTA) is pleased to submit the following comments for the Senate Health, Education, Labor and Pensions (HELP) Subcommittee on Employment and Workplace Safety hearing on the growing shortages in the health care workforce.

The American Occupational Therapy Association (AOTA) is the national professional association representing the interests of more than 213,000 occupational therapists, occupational therapy assistants, and students of occupational therapy. The practice of occupational therapy is science-driven, evidence-based, and enables people of all ages to live life to its fullest by promoting health and minimizing the functional effects of illness, injury, and disability.

The ongoing public health crisis due to COVID-19 is a challenge in two parts and therefore recovery must continue two-fold. First: treatment and immediate care. Second: recovery in the long term. We urge Congress to focus its efforts on ensuring our Nation can meet both aspects of this crisis in part by working to promote a workforce adequate to meet the needs of the country, and one that reflects the di-

verse communities it serves. The Allied Health professions are well positioned to assist with both the immediate care and long-term recovery and rehabilitation of those affected by COVID-19 and diversifying this workforce will help better enable these health care professionals to meet the current and future needs of this population.

The Allied Health professions play a crucial role in recovery from COVID-19 infections, as well as treatment of the effects of “Post-Acute Sequelae of SARS-CoV-2 infection,” (PASC),<sup>1</sup> often self-described as “long-haulers” or “long-COVID”. Issue 13 of *The Exchange*, an information sharing publication produced by the Office of the Assistant Secretary for Preparedness and Response (ASPR) in the Department of Health and Human Services, entitled *The Work of Hospital Allied and Supportive Care Providers During COVID-19* states, “The articles in this section illustrate the work performed by physical, respiratory, and occupational therapists to ensure patient comfort and assist COVID-19 patients through the recovery process.”<sup>2</sup>

It is vital to anticipate what is required to promote a thriving, diverse health workforce. Health workforce diversity was important prior to the pandemic, as the Institute of Medicine raised concerns about the diversity of the health care workforce in its 2004 study: *In the Nation’s Compelling Interest: Ensuring Diversity in the Health Care Workforce*.<sup>3</sup> The report found that racial and ethnic minorities receive a lower quality of healthcare than non-minorities.<sup>4</sup>

Overall, increasing diversity will lead to improved access to care, greater patient choice and satisfaction, and better education experience for health professions students, among many other benefits.<sup>5</sup> In particular, a diverse health care workforce can help to both address preexisting health disparities among the population, as well as those disparities exacerbated by the COVID-19 pandemic.

In addition to these reasons, a more diverse healthcare workforce is important because:

- Patients who receive care from members of their own racial and ethnic background tend to have better outcomes;<sup>6</sup>
- Health professionals from underrepresented and minority backgrounds are more likely to practice in medically underserved areas;<sup>7</sup>
- Minority groups disproportionately live in areas with provider shortages.<sup>8</sup>

We appreciate the support of Senators Casey and Murkowski, Members of the full HELP Committee, who have been strong champions for diversifying the allied health professions by introducing the Allied Health Workforce Diversity Act (S. 1679), which would create a workforce development program for rehabilitation therapy providers and audiologists to increase the percentage of individuals from underrepresented communities in these professions. We urge you to build on their efforts to create this new program to support better representation in the professions of audiology, physical therapy, occupational therapy, respiratory therapy, and speech-language pathology.

Solving the diversity gap in our Nation’s health systems will need a multistep approach. The step presented in this letter includes the creation of a workforce development program for rehabilitation therapy providers. The potential program under the Health Resources and Services Administration (HRSA) would be the modeled after the Title VIII Nursing Workforce Diversity program that has successfully increased the percentage of racial and ethnic minorities pursuing careers in nursing. This new program would help strengthen and expand the comprehensive use of evi-

<sup>1</sup> <https://www.usatoday.com/story/news/health/2021/02/24/covid-19-long-haulers-fauci-announces-launchnationwide-initiative/4572768001/> viewed March 4, 2021

<sup>2</sup> U.S. Department of Health & Human Services. (2021). *The work of hospital allied and supportive care providers during COVID-19*. *The Exchange*, 13. <https://files.asprtracie.hhs.gov/documents/aspr-tracie-the-exchange-issue-13.pdf>

<sup>3</sup> Institute of Medicine. (2004). *In the Nation’s compelling interest: Ensuring diversity in the health care workforce*. Washington, DC: National Academy Press

<sup>4</sup> Institute of Medicine. (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Washington, DC: National Academy Press.

<sup>5</sup> Institute of Medicine. (2004). *In the Nation’s compelling interest: Ensuring diversity in the health care workforce*. Washington, DC: National Academy Press.

<sup>6</sup> Institute of Medicine. (2004). *In the Nation’s compelling interest: Ensuring diversity in the health care workforce*. Washington, DC: National Academy Press.

<sup>7</sup> Cooper-Patrick, L., Gallo, J. J., Gonzales, J. J., Vu, H. T., Powe, N. R., Nelson, C., & Ford, D. E. (1999). Race, gender, and partnership in the patient-physician relationship. *JAMA*, 282, 583–589.

<sup>8</sup> Reyes-Akinbileje, B. (2008, February 7). *Title VII health professions education and training: Issues in reauthorization*. Washington, DC: U.S. Congressional Research Service.

dence-based strategies shown to increase the recruitment, enrollment, retention, and graduation of students from underrepresented and disadvantaged backgrounds for the professions of audiology, physical therapy, occupational therapy, respiratory therapy, and speech-language pathology. The result would be better care for individuals who live in areas with provider shortages.

Thank you for the opportunity to provide input on solving the Nation's health care workforce challenges. We stand ready to provide any additional information you need, as well as collaborate on any efforts in this area.

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PHYSICIAN ASSISTANT EDUCATION ASSOCIATION

The Physician Assistant Education Association (PAEA), representing the 282 accredited physician assistant (PA) programs in the United States, welcomes the opportunity to submit a statement for the record regarding health care provider shortages and health workforce diversity.

Throughout the course of the COVID-19 pandemic, the implications of chronic underinvestment in the development of our Nation's health workforce have been starkly illustrated. As hospital systems have been overwhelmed by COVID-19 patients, an already insufficient supply of frontline providers has faced unprecedented demands, leading to significant burnout among clinicians and reduced access to needed care for patients. As Congress seeks to develop policy to improve preparedness for future public health threats, ensuring the availability of a sufficient supply of well-trained, diverse providers must be a top priority.

To effectively respond to the issue of workforce shortages, Congress must take immediate action to address the most urgent challenges limiting both the overall number of graduates being produced by health professions programs and the diversity of matriculants. As **PA programs have sought to expand, the most challenging barrier that they have consistently encountered is the availability of clinical training sites necessary for students to complete their required rotations.** As a condition of graduation, every PA student is required to complete a series of clinical training experiences in family medicine, emergency medicine, internal medicine, surgery, pediatrics, women's health, and behavioral/mental health. According to a recent survey of PA programs, however, more than 85 percent of respondents indicated that their clinical training sites are now taking fewer students than prior to the pandemic.<sup>1</sup> This dramatic reduction in clinical education capacity threatens the ability of PA programs to meet the demand of health systems for graduates and must be addressed to reduce projected shortages.

Beyond addressing clinical education limitations, PAEA strongly supports congressional action to help develop pathways to PA education for underrepresented minority (URM) students. According to PAEA's most recent Student Report, only 3.9 percent of first-year PA students identified as Black or African American while 9.1 percent identified as Hispanic or Latino as of 2019.<sup>2</sup> Federal policy can play a critical role in addressing the barriers that have long prevented URM students from matriculating into PA programs, successfully graduating, and providing care to the communities most in need.

To address these challenges, PAEA has endorsed legislation in both the House and Senate. PAEA would encourage the Subcommittee to advance the following legislation that has been introduced in the Senate and integrate that which has been introduced in the House into broader legislative proposals.

*The Perinatal Workforce Act (S. 287)*

To combat significant rates of maternal morbidity and mortality among Black women, Senators Tammy Baldwin and Jeff Merkley introduced the Perinatal Workforce Act in 2021. This bill is intended to ensure the provision of culturally competent care by facilitating the recruitment and retention of maternal care providers that are reflective of the communities that they serve. To break down barriers facing URM students seeking to become health care providers, the bill would authorize \$15 million annually over 5 years to support PA and other programs training students intending to specialize in obstetrics/gynecology/women's health. This bill

<sup>1</sup> Physician Assistant Education Association. (2021). COVID-19 Rapid Response Report 3. <https://paea.edcast.com/insights/ECL-c621408d-c82a-43f5-a067-75a03494d8be>

<sup>2</sup> Physician Assistant Education Association. (2020). By the Numbers: Student Report 4: Data from the 2019 Matriculating Student and End of Program Surveys. <https://paeaonline.org/wpcontent/uploads/imported-files/student-report-4-updated-20201201.pdf>.

would support training experiences, scholarship aid, and other interventions proven to significantly contribute to the success of URM students.

*The Physician Assistant Education Public Health Initiatives Act (H.R. 3890)*

In response to the growing issue of clinical site shortages, Rep. Karen Bass introduced the Physician Assistant Education Public Health Initiatives Act in mid-2021. Based upon the success of the Teaching Health Center Graduate Medical Education program in retaining physicians in underserved communities after the completion of their residency training, this bill would authorize a Rural and Underserved Clinical Training Demonstration at \$5 million annually over 5 years. This funding would allow PA programs to facilitate partnerships with federally qualified health centers, critical access hospitals, and rural health clinics to both immediately expand clinical site access and build a sustained pipeline of graduates to these underserved settings following the completion of their training.

*The Physician Assistant Higher Education Modernization Act (H.R. 2274)*

Under the Higher Education Act, existing sources of aid intended to support minority-serving institutions explicitly prioritize the development of programs for certain named high-demand professions, not including the PA profession. In early 2021, Rep. Karen Bass and Rep. David Trone the Physician Assistant Higher Education Modernization Act, which would explicitly prioritize PA program development at minority-serving institutions, such as Historically Black Colleges and Universities (HBCUs) and Hispanic-serving institutions, to create a sustainable pipeline of diverse PA graduates to the health workforce.

PAEA appreciates the opportunity to share the Association's perspective on effective policy solutions to promote the development of a sufficient supply of diverse health care providers and looks forward to the opportunity to serve as a resource to the Subcommittee. Should you require additional information or have questions, please contact Tyler Smith, Senior Director of Government Relations, at [tsmith@PAEAonline.org](mailto:tsmith@PAEAonline.org).

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CHILDREN'S HOSPITAL ASSOCIATION

On behalf of the Nation's more than 220 children's hospitals and the children and families we serve, thank you for holding this hearing on ways to address the health care workforce shortage. We appreciate your leadership on this issue and look forward to working together to improve this imminent need. As you consider program improvements and other policy options, we urge you to recognize the unique staffing challenges that our Nation's children's hospitals face and the tailored support and care children, adolescents and young people we serve need.

**Children's Hospital Staffing Needs**

Children's hospitals' frontline health care workers are facing extraordinary burdens as a result of the COVID-19 pandemic. We have unparalleled numbers of children in need of inpatient pediatric care at the same time that our frontline providers are themselves coming down with COVID-19, exacerbating persistent pediatric workforce shortages that have existed for years. Staff retention is a critical issue for children's hospitals and is reducing the amount of care they can provide. We are seeing nurses and other bedside staff reducing their work hours, with many others leaving health care completely. Some children's hospitals have been forced to resort to temporary staffing agencies to fill their workforce gaps, further straining financial resources. At the same time, many children's hospitals have reduced their care capacity, with some forced to temporarily close entire pediatric intensive care units and other critical services.

We urge you to give special consideration to ways to immediately help the pediatric physical and mental health care workforce so children can get the care they need when they need it. Solutions must be pediatric-specific and not based on Medicare metrics as self-governing children's hospitals operate outside of the Medicare program and care for very large numbers of pediatric Medicaid beneficiaries. An immediate targeted investment is needed, as our continued time in this pandemic is steadily weakening the health care system for our Nation's children. Several key opportunities for committee action to address our pediatric workforce challenges are highlighted below.

**Immediately address the current pediatric workforce crisis.** Existing loan forgiveness programs can sometimes be difficult for pediatric specialty providers to

access. We therefore support robust funding for the pediatric subspecialty loan repayment program, which would provide loan forgiveness for pediatric subspecialists, including mental health providers, practicing in underserved areas. We strongly support the \$30 million for fiscal year 2022 proposed by Senate appropriators, but additional funding would expand the reach of this program to better meet the crisis moment we face. We look forward to working with you to identify realistic and effective immediate solutions.

**Increase funding for the Children’s Hospitals Graduate Medical Education (CHGME) program.** The CHGME program supports the training of more than half of the Nation’s pediatric physician workforce and is essential to the continued access of children to needed pediatric specialists. However, CHGME represents only 2 percent of the total Federal spending on GME. These funding shortfalls must be financed by children’s hospitals’ child-patient care operations and are a key contributor to the overall pediatric workforce shortage. We appreciate the funding levels included in the House and Senate appropriations bills, but we would encourage Congress to consider a higher overall appropriations level to reduce the growing and unsustainable gap between GME and CHGME funding. Additionally, we believe a future reconciliation package would be an appropriate vehicle to increase CHGME funds. CHGME is vital to those self-governing children’s hospitals that cannot receive Medicare GME funding, and other sources of financial support for training, such as Medicaid GME, are not available to many children’s hospitals.

### Children’s Mental Health

Congress must address the urgent need to relieve pressure on the existing pediatric mental health workforce, as well as invest in its long-term expansion across disciplines to meet the ongoing and growing mental health needs of our children. Pediatric mental health workforce shortages are persistent and projected to increase over time. Nationally, there are approximately 8,300 practicing child and adolescent psychiatrists and only 5.4 clinical child and adolescent psychologists per 100,000 children 18 years of age and younger,<sup>1</sup> far fewer than needed to meet the existing and increasing demand. Shortages also exist for other vital pediatric mental health specialties critical to improving early identification and intervention for children with mental health needs. Additionally, there is a dire shortage of minority mental health providers, which represents an added burden on racial and ethnic minority communities who already face inequitable access to care. More dedicated support for a larger and more diverse pediatric workforce is critical to addressing children’s mental health needs now and into the future. Congress can take several immediate steps to address the current and ongoing mental health workforce shortage.

**Mental and Behavioral Health Education and Training grants.** The Mental and Behavioral Health Education and Training (BHWET) grants program was introduced as part of the Now is the Time initiative to increase the mental and behavioral health workforce serving children, adolescents and young adults. The program supports pre-degree clinical internships and field placements for doctoral-level psychology students, master’s level social workers, school social workers, behavioral pediatricians and psychiatric mental health nurse practitioners, among others. Over the years, the program has expanded to include programs to train mental health providers and provide services for individuals across their lifespan. Several children’s hospitals have received funding through this program, and we support further targeting existing funding toward pediatric providers. We also support an additional designated pool of funding under the oversight of the Health Resources and Services Agency (HRSA) to support training and development in children’s hospitals, pediatric practice and clinical settings and related mental health disciplines providing pediatric behavioral health.

**Minority Fellowship Program.** The value of a diverse pediatric mental health workforce prepared to deliver culturally and developmentally appropriate care cannot be overstated. While all mental health professionals receive training that prepares them to provide care with cultural sensitivity and awareness, the ability of a child, adolescent and their family to connect and identify with a mental health professional can be critical. Shared cultural beliefs and experiences can further strengthen therapeutic relationships and lead to better outcomes for kids and families. The Minority Fellowship Program provides training, career development opportunities and mentorship to racial and ethnic minority mental health professionals and researchers with the goal of reducing health disparities within minority commu-

<sup>1</sup> American Psychological Association. *The Child and Adolescent Behavioral Health Workforce*. Accessed Oct. 22, 2021.

nities. We support the essential aims of this program and encourage the Committee to explore how to sustainably expand its reach, including enhanced support for the participation of fellows who plan to serve pediatric populations.

**Enact H.R. 4944, the Helping Kids Cope Act.** At the core of a strong pediatric mental health care delivery system is a strong, interconnected network of pediatric mental health providers and supportive services that are available to deliver high-quality, developmentally appropriate care. To expand and strengthen these networks at the community level, the Senate should consider H.R. 4944, the Helping Kids Cope Act of 2021, bipartisan legislation that supports flexible funding for communities to support a range of child and adolescent-centered, community-based services, as well as to support efforts to better integrate and coordinate across the continuum of care. It also supports pediatric mental health workforce development for a wide array of physician and non-physician mental health professions to expand children's long-term access to providers and services across the continuum of care.

**Pediatric Mental Health Care Access (PMHCA) program.** While workforce shortages persist, innovative solutions like the Pediatric Mental Health Care Access (PMHCA) program, which this Committee has championed, help children's hospitals expand the reach of their workforce and ultimately ensure that more children receive the behavioral health screenings, assessments and referrals they need. As of today, 45 states, Washington, DC, tribal organizations and territories have received a grant from HRSA to create or expand their programs. Integrating mental health with primary care has been shown to substantially expand access to subspecialist physicians, such as child and adolescent psychiatrists, while boosting a pediatric provider's knowledge of mental health care, improving health and functional outcomes, increasing satisfaction with care and achieving cost savings. Expanding the capacity of pediatric primary care providers to deliver behavioral health through mental and behavioral health consultation programs is one way to maximize a limited subspecialty workforce and to help ensure more children with emerging or diagnosed mental health disorders receive early interventions and continuous treatment.

Thank you again for your commitment to improving the current health care workforce shortage. Children's hospitals and their affiliated providers stand ready to partner with you to advance workforce policies that will make measurable improvements in the lives of our Nation's children.

Children need your help now.

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Hon. JOHN HICKENLOOPER, Chairman,  
Hon. MIKE BRAUN, Ranking Member,  
*U.S. Senate Committee Health, Education, Labor, and Pensions,  
Subcommittee on Employment and Workplace Safety,  
428 Dirksen Senate Office Building,  
Washington, DC 20510.*

Dear CHAIRMAN HICKENLOOPER AND RANKING MEMBER BRAUN:

On behalf of the 75,000 employees, including more than 10,000 physicians and 22,000 nurses of Advocate Aurora Health (Advocate Aurora), I am writing to thank you for this opportunity to submit written testimony for the record of the Thursday, February 10, 2022 hearing titled, "Recruiting, Revitalizing & Diversifying: Examining the Health Care Workforce Shortage." We very much appreciate your attention to the current health care workforce shortage and, in particular, highlighting the need to strengthen and diversify the Nation's health care workforce. We stand ready to work with you and your colleagues to ensure that the patients, families, and communities we serve across Illinois and Wisconsin can continue to receive the emergency, urgent, primary, specialty, post-acute, and home care they need and deserve in the setting most appropriate for their particular condition.

As you may know, Advocate Aurora is comprised of 27 acute care hospitals, an integrated children's hospital and a psychiatric hospital, and we offer inpatient, outpatient and physician-office based primary and specialty physician services, pharmacy, rehabilitation, home health, and hospice care. We provide a continuum of service at more than 500 sites of care in northern Illinois and eastern Wisconsin. We maintain a strong commitment to recruiting and retaining a diverse workforce and creating and maintaining an inclusive, engaged working environment across all our sites of care, where team members can pursue their passion and feel supported, valued, and recognized.

Since the COVID-19 public health emergency (PHE) began, our team members have experienced significant strain and stress due to the heavy burdens associated

with providing care to people infected with COVID-19. Moreover, many of our team members themselves have been exposed, requiring quarantine, and/or infected with COVID-19, turning our caregivers into patients. The negative physical and mental health impact of the PHE on our team member—and health care employees across the country—has been sustained and must be recognized and addressed.

We are working hard to ensure our team members have the support they need, as you will read in the attached Advocate Aurora Health Workforce Issue Brief, which we submit as our written testimony. Nonetheless, there remain myriad challenges facing front-line health care workers as we enter the third year of the PHE and, we—like our colleagues—continue to experience staff departures, turnover, and other recruitment and retention challenges. Our normal vacancy rate across our whole system typically—at any given time is 3,000 open positions; currently, we have more than 6,000 unfilled positions.

Again, we thank you for holding this important hearing and draw your attention to the attached Advocate Aurora Health Workforce Issue Brief, which outlines what we are doing within Advocate Aurora to diversify, strengthen, and retain our workforce as well as enumerates the Federal policies and programs we need you and your colleagues to support so that the Nation can bolster our health care workforce. We thank you for your attention to our recommendations.

Please do not hesitate to contact me (Meghan.Woltman—aah.org, 312/933-0455) or Tom McDaniels, Advocate Aurora Director Federal Government Relations (Thomas.Mcdaniels@aah.org, 202/409-0865) if we can answer any questions or be of any assistance to you or your staff as you consider next steps following the hearing.

Sincerely,

MEGHAN WOLTMAN CHIEF,  
*Government Affairs Officer*

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AMERICAN FEDERATION OF TEACHERS

Senator JOHN HICKENLOOPER, Chairman  
 Senator MIKE BRAUN, Ranking Member  
*U.S. Senate Committee on Health, Education, Labor, and Pensions,  
 Subcommittee on Employment and Workplace Safety  
 428 Dirksen Senate Office Building,  
 Washington, DC 20510.*

Chairman HICKENLOOPER:

On behalf of the 1.7 million members of the American Federation of Teachers, including 230,000 healthcare professionals, I write to offer our views on the workforce shortage in our Nation's health care system in advance of your February 10, 2022, hearing (Recruiting, Revitalizing & Diversifying: Examining the Health Care Workforce Shortage).

Simply put, there is a staffing crisis in our Nation's hospitals. As Lucy King and Jonah Kessel powerfully laid out in their Jan. 19 New York Times video editorial titled "We Know the Real Cause of the Crisis in Our Hospitals. It's Greed," our Nation's hospitals are responsible for this crisis, which undermines the access to care and the quality of care we all depend on, especially during a pandemic. While the pandemic has strained our Nation's healthcare system and its frontline healthcare workers to the breaking point and beyond, this is a crisis that started well before the COVID-19 pandemic. Hospitals were understaffed, in many cases dangerously so, long before the current public health emergency. And now, frontline care givers are burned out, exhausted from the moral injury of being forced to provide inadequate care, and leaving hospital employment in record numbers.

As one of the Nation's largest unions of healthcare workers, a week does not go by when we don't hear from frontline workers about dangerously high patient loads; dangerous working conditions; and the mental, physical and emotional toll this crisis has taken on them and their families. The data paints an alarming picture. Since the beginning of the COVID-19 pandemic, 18 percent of healthcare workers (nearly 1 in 5) have quit their jobs. And for healthcare workers who have stayed in their jobs, nearly 1 in 3 (31 percent) has considered leaving.<sup>1</sup> In a survey conducted by Mental Health America in summer 2020, 76 percent of healthcare work-

<sup>1</sup> Morning Consult: <https://morningconsult.com/2021/10/04/health-care-workers-series-part-2-workforce/>

ers reported exhaustion and burnout.<sup>2</sup> According to a Kaiser Family Foundation/Washington Post survey, a majority of frontline healthcare workers (62

percent) say worry or stress related to COVID-19 has had a negative impact on their mental health; and 13 percent of healthcare workers say they have received mental health services or medication specifically due to worry or stress related to COVID-19, with an additional 1 in 5 (18 percent) saying they thought they might need such services, but did not get them.<sup>3</sup> So it should come as no surprise that healthcare workers are quitting; they are not just retiring early. Rather, we are hearing increasing reports of mid-and early career health professionals, some still paying off their student loans, quitting their jobs because they simply cannot take it any longer. They are not necessarily leaving the healthcare field, but they are definitely leaving their hospital jobs.

While the American Hospital Association tries to dance around the cause of this crisis, there is no denying its culpability in creating it. The revenue-and profit-driven, often callous, decisionmaking of hospitals put their economic bottom line ahead of patient care and the safety of their frontline healthcare workers long before the current pandemic. Quite simply, too many members of the AHA have failed their most basic responsibility: providing a safe place for patients to receive care from healthcare professionals.

Early in the pandemic, hospitals' decisions to save money by not keeping sufficient stockpiles of personal protective equipment needlessly exposed frontline care givers to infections. As a result, 34 percent of healthcare workers employed in either hospitals or nursing homes said in the spring that at some point during the pandemic, their workplace ran out of PPE for its employees.<sup>4</sup> Sadly, 3,600 healthcare workers paid the ultimate price, tragically dying during this pandemic.<sup>5</sup> Yet hospitals opposed the Occupational Safety and Health Administration (OSHA) Healthcare Emergency Temporary Standard, which was enacted far too late, and then following its withdrawal, too many removed the limited protections that were put in place. And now an increasing number of hospitals are considering requiring their COVID-19-positive care givers to return to work before they are COVID-19-free, denying them the time to get healthy themselves before they care for others.

But the indifference of our Nation's hospitals to the safety of their workforce started long before COVID-19. Hospitals have been one of most dangerous places to work in America. Healthcare workers are five times more likely to experience workplace violence than other workers. In fact, in 2018, long before the COVID-19 pandemic, assaults on healthcare workers accounted for 73 percent of all nonfatal workplace violence.<sup>6</sup> And there is every reason to believe that these rates have only gotten worse during the pandemic. There is a desperate need to pass legislation like the Workplace Violence Prevention for Health Care and Social Service Workers Act.

Patient loads before the pandemic undermined the quality of care. Oppressive patient loads during the pandemic have broken the Nation's healthcare workforce. Data tells us that adding just one additional patient to a nurse's workload results in an increased risk of urinary tract infections and surgical site infections,<sup>7</sup> a 48 percent increased risk of a child being readmitted to the hospital within 30 days,<sup>8</sup> and a 7 percent increased risk of 30-day in hospital mortality.<sup>9</sup> This was true before the pandemic and will be true after the pandemic. To address this issue, the Senate should move reasonable legislation to require minimum staffing levels such as Sen. Sherrod Brown's Nurse Staffing Standards for Hospital Patient Safety and Quality Care Act.

There are additional strategies to address this crisis, such as improving the pipeline for healthcare workers through expanded funding for training programs as well

<sup>2</sup> Mental Health America: <https://mhanational.org/mental-health-healthcare-workers-covid-19>

<sup>3</sup> Kaiser Family Foundation: <https://www.kff.org/report-section/kff-the-washington-post-frontline-health-care-workers-surveytoll-of-the-pandemic/>

<sup>4</sup> Kaiser Family Foundation: <https://www.kff.org/report-section/kff-the-washington-post-frontline-health-care-workers-surveytoll-of-the-pandemic/>

<sup>5</sup> Kaiser Health News: <https://khn.org/news/as-coronavirus-spreads-widely-millions-of-older-americans-live-in-counties-with-no-icu-beds/>

<sup>6</sup> U.S. Bureau of Labor Statistics: <https://www.bls.gov/iif/oshwc/cfoi/workplace-violence-healthcare-2018.htm>

<sup>7</sup> Cimiotti et al., 2012: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3509207/pdf/nihms387953.pdf>

<sup>8</sup> Tubbs-Cooley et al., 2013: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3756461/pdf/bmjqs-2012-001610.pdf>

<sup>9</sup> Aiken et al., 2014: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4035380/pdf/nihms571000.pdf>

as student financial aid, and making the compensation more competitive with that provided by staffing agencies. However, hospitals will continue to lose care givers more quickly than they can be trained until hospitals stop treating healthcare workers like disposable parts, and instead treat them like highly trained professionals and provide them an appropriately staffed, safe place to work that puts the quality of care above hospital profits.

Thank you for considering our views on this crucial topic. The AFT looks forward to working with you on solutions to address the current workforce shortages in our health care system.

Sincerely,

RANDI WEINGARTEN,  
*President, American Federation of Teachers.*

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NATIONAL NURSES UNITED  
SILVER SPRING, MD 20910  
*February 8, 2022*

Senator JOHN HICKENLOOPER, Chairman  
Senator MIKE BRAUN, Ranking Member  
*U.S. Senate Committee on Health, Education, Labor, and Pensions,  
Subcommittee on Employment and Workplace Safety,  
428 Dirksen Senate Office Building,  
Washington, DC 20510.*

Dear Chairman HICKENLOOPER AND RANKING MEMBER BRAUN:

National Nurses United is the largest union and professional association of registered nurses (RNs) in the United States, representing more than 175,000 nurses across the country. Our members have been on the frontlines of the Covid-19 response for 2 years and are dealing first-hand with the repercussions of the nurse staffing crisis that the health care industry is facing today. I write to you today in advance of your hearing on “Recruiting, Revitalizing & Diversifying: Examining the Health Care Workforce Shortage,” to provide you with frontline insights into the working conditions that have created this staffing crisis, and to discuss the important solutions needed to address this crisis and ensure a robust health care workforce in the future.

Throughout the Covid-19 pandemic, nurses have been dealing with dangerous working conditions, including low RN staffing levels, inadequate health and safety protections, insufficient stock of critical medical supplies and PPE, and increasing levels of violence in the workplace. While the Covid crisis has exacerbated these challenges, nurses have been facing these issues in their hospital workplaces for decades. The staffing crisis we are experiencing now is the result of years of industry neglect and intentional policies of short-staffing and cost-cutting measures enacted by hospital employers.

According to statistics from the National Council of State Boards of Nursing and the U.S. Bureau of Labor Statistics, there are at least 1.2 million actively licenses registered nurses who are not employed as RNs. **There is no shortage of trained and licensed RNs, but there is a shortage of good nursing jobs where RNs are valued for their work, have strong health and safety protections, and are not required to care for more patients at any given time than is safe for optimal, therapeutic care. We don’t have a shortage of nurses, but we do have a staffing crisis.**

**The first step to addressing this staffing crisis is to revitalize the workforce by increasing nurse retention and bringing licensed nurses back to work.** To do this, it is critical that the Federal Government implement policies that will require the hospital industry to provide safe and healthy workplaces.

Nurses are leaving the bedside because their employers refuse to staff their units appropriately and fail to supply the resources necessary to provide safe, therapeutic patient care. Many hospitals have chosen to adopt policies that result in high patient caseloads that compromise the health and safety of both nurses and patients. Moreover, hospital employers have failed to implement programs to protect nurses from infectious diseases, prevent violence, and enable safe patient handling.

Although working conditions have been deteriorating for decades, the problems intensified during the pandemic. Hospital employers showed their disregard for nurses’ health and safety by failing to implement infection control practices and failing to provide appropriate PPE. Nurses working on the pandemic’s front lines are experiencing severe moral distress and injury (often incorrectly labeled “burnout”);

mental health issues such as stress, anxiety, depression, and post-traumatic stress disorder; and physical exhaustion.

To bring nurses back to the bedside and increase nurse retention, NNU recommends the following solutions:

- Congress must mandate minimum nurse-to-patient staffing ratios, through passage of the Nurse Staffing Standards for Hospital Patient Safety and Quality Care Act, sponsored by Senator Sherrod Brown and Congresswoman Jan Schakowsky.
- The Occupational Safety and Health Administration (OSHA) must issue a final permanent Covid-19 Health Care Standard to enforce Covid protections for health care workers and retain its Emergency Temporary Standard until the permanent standard takes effect. Further, OSHA should issue an Infectious Diseases standard, so that workplace protections will be enforced during future infectious disease outbreaks.
- Congress must pass the Workplace Violence Prevention for Health Care and Social Service Workers Act, sponsored by Congressman Joe Courtney and passed in the House of Representatives, and introduced by Senator Tammy Baldwin in the 116th Congress. The bill would mandate that OSHA issue a Workplace Violence Prevention Standard for health care and social service workplaces.
- The Federal Government must do everything in its power to restore and protect the right of nurses and other health care workers to organize and bargain collectively.

While there is no general nursing shortage in the United States, there is a lack of racial, ethnic, cultural, linguistic, and socioeconomic diversity within the current nursing workforce. This challenge has resulted from a lack of investment in nursing education, job placement, and hospital industry practices that have restricted the pipeline of nurses from socioeconomically diverse and underserved communities. **The Federal Government should take measures to recruit nurses from underserved communities, and to ensure that hospital industry practices support a diverse nursing pipeline.**

Diversity in the health care workforce facilitates health care access and health care quality, necessary elements of health equity. Patient-provider racial, ethnic, and linguistic concordance improves communication, trust, and health care quality. Black, Indigenous, and People of Color (BIPOC) communities, along with rural communities, often have fewer health care professionals practicing locally and even fewer who are culturally and linguistically competent. Studies show that Black, Hispanic/Latinx, and Native American health care providers are more likely to practice in underserved communities.<sup>1</sup> Similarly, students from rural areas are more likely to practice in rural communities.<sup>2</sup>

To increase diversity within the nursing workforce, investments must be made to support education and job placement for nurses from underrepresented communities. This should include the following investments:

- Long-term funding for tuition free nursing programs at community colleges
- Increased funding for the Nursing Workforce Diversity Program
- Increased funding for Nurse Corps scholarship and loan repayment programs

At the hospital level, the industry needs to adjust practices that have limited the ability for nurses from underrepresented communities to find work. Most notably, some hospitals refuse to hire nurses with an associate degree in nursing (ADN), choosing to prioritize hiring of nurses with 4-year bachelor's degrees of nursing (BSNs). Nurses with ADN and BSN degrees must fulfill the same education and

<sup>1</sup> Pittman P et al. 2021. Health Workforce for Health Equity. *Medical care*, 59(Suppl 5), S405–S408. <https://doi.org/10.1097/MLR.0000000000001609>. Citing Goodfellow A et al. Predictors of primary care physician practice location in underserved urban or rural areas in the United States: a systematic literature review. *Acad Med*. 2016;91:1313–1321 and Mertz E et al. Underrepresented minority dentists: quantifying their numbers and characterizing the communities they serve. *Health Aff*. 2016;35:2190–2199

<sup>2</sup> *Ibid.*. Citing Rabinowitz H et al. The relationship between entering medical students' backgrounds and career plans and their rural practice outcomes three decades later. *Acad Med*. 2012;87:493–497. MacQueen I et al. Recruiting rural healthcare providers today: a systematic review of training program success and determinants of geographic choices. *J Gen Intern Med*. 2018;33:191–199

clinical experience requirements, and they must pass the same licensing examination. By choosing to prioritize BSN nurses, hospitals are restricting diversity in the workforce. A BSN requires a larger time and financial commitment, and statistics on RN graduates show that nurses from underrepresented communities, and specifically communities of color, are more likely to graduate with an ADN. It is important to note that hospitals refusing to hire nurses with ADNs is happening while the hospital industry is lobbying to delegate nursing work to lesser licensed and unlicensed personnel and family members.

As the Committee explores approaches to addressing the current health care staffing crisis, it is crucial to protect RNs' scope of practice. **We urge you to focus on providing the resources needed to educate more RNs in 2-year nursing programs rather than on "upskilling" other workers.** Nursing practice is fundamentally holistic in nature. Registered nurses have extensive education and clinical experience that enables them to provide safe, therapeutic patient care. Attempts to break down registered nursing practice into tasks, and shifting the tasks to unlicensed workers, undermines patient care. Even the simplest RN-patient interactions involve skilled assessment and evaluation of the patient's overall condition. Subtle changes in a patient's skin tone, respiratory rate, demeanor, and affect provide critical information to their health and well-being that can be easily overlooked or misinterpreted by those without an RN's education and clinical experience.

Attached to this letter is NNU's report, "Protecting Our Front Line: Ending the Shortage of Good Nursing Jobs and the Industry-Created Unsafe Staffing Crisis," which contains more detailed information on the hospital industry practices that have created the nurse staffing crisis we are experiencing right now, and NNU's proposed solutions to increase nurse retention and diversity.

We look forward to working with your Committee to protect the workplace health and safety of nurses, improve staffing levels and nurse retention, and build a sustainable nursing workforce well into the future.

Sincerely,

ZENEI TRIUNFO-CORTEZ (RN),  
President,  
National Nurses United

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NATIONAL HEALTHCAREER ASSOCIATION  
LEAWOOD, KS 66211  
February 10, 2022

Senator JOHN HICKENLOOPER, Chairman  
Senator MIKE BRAUN, Ranking Member  
U.S. Senate Committee on Health, Education, Labor, and Pensions,  
Subcommittee on Employment and Workplace Safety  
428 Dirksen Senate Office Building,  
Washington, DC 20510.

Dear Chairman HICKENLOOPER AND RANKING MEMBER BRAUN:

On behalf of the more than 380,000 nationally certified allied health professionals that the National Healthcareer Association (NHA) represents, thank you for holding the important hearing on Recruiting, Revitalizing & Diversifying: Examining the Health Care Shortage. This is an extremely important and timely topic.

Since 1989, NHA has prepared and awarded more than one million certifications to healthcare students and professionals, providing them with nationally recognized measurements of competency and easy-to-use training and study resources paired with high quality, personalized customer care. NHA is passionately committed to develop, advance, and advocate for the frontline healthcare worker, resulting in improved patient care. It does this by working with thousands of secondary, post-secondary schools, and health care employers across the country to assist with the training and certification of professionals in the following areas:

- Medical Assisting (Clinical and Administrative)
- Pharmacy Technician
- Phlebotomy
- EKG Technician
- Patient Care Technician
- Billing and Coding Specialist
- Electronic Health Records Specialist

In 2022, more than ever, the healthcare industry is at the core of our Nation's success. The pipeline to healthcare careers has been greatly impacted by Covid-19 challenges and shutdowns. Based on research we conducted in 2021, enrollments of first-year students at 2-year institutions is down 21 percent compared to pre-pandemic numbers. For example, in 2019 schools were producing around 60,000 medical assistants (MA). In March 2021, ZipRecruiter.com had nearly 700,000 open MA positions. We also have data showing that 88 percent of healthcare leaders report having difficulty recruiting medical assistants. In addition, female workers represent nearly 70 percent of the global healthcare workforce and according to the National Women's Law Center Analysis, four times as many women as men dropped out of the labor force in September 2020. Please use this link to access these statics and more compelling articles as a part of NHA's annual allied health industry journal Access.

As the Committee on Health, Education, Labor & Pensions considers this important topic, we urge your support for the following principles and urge the Committee to consider and pass these principles into legislation as swiftly as possible:

- Reauthorization of the Health Profession Opportunity Grant (HPOG) Program, which provides grants for the purpose of preparing certain low-income individuals to enter into the health care profession;
- Inclusion of authorization for increased home care funding to recruit and retain direct care workers and improve care wages through training, registered apprenticeships, the creation of career pathways, and mentoring;
- Authorization for funding for higher education and workforce development, including:
  - Adult and Dislocated Worker Employment and Training Activities and for Youth Workforce Investments under the Workforce Innovation and Opportunity Act
  - Expanded registered apprenticeships, pre-apprenticeships, and youth apprenticeships. We urge the Committee to ensure these opportunities include people with barriers to employment, people with disabilities, and populations underrepresented in apprenticeships;
  - Industry or private sector partnerships that would bring together state and local workforce boards, employers, labor organizations, and education and training providers to expand training for high-skill, high-wage, or in-demand industries such as health care;
  - Authorization and funds for core Title I WIOA program activities;
  - Dedicated funding for state and local workforce development boards to implement industry and sector partnership grants;
  - Inclusion of an increase in the maximum Pell Grant award;
  - Retention and Completion Grants to eligible states and state systems to support the development of practices that have been shown to improve student outcomes, such as providing comprehensive academic, career, and student support services; assistance in applying for financial aid or mean-tested benefits; accelerated learning opportunities; an improved developmental education and transfer pathways; and
  - Career and technical education grants for CTE programs and to carry out an innovation and modernization programs.

As NHA continues to advance and advocate for frontline healthcare workers, we strive to create a ripple effect on the healthcare industry. By working to certify professionals who meet a national recognized measure of competency, we help improve patient care and make for a better, more thoughtful patient experience. As the current COVID pandemic continues to demonstrate, the need for high quality healthcare workers is more important than ever. Continued support of the above principles is essential to meet the need for qualified healthcare workers now and in the future.

Sincerely,

JESSICA LANGLEY,  
*Executive Director of Education and Advocacy,*  
*National Healthcareer Association*

FEDERATION OF AMERICAN HOSPITALS,  
 WASHINGTON, DC 20001,  
 February 10, 2022.

Senator JOHN HICKENLOOPER, Chairman,  
 Senator MIKE BRAUN, Ranking Member,  
 U.S. Senate Committee on Health, Education, Labor, and Pensions,  
 Subcommittee on Employment and Workplace Safety,  
 428 Dirksen Senate Office Building,  
 Washington, DC 20510.

Dear Chairman HICKENLOOPER AND RANKING MEMBER BRAUN:

On behalf of the Federation of American Hospitals (FAH), thank you for the opportunity to comment in advance of the Senate Health, Education, Labor, and Pensions (HELP) Subcommittee on Employment and Workplace Safety hearing, *Recruiting, Revitalizing & Diversifying: Examining the Health Care Workforce Shortage*.

The FAH is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural areas across 46 states, plus Washington, DC and Puerto Rico. Our members include teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services.

### Health Care Workforce: Challenges and Solutions

As the third year of the pandemic begins, the mental and physical toll of the COVID-19 public health emergency (PHE or pandemic) has put an unprecedented strain on our frontline caregivers and hospital support staff. The struggle to maintain a robust workforce has been exacerbated in recent months as Omicron has rapidly spread, while potential future variants also threaten to sideline critically needed health care providers. At the same time, caregivers are still bearing the emotional burden of treating patients throughout multiple COVID-19 waves.

The pandemic continues to have lingering effects on health care providers, as we are seeing rising instances of burnout and resignation. According to the American College of Healthcare Executives' annual survey, hospital CEOs reported 'personnel shortages' as their top organizational concern.<sup>1</sup> FAH members are experiencing staffing shortages that existed prior to COVID-19 and have become significantly more pronounced and problematic due to the strain and ongoing nature of the PHE. **We therefore must implement policy solutions that will yield short and long-term stability in the recruitment, retention, and diversification of our health care workforce.**

FAH members are experiencing shortages of medical technicians, laboratory assistants, and nurses, as well as food service, housekeeping, and sanitation staff, and in some instances, hospitals do not have enough staff to operate at full capacity. To ensure that patient care and general operations are not compromised, hospitals have been forced to significantly increase their reliance on contract labor and staffing companies.

It has been widely reported that nurse-staffing agencies are exploiting the COVID-19 crisis with predatory price increases that can be disconnected from the wages paid to these contract nurses who are providing needed clinical care to hospitals. Bipartisan Members of the House and Senate have expressed concerns over these practices and, in particular, worry that hospitals will be unable to sustain these exorbitant staffing costs. We join those in Congress to urge the Administration to investigate nurse-staffing agencies' conduct during the pandemic through Federal agencies with jurisdiction.

- We further urge Congress to prioritize certain measures to support frontline health care providers and maintain a strong workforce, including:
- Extending the Medicare-funded residency training slots cap building period to 10 years, as opposed to the current 5 years, for new teaching hospitals
- Enacting the *Healthcare Workforce Resilience Act* to recapture 25,000 unused immigrant visas for nurses and 15,000 unused immigrant visas for

<sup>1</sup> <https://www.ache.org/learning-center/research/about-the-field/top-issues-confronting-hospitals>

doctors that Congress has previously authorized and allocate those visas to international doctors and nurses

- Enhancing investment in provider loan repayment programs, including the Nurse Corps, to incentivize providing care in rural and underserved communities
- Enacting the *Technical Reset to Advance the Instruction of Nurses (TRAIN) Act*, which would prohibit the Centers for Medicare and Medicaid Services (CMS) from recouping overpayments made in past years to hospital-based nursing and allied health education programs when CMS failed to make technical annual updates to the program, and instead invest those resources in training the next generation of caregivers
- Ensuring any policy that increases Pell Grant funding makes certain that nursing students are eligible to receive such benefits to attend high-quality nursing schools, regardless of the educational institution's tax status
- Enacting the *Conrad State 30 and Physician Access Reauthorization Act* to extend and expand the Conrad 30 program.

**Parity for Tax-Paying Hospitals—and Our Workforce—is Needed Regarding Eligibility for Federal Health-Related Programs**

We strongly urge Congress to expand the eligibility of Federal health-related programs that currently and unjustly exclude tax-paying hospitals—and thereby our workforce—to the detriment of our patients and communities. Tax-paying hospitals are not eligible to apply for many Federal programs, including some within the *Public Health Service Act*, based solely on their tax-filing status. This lack of program access among tax-paying hospitals, especially in rural communities, unjustly ignores a significant component of the health care safety net serving impoverished and uninsured patients.

For example, for years, nurses practicing at tax-paying hospitals located in a critical shortage area were ineligible to benefit from the Nurse Corps Loan Repayment program—a key recruitment tactic that incentivizes patient care in rural and underserved communities. With the leadership of the Senate HELP Committee and other bipartisan Members of the House and Senate, this eligibility restriction was finally struck in *The Coronavirus Aid, Relief, and Economic Security (CARES) Act* in the 116th Congress. But we now need an across-the-board solution that can play a pivotal role in addressing the health care workforce crisis.

As a first step toward rectifying this matter, we urge the Senate HELP Committee to direct the Government Accountability Office (GAO) to prepare a comprehensive analysis of all Federal health care programs that exclude tax-paying hospitals (and/or providers serving in such facilities) from eligibility. Such an analysis will shed light on how this lack of parity is a disservice to the health care workforce and our patients, and further demonstrate the dire need for Congress to take corrective action.

We appreciate the opportunity to comment and look forward to working with you in 2022 to meet the significant challenges that hospitals face in treating patients during these unprecedented times. If you have any questions or wish to discuss these issues further, please do not hesitate to reach out to me or a member of my staff at 202–624–1534.

Sincerely,

CHARLES N. KAHN, III,  
*President and CEO.*

GLOBAL MEDICAL RESPONSE,  
GREENWOOD VILLAGE, CO 80111,  
*February 10, 2022.*

Senator JOHN HICKENLOOPER, Chairman  
Senator MIKE BRAUN, Ranking Member  
*U.S. Senate Committee on Health, Education, Labor, and Pensions,  
Subcommittee on Employment and Workplace Safety  
428 Dirksen Senate Office Building,  
Washington, DC 20510.*

Dear Chairman HICKENLOOPER AND RANKING MEMBER BRAUN:

We appreciate the opportunity to submit written testimony for the Senate Health, Education, Labor, and Pensions Committee's Subcommittee on Employment and Workplace Safety hearing: Recruiting, Revitalizing & Diversifying: Examining the Health Care Workforce Shortage. While workforce shortages are impacting every aspect of the health care industry, the multiple headwinds facing the private ambulance industry in particular have resulted in a staffing crisis at a time when our EMS professionals have been challenged with unprecedented numbers of acutely ill and injured patients during the COVID-19 pandemic, natural disasters and other emergencies. We appreciate the attention this Committee is providing to resolving this crisis and we urge you to address and incorporate EMS professionals in any of your policy solutions to help recruitment and efforts to diversify the health care workforce.

Global Medical Response (GMR) is the largest air and ground medical transportation company in the United States with more than 36,000 employees, including 25,000 clinicians and 11,000 support staff across most of the lower 48 states, Alaska and Hawaii. GMR team members perform a critical intervention every 9 minutes and completed more than five million patient transports last year, utilizing 8,700 ground vehicles, 158 fire vehicles, 344 helicopters and 111 airplanes. As the Nation's largest provider of emergency medical services and medical transportation, we are on the frontlines both in the communities we serve, as well as in the areas that needed additional aid to supplement fellow emergency service providers. We are especially proud to service rural and underserved areas, where so many Americans rely on our services to navigate long distances to reach facilities that can provide the appropriate level of care. GMR provides the "last mile" infrastructure that helps secure critical care for over 43 percent of the rural counties in the United States.

Our mission is to provide care at a moment's notice, and this guides our emphasis on patient-driven care that can respond to any health issue in any emergency scenario with the utmost quality. Due to our emphasis on giving the patient the highest quality care, we provide extensive training to our paramedics, emergency medical technicians (EMTs), and registered nurses (RNs). We value the skill set of these EMS professionals—who are called on to provide care on wheels or in the sky in high-stress situations—and we work with states and municipalities around the country to meet their unique requirements and needs. Many of our workforce moves around the health care field to serve in other capacities, and we take pride in ensuring that they can transfer the skills they learn with GMR into other segments of the industry.

Since the start of the pandemic, GMR's EMTs, paramedics, nurses, physicians, and other caregivers have led the country's COVID-19 response, risking their personal safety to administer life-saving care. We have made more than 350,000 COVID-19 patient transports and made emergency FEMA deployments to 31 states including six states represented on this Subcommittee during coronavirus surges. GMR employees also screened more than 500,000 passengers for COVID-19 at airports and other ports of entry.

Proud of our partnership with the Federal Emergency Management Agency (FEMA), GMR continued to respond to natural disasters, whose impact have been exacerbated by the pandemic. Since the virus first appeared in the United States, we participated in 7,874 patient missions in response to devastating wildfires and led operations deploying more than 600 ambulances and 25 airplanes in response to Hurricane Laura, Hurricane Delta, and Hurricane Zeta. To support these operations, we procured more than 25 million medical and K-95 masks, as well as 55 million gloves and gowns.

In addition to the substantial time and effort GMR's first responders have devoted to confronting COVID-19, the company has made significant economic investments to protect its employees during the pandemic. Since March 2020, GMR has incurred \$230 million in incremental expenses related to COVID. This includes \$70 million in employee assistance like payments to staffers under quarantine, childcare stipends, workers compensation and health insurance, and one-time bonuses. It also included \$40 million for personal protective equipment (PPE) and cleaning costs. Additionally, GMR delivered approximately \$30 million in one-time retention payments, made \$90 million in annualized wage adjustments, and approved nearly 93 percent of its 632 childcare stipend application requests. This has come at significant financial cost to the company, but we have done it because without our first responders, we would be unable to service vulnerable populations under our care.

As a company, GMR has also been proactive in recruiting talent and training the next generation of EMS providers. Our driving force for retention and recruitment is the ability to save lives and impact patient care and outcomes. In 2018, we

launched the Earn While You Learn program, a GMR academy that pays prospective EMTs during their training and certification process. Since 2018, more than 800 students have graduated from Earn While You Learn programs at 59 locations nationwide, over 35 percent of whom were minorities. In addition to our Earn While You Learn program, 593 students graduated from paramedic and EMT training programs from GMR's National Training Center in 2021 joining 523 graduates in 2020.

We have put into place a variety of other recruitment and incentive programs to attract and retain staff. These include reducing hours on call, providing bonuses and increased wages, providing wellness and stress management resources. And 10 years ago, the company established a GMR employee foundation to provide paid time off (PTO) and financial assistance in times of need to other GMR employees. In the last 2 years the company has provided over \$1 million to employees to cover emergent personal needs.

Despite our best efforts, this has not been enough. Even before the pandemic, the EMS workforce was hobbled by a lack of a pipeline to train professionals, significant burnout and stress, a competitive market, and unpredictable needs for ground ambulance protocols. According to a 2021 survey by the American Ambulance Association involving nearly 20,000 employees and 258 EMS organizations, overall turnover among paramedics and EMTs ranges from 20 to 30 percent annually, meaning that ambulance services could face a 100 percent turnover in a 4-year period. This has only been exacerbated by the coronavirus pandemic when in-person training was halted for a period of time further straining an already deteriorating pipeline and the industry began to face increased competition from others in the healthcare industry who were able to hire away EMS professionals to work in other settings for higher pay. These staffing shortages are problematic, and compromise GMR's ability to respond to healthcare emergencies.

Despite the essential work our EMS professionals perform, economic headwinds facing the industry continue to contribute to a staffing crisis for private ambulance companies. These systemic headwinds have been left unaddressed for years and we hope to work with this Committee to enact policy changes that result in a viable, sustainable workforce. This crisis is driven largely by the low reimbursement rates these companies receive from Medicare and Medicaid. While Medicare and Medicaid rates for ground and air transports are well below cost and comprise close to 70 percent of GMR's total transports along with uninsured patients, our crews are required to respond to patient emergency requests regardless of the patient's ability to pay; medical crews respond to these requests within minutes—day or night, operating 24 hours per day 7 days per week.

GMR strongly believes the best way to alleviate the issue is to permanently update the Medicare and Medicaid reimbursement rates to reflect the standard of care. In the meantime, a temporary Medicare payment increase that reflects costs to increase wages and competes with the rest of the health care could also infuse additional funds into the workforce and spur innovative responses to workforce shortages. Appropriate reimbursement by government payors will allow private companies to increase wages for EMTs and alleviate the staffing crisis.

In addition, we support additional steps Congress can take to alleviate the impact of the workforce shortage. Congress can provide specific direction and funds to the Health Resources and Services Administration (HRSA), which can be used to pay for training and professional development programs. HRSA can also disburse funds through grant programs to be paid directly to paramedics and EMTs for training initiatives. In addition, Congress should strongly consider expanding HRSA loan repayment programs to include EMS professionals and establish a grant program providing funding to payors, public and private universities, and local governments to reimburse costs associated with education, loan forgiveness, and relocation for individuals who are pursuing careers in emergency transportation services.

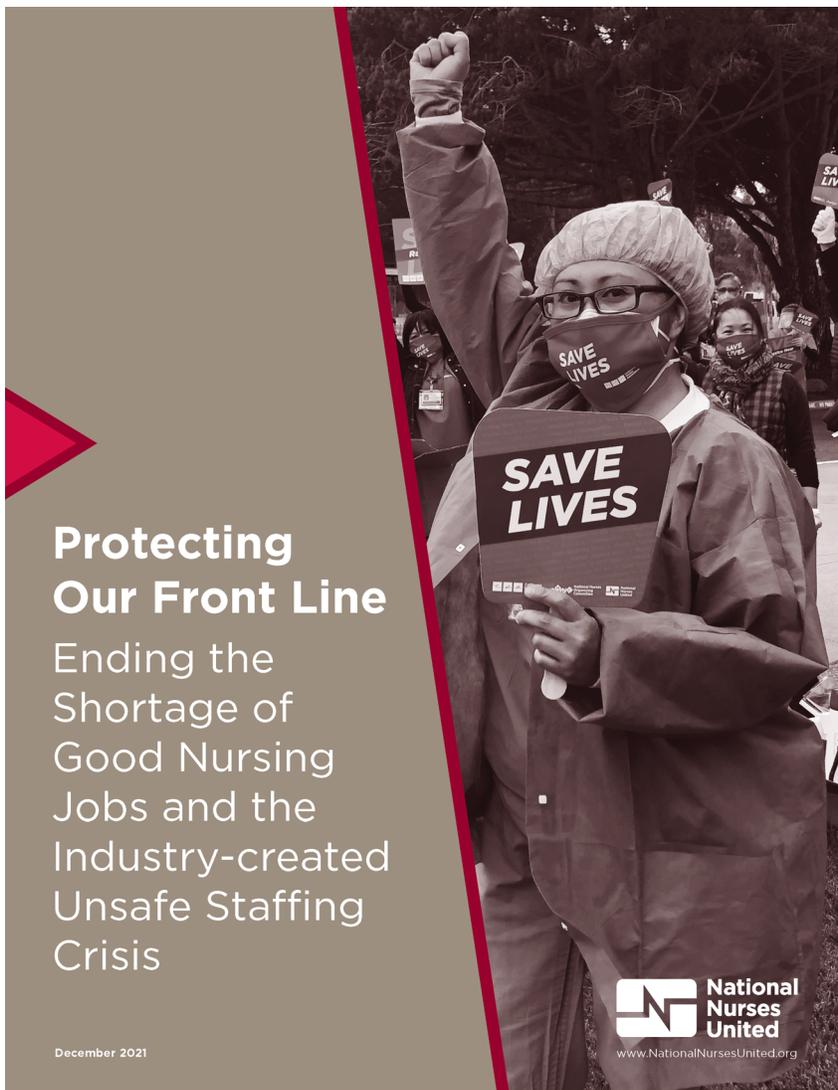
While a temporary solution, we support a Medicaid Federal Medical Assistance Percentage (FMAP) increase of 10 percent for emergency transportation services, identical to what was provided to home and community-based services during the pandemic.

Finally, we support tax incentives for organizations who absorb significant costs due to uncompensated care and allocate significant resources to paying prospective EMS professionals while they get certified so they may serve their local community.

It is important to note that many of our clinicians further their medical training to become nurses and even doctors. EMS is a pathway for recruitment and advancement of medical professionals across the health care system. We work with our team members to advance their learning and graduate from medical technician status to paramedic and to even become flight nurses and partner with hospitals on their

staffing needs. We also invest in recruitment efforts to have our teams reflect the communities they serve.

The more we can professionalize the emergency response industry and recognize the essential contributions EMS make to keeping our country healthy, the better it will be to retain and recruit people at this critical time while establishing a long-term sustainable workforce. Unfortunately, in the meantime, healthcare workforce shortages continue to meaningfully compromise our ability to respond to medical emergencies. Our workforce delivers services that are integral to the health care ecosystem. When frontline EMS is not available or delayed in responding due to staffing issues, the end result can be devastating to patients in need of critical care within minutes to prevent irreversible harm or even death. We thank you for your attention to this essential matter. We stand prepared to assist in ensuring the continuity of emergency medical care and are eager to work with you on how revitalize and diversify the health care workforce.



## Protecting Our Front Line

Ending the  
Shortage of  
Good Nursing  
Jobs and the  
Industry-created  
Unsafe Staffing  
Crisis

December 2021

 **National  
Nurses  
United**  
[www.NationalNursesUnited.org](http://www.NationalNursesUnited.org)

## INTRODUCTION

In this report, National Nurses United (NNU) describes how the hospital industry has driven registered nurses (RNs) from the bedside. As the largest union and professional association of registered nurses with more than 175,000 members working at the bedside in nearly every state in the nation, NNU proposes steps that Congress and the executive branch must take to keep RNs at the bedside, encourage licensed RNs not currently providing direct patient care to return to the bedside, and improve patient care in U.S. hospitals. This report begins with an executive summary, followed by sections detailing how pre-pandemic hospital industry practices of unsafe staffing and poor working conditions have driven nurses away from the bedside. Next, the report details the hospital industry's failure to prepare for the pandemic despite repeated, urgent calls from RNs, and hospital employers' active transgressions that resulted in the horrific conditions nurses experienced during the pandemic. Finally, the report discusses legislative and regulatory actions to address both retention and recruitment of bedside registered nurses, calling on Congress and the executive branch to act immediately to end the industry-created unsafe staffing crisis by ensuring safe and optimal working conditions for nurses and by supporting programs to create a culturally competent and diverse pipeline of nurses into bedside care. Lastly, the report offers concluding remarks on the pandemic's effects on nurses, their coworkers, and their patients.



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## EXECUTIVE SUMMARY: A SHORTAGE OF GOOD NURSING JOBS, NOT A SHORTAGE OF NURSES

For decades, the hospital industry has operated on a model with one goal: maximize net revenue. These profits come at the expense of both patient care as well as worker health and safety. A hospital is not a factory, and health care workers are not machines. After years of industry neglect and intentional policies of short-staffing, registered nurses (RNs) and their patients are facing a crisis of unsafe staffing and unsafe working conditions, exposed by the Covid-19 pandemic but dating back far longer.

**There is no shortage of RNs.** As of Nov. 6, 2021, the National Council of State Boards of Nursing reported that there are more than 4.4 million RNs with active licenses,<sup>1</sup> yet according to the U.S. Bureau of Labor Statistics, there are only 3.2 million people who are employed as RNs, with 1.8 million employed in hospitals.<sup>2</sup> In addition, except for a handful of states, there are sufficient numbers of registered nurses to meet the needs of the country's patients, according to a 2017 U.S. Department of Health and Human Services (HHS) report on the supply and demand of the nursing workforce from 2014 to 2030.<sup>3</sup> Moreover, HHS

projected that most states (43) would have surpluses in 2030.<sup>4</sup> **Again, there is no shortage of RNs. Rather, there is a shortage of good, permanent nursing jobs where RNs are fully valued for their work at the bedside through safe patient staffing levels, strong union protections, and safe and healthy workplaces.**

Importantly, registered nursing can be a pathway to good union jobs for people from Black, Indigenous, people of color (BIPOC) communities and underserved communities, but hiring and educational policies by the hospital industry have restricted the pipeline of nurses from socioeconomically diverse and underserved communities. **Although there is no general nursing shortage, the lack of racial, ethnic, cultural, linguistic, and socioeconomic diversity within the current nursing workforce reflects the need for increasing the numbers of and support for socioeconomically diverse registered nurses from BIPOC communities and other underserved communities.** Racial and socioeconomic diversity within the nursing workforce is crucial for both improving our nation's health and achieving health equity.<sup>5</sup>

### What is understaffing or short-staffing?

An intentional practice in which hospital management does not schedule an appropriate number of registered nurses, with the appropriate clinical experience, to safely care for patients in a hospital unit, driven by a desire to increase hospital profits. Employers do not maintain a robust pool of nurses from which they can increase staffing when patient loads increase, repeatedly cancel or "call-off" nurses who are scheduled to work, and are slow to fill permanent RN positions.

**HOSPITALS PROFIT:** To reduce labor costs and to increase profits, the hospital industry deliberately refuses to staff our nation's hospitals with enough nurses to care for patients safely and optimally, harming both nurses and patients in the process. Even before Covid-19, the hospital industry had driven nurses away from direct nursing care at the bedside by adopting policies that result in high patient caseloads and unsafe working conditions, such as intentional understaffing of units across the hospital. Further, hospitals consistently fail to protect nurses from health and safety hazards in the hospital including infectious diseases, workplace violence, and musculoskeletal injury. Because hospital employers fail to protect nurses on the job and fail to provide nurses with the staff and resources needed for them to give safe, therapeutic care, nurses face moral distress, preventable dangers, and job dissatisfaction, leading many nurses to leave the bedside — or to leave the nursing profession altogether — to protect themselves, their nursing licenses, their families, and their patients. All the while, the profit margins of hospitals continue to grow at the expense of nurse safety and patient care.

**PATIENTS SUFFER:** Unsafe staffing levels and poor working conditions make it impossible for nurses to meet their ethical and professional obligations as RNs to provide safe, effective, and therapeutic nursing care. Studies have shown that adequate staffing levels through RN-to-patient ratios result in better patient outcomes, and health and safety programs not only protect workers, but improve the health and safety of patients as well.

**NURSES LEAVE:** Hospital employers' utter disregard for the lives of nurses, their patients, and their families during the pandemic has resulted in both a physical and psychological toll on nurses. The failure by hospital employers to staff appropriately and provide the resources needed to provide safe, therapeutic patient care has caused nurses to experience severe moral distress and injury (often incorrectly labeled "burnout"); mental health issues such as stress, anxiety, depression, and post-traumatic stress disorder; and physical exhaustion. As a result, many nurses are leaving the bedside. If hospitals protected nurses with safe working conditions and safe staffing rather than pushing nurses to do more and more with less and less, we could keep more nurses at the bedside.



## What are mandatory minimum RN-to-Patient Ratios?

Believe it or not, there are no federal mandates regulating the number of patients a registered nurse can care for at one time in U.S. hospitals. As a result, RNs are consistently required to care for more patients than is safe, compromising patient care and negatively impacting patient outcomes. Mandatory minimum RN-to-patient ratios would require that hospitals adequately staff every unit. This will improve patient care and reduce nurse turnover.



**THERE'S A SOLUTION TO THIS CRISIS.** To end the nurse staffing crisis and to bring nurses back to the bedside, NNU calls on Congress and the Biden administration to adopt federal policies that value the vital work of direct patient care RNs and that ensure employers meet their legal obligations to provide safe and healthy workplaces.

First, the federal government should take measures to ensure the retention of nurses at the bedside by valuing the lives of nurses through quality, permanent jobs. This must include passage of the Nurse Staffing Standards for Hospital Patient Safety and Quality Care Act, which would establish mandatory, minimum RN-to-patient ratios. It must also include optimal workplace safety protections, fair wages, and robust union rights — including conditioning future pandemic relief funding for the hospital industry on implementing nurse retention measures.

Second, the federal government should take measures to recruit nurses from underserved communities by vigorously funding nursing education and job placement in a manner that realigns our health care system to meet the needs of patients rather than the aims of the hospital industry's bottom line, and that ensures the nursing workforce reflects the racial, ethnic, cultural, linguistic, and socioeconomic diversity of patients. The unprecedented crisis of the Covid-19 pandemic provides the opportunity to fight for the protections, pay, and dignity that nurses deserve.

## NNU PROPOSALS TO END THE INDUSTRY-CREATED NURSE STAFFING CRISIS

### SOLUTIONS: CONGRESSIONAL ACTIONS

#### Nurse Retention Measures

- » Pass the Nurse Staffing Standards for Hospital Patient Safety and Quality Care Act (S. 1567, H.R. 3165 in the 117<sup>th</sup> Congress)
- » Pass the Workplace Violence Prevention for Health Care and Social Service Workers Act (H.R. 1195 in the 117<sup>th</sup> Congress)
- » Pass the Protecting the Right to Organize (PRO) Act (S. 420, H.R. 842 in the 117<sup>th</sup> Congress)
- » Pass the VA Employee Fairness Act (S. 771, H.R. 1948 in the 117<sup>th</sup> Congress)
- » Increase funding for OSHA enforcement programs and OSHA hiring of health care sector inspectors
- » Pass legislation mandating paid sick, family, and precautionary leave for nurses and other workers

#### Pandemic Risk Mitigation Measures

- » Pass legislation requiring hospitals and government to maintain and report on personal protective equipment (PPE) and medical supply stockpiles
- » Pass legislation expanding Defense Production Act of 1950 (DPA) powers over PPE and medical supply chains during public health emergencies
- » Pass legislation prohibiting the reuse and extended use of single-use PPE

#### Pandemic Effects Mitigation Measures

- » Pass legislation to establish presumptive eligibility for workers' compensation and disability and death benefits for nurses
- » Pass legislation providing free crisis counseling and mental health services to nurses
- » Pass legislation on educational debt cancellation for nurses

### “They call us heroes and treat us like zeroes!”

Throughout the pandemic, there has been a jarring contradiction between the saccharine and excessive celebration of nurses as heroes for risking their and their families' lives and the utter disregard of nurse safety by the hospital industry. The disposability of nurses during the pandemic could be plainly observed as the hospital industry refused to provide necessary optimal personal protective equipment; sick or quarantine leave and pay; Covid-19 tests for employees; mandated excessive hours and unsafe shifts; demanded nurses work even if they had been exposed to Covid-19 or were recovering from it; and disciplined nurses who spoke out about unsafe conditions for workers and their patients.<sup>6</sup>

For hospital employers, the Covid-19 pandemic has become the ready excuse to waive their legal duties as employers to protect nurses and other workers who provide essential, life-sustaining labor, and who have a duty to provide optimal, therapeutic care to their patients. Registered nurses are a critical public health resource.

- » Pass legislation establishing social support programs for nurses (e.g., programs providing free childcare, alternate housing, meals, and transportation)
- » Pass legislation to provide nurses essential worker pay

#### **Measures to Strengthen and Support the RN Workforce Pipeline**

- » Create a long-term, dedicated funding stream for tuition-free nursing programs at public community colleges
- » Increase funding for the Nursing Workforce Diversity Program
- » Increase funding for the Nurse Corps Scholarship and Loan Repayment Programs

#### **SOLUTIONS: EXECUTIVE AND REGULATORY ACTIONS**

##### **Nurse Retention Measures**

- » The Centers for Medicare and Medicaid Services (CMS) should require that hospitals meet minimum safe RN-to-patient ratios as a condition of participation in Medicare
- » Issue a permanent OSHA standard on Covid-19 based on the Covid-19 Health Care Emergency Temporary Standard
- » Issue an OSHA standard on infectious disease
- » Issue an OSHA standard on workplace violence prevention in health care and social service settings
- » Issue an OSHA standard on safe patient handling
- » Issue an OSHA directive to improve enforcement activities in the health care sector
- » Hire and train more OSHA inspectors with health care sector expertise
- » Adopt CMS rules to penalize hospitals that cannot ensure labor peace
- » Support the PRO Act (S. 420, H.R. 842) and the VA Employee Fairness Act (S. 771, H.R. 1948 in the 117<sup>th</sup> Congress)
- » Issue an executive order or take regulatory action to provide all federal workers and federal contractors paid sick, family, and precautionary leave

##### **Pandemic Risk Mitigation Measures**

- » Require hospitals and government to maintain and report on PPE and medical supply stockpiles through CMS regulation
- » Fully invoke and exercise Defense Production Act of 1950 powers to coordinate the manufacture and distribution of PPE and medical supplies
- » Rescind all CDC and other federal agency crisis standards that allow the reuse and extended use of single-use PPE and that do not fully recognize aerosol transmission of Covid-19
- » Require hospitals to adopt Covid-19 infectious disease precautions, including:
  - › Patient isolation, screening, universal masking, and more
  - › Free vaccines and testing of workers and patients
  - › Contact tracing and communication about Covid-19 cases

##### **Pandemic Effects Mitigation Measures**

- » Establish presumptive eligibility for disability and death benefits for nurses and workers' compensation for federally employed nurses
- » Require hospitals to provide free crisis counseling and mental health services of the nurse's choosing
- » Take executive action on nurse educational debt cancellation
- » Provide essential worker pay for nurses who are federal employees or contractors

##### **Measures to Strengthen and Support the RN Workforce Pipeline**

- » Improve the Nursing Workforce Diversity Program
- » Improve the Nurse Corps Scholarship Program
- » Improve the Nurse Corps Loan Repayment Program

## PART I. HOSPITAL INDUSTRY PRACTICES DRIVE NURSES AWAY FROM THE BEDSIDE

In recent decades, the hospital industry has deliberately deprioritized patient care and nursing health and safety in order to maximize profits. As a result, nurses and their patients are facing a crisis of unsafe staffing and unsafe working conditions that has resulted in nurses fleeing the unbearable working conditions in acute-care hospitals. Nurses are pursuing nursing work in other settings, leaving the profession for other types of work, or retiring. As discussed below, the hospital industry's devaluation of RNs began long before the Covid-19 pandemic through inadequate health and safety protections; understaffing; deskilling; and the substitution of unpaid family care,<sup>7</sup> unlicensed, or lower-licensed care to reduce labor costs.

### THE HOSPITAL INDUSTRY INTENTIONALLY ADOPTS POLICIES OF UNDERSTAFFING

The unsafe staffing crisis is part and parcel of the hospital industry's attempt to squeeze profits out of nurses and their patients. With an eye on reducing costs and increasing profits, the hospital industry purposely adopted models from the manufacturing industry — like bare-bones staffing that makes nurses unable to safely care for patients and “just-in-time” supplies that arrive precisely when needed — to limit spending on human and other resources. Hospital employers spent much of the mid- to late-1990s reducing their RN workforce through layoffs and attrition in attempts to reengineer and restructure health care services to emulate industrial models of productivity improvement.<sup>8</sup> Hospitals regularly understaff units with fewer numbers of nurses than are actually required to safely and optimally care for the numbers of admitted patients and their severity of illness.<sup>9</sup> Rather than scheduling sufficient numbers of nurses to ensure that each RN has a manageable patient load to safely provide all needed care and maintaining a robust pool of nurses from

which to draw when patient loads increase unexpectedly, hospitals routinely opt for bare-bones staffing. Hospitals often cancel or “call off” nurses who are scheduled to work and are slow to fill permanent RN positions. Even during Covid-19 surges, hospitals have canceled contracts with travel or agency nurses and laid off nurses,<sup>10</sup> instead requiring the remaining nursing staff to work mandatory overtime or to assign more patients than can be cared for safely and therapeutically. For example, two HCA Healthcare hospitals in California sought staffing waivers to allow them to assign more patients to an RN than California law allows after one of the hospitals had summarily cut short traveler contracts and failed to book per diem staff who were available to work. Fortunately for nurses and patients alike, the state denied HCA's staffing waiver request and revoked another that was in place after hearing the experiences of NNU members working in HCA facilities.

### The dangerous application of “just-in-time” models to health care.

“Just-in-time” supply chain management is a business model that attempts to have supplies arrive precisely when needed by (1) eliminating labor and other operating costs associated with putting things away in storage closets and warehouses and pulling them as needed, (2) freeing up the space used by the storage closet for other purposes, and (3) eliminating the need for warehouses which reduces real estate purchase or lease costs. Hospitals inappropriately apply this manufacturing industry model to health care, placing nurses and patients in danger.

## HOSPITAL EMPLOYERS PUT NURSES IN DANGER OF INJURY AND ILLNESS ON THE JOB

Hospitals regularly fail to take preventive measures known to protect nurses from occupational hazards such as workplace violence,<sup>11</sup> back and other musculoskeletal injuries,<sup>12</sup> and infectious diseases, including Covid-19.<sup>13</sup> Working conditions have dramatically deteriorated during the pandemic as hospitals continue to fail to take protective measures that the science of industrial hygiene has long known can prevent workplace exposure to airborne viruses, such as SARS-CoV-2, the virus that causes Covid-19.<sup>14</sup>

Nurses face high rates of workplace violence and back injuries. According to the U.S. Bureau of Labor Statistics (BLS), in 2020, registered nurses in private industry in the United States experienced a rate of 18.2 nonfatal violence-related injuries per 10,000 full-time employees.<sup>15</sup> The violence-related injury rate for registered nurses is more than four and a half times higher than the violence-related injuries for workers overall in the same year.<sup>16</sup> Compared to pre-pandemic violence-related injury rates, the rate of workplace violence injuries for RNs in private industry has increased by 30 percent.<sup>17</sup> With respect to back injuries, RNs in the United States experienced a rate of 53.0 nonfatal musculoskeletal disorders and a rate of 30.1 nonfatal back injuries per 10,000 full-time employees in 2020. RN musculoskeletal disorder rates are nearly twice as high than the rate for workers overall, and RN back injuries are more than twice as high as the rate for workers overall.<sup>18</sup>

Further, when hospital employers intentionally adopt policies of understaffing, this places RNs at higher risk of occupational injuries and illnesses. When hospital employers treat nurses as expendable by failing to staff appropriately and providing key health and safety protections, this comes at a cost: Nurses are forced to leave the bedside workforce after experiencing preventable injuries or illnesses on the job. Several studies show that poor RN staffing levels led to higher rates of nurse occupational injury.

- » An increased patient load per nurse was associated with significantly higher likelihood for neck, shoulder, and back musculoskeletal disorders.<sup>19</sup>
- » The risk for workplace violence injuries was twice as high for lower-staffed hospitals as compared to higher-staffed hospitals.<sup>20</sup>
- » Nurses from units with low staffing and poor organizational climates were twice as likely as nurses on well-staffed and better organized units to report risk factors for needlestick injuries and near misses.<sup>21</sup>

Finally, during the ongoing Covid-19 pandemic, RNs are more likely to be exposed to and infected with Covid-19 when they work under unsafe conditions without adequate personal protective equipment, isolation precautions, testing, contact tracing, and the full range of precautions, further sidelining them from caring for patients.

## THE HOSPITAL INDUSTRY DEVALUES RNS' PROFESSIONAL PRACTICE AND RESTRICTS THEIR AUTONOMY

The hospital industry devalues RNs' professional practice and restricts their autonomy in myriad ways. Most notably, the industry focus on patient satisfaction scores and the routinization that breaks holistic nursing care into discrete tasks have been particularly troublesome for nurses. Both trends are driven by the industry goal of maximizing net revenue and restricts the autonomy nurses have to use their knowledge and experience to care for their patients.

In its preoccupation with patient satisfaction scores, the hospital industry typically focuses on managing patients' perception of their clinical care rather than on improving their clinical care, which ultimately degrades RNs' professional practice.<sup>22</sup> The Centers for Medicare and Medicaid Services (CMS) began requiring hospitals to report their patient satisfaction scores using the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey as mandated by the Deficit Reduction Act of 2005, though hospitals began surveying patients for marketing purposes prior to the CMS requirement. Reporting survey data was required to receive full Medicare reimbursement but was not affected by how the hospital scored on the surveys. In October 2012, CMS began calculating hospital incentive payments based in part on how the hospital scores on HCAHPS patient satisfaction surveys, as required by the Patient Protection and Affordable Care Act of 2010.

To improve patient satisfaction scores, and thus maximize CMS incentive payments, many hospitals have adopted rigid customer service practices such as scripting of nurse-patient interactions. Unfortunately, scripting comes at the expense of RN autonomy, their professional practice, and, in some cases, appropriate clinical treatment.<sup>23</sup> As the name suggests, scripting requires nurses to use specific language when talking to patients.<sup>24</sup> For example, the AIDET model for patient interactions, developed by

management consultant the Studer Group, is used widely in the hospital industry. AIDET stands for "Acknowledge, Introduce, Duration, Explanation, Thank you."<sup>25</sup> Looking at some of the ways AIDET is implemented reveals both how rigidly controlled RN-patient interactions can be and how they are designed to manage patients' perceptions of their care. As part of the "Acknowledge" step, staff may be directed to "[f]ollow the 10 and 5 Rule: at 10 feet, look up and acknowledge, make eye contact, and smile; at five feet, verbally greet and offer assistance if necessary."<sup>26</sup> According to one description of the AIDET model: "Staff members trained in AIDET are encouraged to use the words 'excellent' and 'thank you' liberally."<sup>27</sup> For example, some scripts require nurses to ask: "Is there anything I can do to make your stay more excellent?" to prompt patients to rate the hospital as excellent on surveys.<sup>28</sup> As part of the Duration step, staff are encouraged to "[u]nder-promise and over-deliver" and told: "There are two types of time: real and perceived. Understand both."<sup>29</sup>

Nurses are stilted and inauthentic while using a script to interact with their patients. Scripting of nurse-patient interactions also leads to substantial dissatisfaction among nurses who are disrespected and devalued when their employer focuses on financial returns rather than sufficient staffing and resources. It also undermines the nurse-patient relationship, which is essential to optimizing health care outcomes, when patients are treated as "customers," rather than patients. These excerpts from RN letters responding to an article about patient satisfaction metrics capture this sentiment:

Instead of institutions spending money to hire consultants to teach nurses customer service, strategies need to be developed by the nursing leadership to get nurses back to the bedside and alleviate patient concerns that nurses aren't spending enough time with them. Nurses can best recognize and address these concerns when given the chance to develop meaningful relationships with their patients.<sup>30</sup>

Organizations need to focus more on providing the resources, staffing, and education necessary to enhance patient outcomes. By ensuring that quality care is delivered, patient satisfaction initiatives will be successful.<sup>31</sup>

Additionally, most hospitals require RNs to follow instructions from algorithms embedded in electronic health records, often leaving nurses with little discretion to exercise their professional judgment even when it is in the best interest of their patient.<sup>32</sup> Rather than providing patient care, they spend much of their time entering information into these systems and then adjusting for the systems' failures to account for the complexity of the hospital environment.<sup>33</sup> The hospital industry's routinization of RN work, coupled with legislative and regulatory moves to weaken RN's scope of practice, enables employers to break apart nursing care, which is an inherently holistic practice, into discrete tasks that can be parceled out to unlicensed and lower-licensed staff, thus reducing labor costs. These hospital industry practices were taken directly from the manufacturing industry's practices of assembly lines and the deskilling of work. Whatever the merits or demerits of these practices in the manufacturing sector, they are unsuited to hospitals and the art and science of healing.

The routinization of RN work fragments patient care and endangers patients.<sup>34</sup> These hospital policies first decouple RNs' knowledge and clinical expertise from the holistic practice of directly assessing patient needs, implementing needed care, and regularly evaluating the patient's condition. Then, these practices allocate tasks to staff without sufficient education and clinical experience. Under these "team-based care" models, RNs spend less time at the bedside where they can get to know a particular patient's needs and use their professional judgment to ensure that the patient's needs are met. Instead, they spend more time on paperwork and monitoring the work of other staff, leaving RNs demoralized and alienated.<sup>35</sup>

### **THE HOSPITAL INDUSTRY'S RESISTANCE TO HIRING RNS WITH ASSOCIATE DEGREES IN NURSING EXACERBATES THE STAFFING CRISIS AND UNDERMINES RN WORKFORCE RACIAL AND ETHNIC DIVERSITY**

Hospitals have increasingly adopted the arbitrary hiring practice of excluding nurses with associate degrees in nursing (ADNs) from consideration for open nursing positions, dramatically reducing the pool of potential nurses available to provide patient care. Hospitals more frequently require that RNs have a bachelor's degree of nursing and fail to hire RNs with ADNs regardless of how many years of experience they have providing bedside nursing care as an RN. Additionally, requiring RNs to have bachelor of science in nursing (BSN) degrees doubles the amount of education time required — from two years to four years — for a nurse to be licensed.<sup>36</sup>

A review of the RN education and examination requirements demonstrates that fulfilling licensure prerequisites should serve as the entry point to bedside nursing practice. RN licensure does not depend on whether a nurse has an ADN or BSN. Becoming an RN is a two-fold process: graduating from a nursing program approved by a state board of nursing and passing the National Council Licensure Examination (NCLEX). All RNs must fulfill both classroom science-based education requirements and hands-on clinical experience requirements. Both ADN and BSN programs have similar core curricula for in-class education, with differences between the two largely oriented around RN career paths such as teaching, research, health policy, and management in BSN programs and a greater focus on bedside patient care in ADN programs. Turning to clinical experience, ADN and BSN nursing programs also require a similar number of clinical hours.<sup>37</sup> Additionally, state boards of nursing that specified a minimum number of clinical hours for ADN and BSN degrees nearly always specified an identical

number of hours for both programs.<sup>38</sup> After meeting educational prerequisites to becoming an RN, the final licensure requirement for all U.S. nurses is to pass the NCLEX exam which "has been designed as a legally defensible, psychometrically sound examination to measure student readiness for entry-to-practice."<sup>39</sup> Of note, first-time passage rates of the NCLEX exam, a widely accepted outcome measure for nursing education, are similar for graduates of both ADN and BSN programs.<sup>40</sup>

Not only does requiring a BSN for employment as a bedside RN slow the RN education pipeline, the additional financial and time requirements for nursing students to obtain a BSN over an ADN also undermines racial, ethnic, and other socioeconomic diversity in the nursing workforce. Among the RN workforce, only non-Hispanic white, Native Hawaiian, and other Pacific Islander RNs meet or exceed their representation in the general U.S. population.

Latinx and Black nurses are most underrepresented, with the gap between the percentage working as RNs compared to their percentage of the population at approximately 8.1 percent for Latinx RNs and 4.7 percent for Black RNs.<sup>41</sup> Additionally, a review of the RN graduates from 2015 to 2019 shows that more American Indian/Alaskan Native, Black, and Latinx RNs graduated with an ADN than a BSN, averaging respectively 1.64, 1.58, and 1.45 ADN graduates for every BSN graduate compared to white and Asian RNs respectively averaging 1.11 and 0.80 ADN graduates for every BSN graduate. Finally, requiring a BSN compared to an ADN for employment undermines nursing as an avenue of upward economic mobility for the working class, particularly women of color, as well as those with child or elder care responsibilities who may find it more difficult to meet the time or financial commitment required for a BSN.



## PART II. HOSPITAL INDUSTRY PRACTICES DURING THE COVID-19 PANDEMIC CAUSED NURSES DETRIMENTAL MENTAL HEALTH EFFECTS, PROFOUND MORAL DISTRESS, AND MORAL INJURY

Nurses' working conditions have deteriorated further since the pandemic began. With the onset of the pandemic, the hospital industry compounded the issues discussed above by its flagrant refusal to protect nurses from exposure and infection from Covid-19, treating RNs as disposable. Nurses caring for Covid patients experience both high rates of infections and deaths and high rates of acute stress, anxiety, depression, and post-traumatic stress as well as moral distress and moral injury, causing them to leave the bedside at high rates.

### THE FAILURE OF THE HOSPITAL INDUSTRY TO PREPARE FOR COVID-19 SURGES CAUSED HIGH RATES OF INFECTION, ILLNESS, AND DEATH IN NURSES

#### The Hospital Industry Failed to Prepare for Covid-19 Patient Surges

NNU sent its first letter to hospital management at all hospitals where the union represents nurses in January 2020, requesting information on their pandemic response plans and urging them to plan for predictable staffing needs, including hiring and training more nurses to work in critical care departments. We have continued to urge them to do so throughout the pandemic in words and deeds — including numerous worksite actions. NNU publicly sounded the alarm on hospitals' lack of preparation in late February 2020, identifying concerns with "optimal staffing, equipment, and supplies" as well as a widespread lack of planning for isolating patients with confirmed or suspected Covid-19 infections.<sup>42</sup> In March 2020, NNU filed more than 125 complaints with Occupational Safety and Health Administration (OSHA) in 16 states, charging hospitals with failing to provide safe workplaces as required by law. Once again, NNU focused on hospitals'

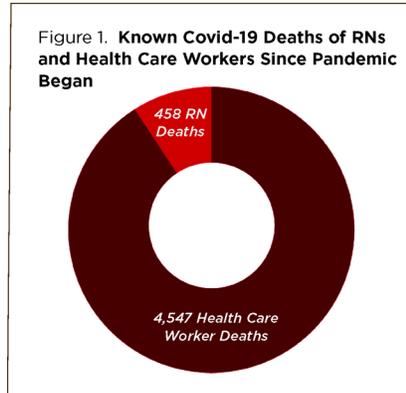
failure to provide lifesaving PPE, but also addressed other health and safety issues such as failure to isolate patients who had, or may have had, a Covid-19 infection.<sup>43</sup>

The hospital industry's "just-in-time" model that tightly manages inventory has been disastrous during the Covid-19 pandemic.<sup>44</sup> Although infectious disease surges are unpredictable, they are inevitable. Hospitals should have been better prepared, especially in the instance of Covid-19 because the initial outbreak in China in late 2019 should have rung alarm bells in U.S. hospitals and with federal and state governments. Yet because employers prioritized profits over preparedness, RNs were forced to choose between staying on the job and caring for their patients, who are also at risk of infection from nurses' lack of PPE,<sup>45</sup> or staying home to protect themselves and their families. For months into the pandemic,

### What is moral distress and moral injury?

**Moral distress** arises when one knows the right thing to do, but institutional constraints and broader sociopolitical contexts make it nearly impossible to pursue the right course of action.<sup>46</sup>

**Moral injury** is the deleterious long-term, emotional, psychological, behavioral, spiritual, and/or social effects that may result from potentially morally injurious events, such as perpetrating or failing to prevent acts that transgress deeply held moral beliefs and expectations in a high-stakes environment.



very few nurses, even those working directly with confirmed Covid-19 patients, had access to appropriate PPE on an as-needed basis. Instead, nurses were forced to go without or to wear PPE manufactured for a single use for days on end. Some nurses were forced to use garbage bags when their employer ran out of surgical gowns.<sup>47</sup> Those who did have access to PPE in the pandemic's early stages generally had to fight for it. Although PPE was a key issue for nurses, it was far from the only issue. Employers also failed to screen and test patients for Covid-19,<sup>48</sup> to notify nurses of a Covid-19 exposure,<sup>49</sup> and to provide testing and sick leave while awaiting test results. This is not an exhaustive list of their failings.

#### **The Hospital Industry's Failure to Prepare for Patient Surges Resulted in High Covid-19 RN Infection and Death Rates**

Although this is certainly an undercount, as of Nov. 3, 2021, at least 1,037,183 health care workers in the United States have been infected with SARS-CoV-2, the virus that causes Covid-19, including thousands of nurses, and at least 4,547 health care workers have died from Covid-19 and related complications, including 458 RNs.<sup>50</sup>

There have been racial disparities in the impacts of Covid-19 on the RN workforce.

Among RNs who have died from Covid-19 and whose race and ethnicity are known, 50.1 percent are white, 22.0 percent are Filipinx, 17.6 percent are Black, 7.6 percent are Latinx, 2.1 percent are other Asian (non-Filipinx), and 0.7 percent are Native American.<sup>51</sup> In sum, nurses of color comprise 49.9 percent of the nurse deaths<sup>52</sup> but only 24.1 percent of the RN workforce.<sup>53</sup> In addition, only 4.0 percent of the RN workforce are Filipinx<sup>54</sup> and only 12.4 percent are Black, thus these nurses are dying at far greater rates than their white colleagues.<sup>55</sup> In a report focusing on U.S. Filipinx health care workers, STAT news explains the increased risk of Filipinx health care workers compared to other health care workers as due to a higher likelihood of working in hospital settings treating Covid-19 patients rather than in other health care settings.<sup>56</sup>

Similarly, sociologist Adia Wingfield contends that Black nurses may be at higher risk based on their desire to give back to their communities and others in need as they are more likely to work in underfunded health care facilities serving communities where Covid-19 is ravaging Black, Latinx, low-income, and/or uninsured patients and lacking sufficient equipment and staff.<sup>57</sup> A study of frontline health care workers in the United States and the United Kingdom confirms the significant racial and ethnic disparities among RNs who die from Covid-19. This study found that Black, Asian, Latinx, and other health care workers of color contracted Covid-19 at nearly twice the rate of non-Hispanic, white health care workers.<sup>58</sup> It also found that non-white health care workers reported having to reuse PPE or having inadequate access to PPE at 1.5 times the rate of non-Hispanic white health care workers, even after adjusting for exposure to patients with Covid-19.<sup>59</sup> Additionally, the Office of the Inspector General for the U.S. Department of Health and Human Services, reporting on the hospital industry's response to the pandemic, confirmed that "widespread shortages of PPE put staff and patients at risk[.]"<sup>60</sup> Thus many, perhaps most, RN infections and deaths could have been prevented but for the utter failure of their employers to provide them appropriate personal protective equipment.

### THE HOSPITAL INDUSTRY'S ACTIVE TRANSGRESSIONS AGAINST RNS COMPOUNDED ITS FAILURE TO PREPARE FOR THE PANDEMIC, ADDING INSULT TO INJURY

The hospital industry's widespread disregard for nurses' well-being throughout the course of the pandemic is undeniable. Moreover, the industry's misdeeds extend beyond mere negligence; it actively opposed measures that would protect nurses from exposure to Covid-19 or compensate them if they contract the virus.

The most egregious active transgression against RNs by the hospital industry is the failure to follow the precautionary principle and provide nurses with optimal respiratory protection. Rather than admitting the failure to prepare for the pandemic or advocating for government assistance to supply optimal levels of respiratory protection, the hospital industry shored up arguments for denying nurses respirators, claiming that respiratory protection was unnecessary except for specific surgical and aerosolizing procedures (e.g., intubation) and, at the beginning of the pandemic, denying outright that the virus was airborne, then shifting to downplaying the evidence for airborne transmission or claiming that the evidence was inconclusive as recently as March 11, 2021.<sup>61</sup> Yet since the pandemic began, numerous studies have demonstrated that the virus is airborne,<sup>62</sup> thus making respirators critical to preventing

infections among health care workers.<sup>63</sup> Regardless, given any uncertainty about Covid-19's mode of transmission, employers should have adhered to the precautionary principle, which holds that we ought not wait until we know for certain that something is harmful before action is taken to protect people's health.<sup>64</sup> The hospital industry's active opposition to providing nurses with respiratory protection exemplifies a failure to recognize nurses' innate value as human beings.

Hospital employers actively opposed nurses who pled with them and the government for PPE on the front lines of the pandemic. When RNs attempted to secure needed PPE by asking for donations on social media, speaking with the press, and holding public protests to expose their employers' failures, employers responded with disparagement and abuse. Some employers prohibited workers from speaking out<sup>65</sup> and fired workers for doing so.<sup>66</sup> Other employers went so far as to prohibit RNs from bringing in their own respirators<sup>67</sup> and even "yank[ed] masks off workers' faces[.]"<sup>68</sup> In cases where employers capitulated to nurses' collective demand for respirators, some continued to deny that respirators were necessary to protect nurses from Covid-19, asserting that they were providing respirators to make RNs feel more comfortable, not to prevent exposure to the virus. And even then, many employers forced nurses to reuse respirators with multiple patients, and often on multiple shifts, even though this practice is known to be unsafe and to contribute to the spread of infectious diseases.

In the legislative arena, the American Hospital Association (AHA), representing hospitals that employ a majority of RNs, vigorously opposed the inclusion of a requirement for OSHA to issue an emergency temporary infectious disease standard requiring respiratory protection in H.R. 6201, the Families First Coronavirus Response Act, and in H.R. 6800, the Health and Economic Recovery Omnibus Emergency Solutions Act.<sup>69</sup> Contrary to scientific consensus, the AHA denied the need for respirators as recently as March 11, 2021 in Congressional testimony:

Given any uncertainty about Covid-19's mode of transmission, employers should have adhered to the precautionary principle, which holds that we ought not wait until we know for certain that something is harmful before action is taken to protect people's health.

The CDC continues to hold that COVID-19 is primarily spread through close contact, not airborne transmission, except when doing certain aerosolizing procedures. ... For health care workers, CDC continues to recommend as appropriate the use of facemasks unless workers are performing aerosolizing procedures or procedures that require very close contact with patients with suspected or confirmed COVID-19 infection.<sup>70</sup>

As stated, the AHA relied on weak CDC guidance in its March 11 testimony — guidance that state hospital associations lobbied for. At the onset of the pandemic, the CDC called for precautions against airborne transmission of SARS-CoV-2. However, concurrently with the urging of California and Washington state hospital associations,<sup>71</sup> the CDC began downgrading its guidance from airborne to droplet precautions and removed the requirement to provide respirators to health care workers except for during aerosol-generating procedures. Finally, in May 2021, the CDC unambiguously acknowledged that Covid-19 is an airborne infectious disease and updated guidance on respirator use stating: “The supply and availability of NIOSH-approved respirators have increased significantly over the last several months. Health care facilities should not be using crisis capacity strategies at this time and should promptly resume conventional practices[.]”<sup>72</sup>

RNs advocated for more than a year and a half for OSHA to issue the Covid-19 Health Care Emergency Temporary Standard (Covid-19 Health Care ETS). OSHA issued the Covid-19 Health Care ETS in June 2021 despite opposition from the hospital industry.<sup>73</sup> This exceedingly important step by the federal government provided mechanisms for nurses to challenge their employers’ continued refusal to recognize the science of Covid-19 and the need for the full range of precautions against aerosol transmission of the virus, including optimal respiratory protections. Since the issuance of the ETS, nurses have campaigned to ensure the hospital industry fully complies with ETS requirements, filing numerous OSHA complaints over failures to provide appropriate respiratory protection

and other compliance issues. However, Arizona, Utah, and South Carolina failed to implement Covid-19 standards that are at least as effective as the federal Covid-19 Health Care ETS as they are required to do as state-run OSHA plans. NNU filed an official “Complaint About State Program Administration” against Arizona with federal OSHA, which is now considering taking over enforcement for these three noncompliant states.

NNU continues to vigorously advocate for nurses and their patients to protect them from the ramifications of the hospital industry’s lack of preparedness for Covid-19 and their active resistance to implementing appropriate health and safety protections. Even with the OSHA ETS on Covid-19 for health care settings, many nurses continue to lack appropriate respiratory protection, according to NNU’s latest survey covering June and July 2021.<sup>74</sup> More than 5,000 RNs from all 50 states, D.C., and Puerto Rico responded. Approximately 60 percent of RNs working in hospitals reported wearing a respirator each time they interacted with a Covid-positive patient, down from nearly 75 percent in our March 2021 survey. In addition, 62 percent reported using surgical masks, which are inadequate to protect health care workers caring for Covid-19 patients, when caring for patients suspected of having Covid-19, or patients awaiting test results.

Lastly, hospital employers opposed RNs’ workers’ compensation claims, taking calculated steps to insist that the thousands of nurses infected because of employers’ reprehensible behavior did not contract the virus on the job. Through their own refusal to test nurses, other health care workers, and patients for Covid-19, employers manufactured a situation where nurses would almost certainly lack the direct evidence of workplace exposure needed to prove a workers’ compensation claim. As nurses became sick, hospital employers went so far as to issue blanket statements that most nurses were infected in the community despite the much higher infection rates among nurses and the fact that many nurses remained isolated from family, friends, and the community at large out of fear they might spread Covid-19.<sup>75</sup>

## UNSAFE WORKING CONDITIONS DURING THE PANDEMIC SEVERELY IMPACTED RN MENTAL HEALTH

Hospital employers' lack of planning and reprehensible behavior have also dramatically and detrimentally affected RN mental health. The intense internal conflict and dissonance nurses have been experiencing during the Covid-19 pandemic is driven by the tension between taking care of themselves or their families, on the one hand, and caring for their patients, on the other.<sup>76</sup> For some, the tension between sheltering in place with their families and their calling to care for their patients has led to traumatic stress, anxiety, and depression.<sup>77</sup> The lack of proper PPE, discussed above, played a fundamental role in this tension. Nurses fear contracting the virus themselves, particularly if their age or a medical condition make them more vulnerable to serious illness or death. In addition, motivated by love and concern, some worry about the effect that contracting Covid-19 would have on their children, spouses, and elderly family members who depend on them, especially if they succumbed to the illness.<sup>78</sup>

For many RNs, their greatest fear is carrying the disease home and infecting their families — especially if any of their family members is in a high-risk group for serious illness or death.<sup>79</sup> Nurses and other health care workers spoke out early in the pandemic about their fears for their families. For example, the *Washington Post* quoted a nurse from New York describing her experience and that of her coworkers:

“There is a tremendous amount of fear and guilt that we could bring this home and hurt people that we love,” said Jane Gerencser, a nurse who has been working 12-hour shifts tending to coronavirus patients at a Westchester Medical Center Health Network hospital in New York state. “We have had colleagues who lived with elderly parents, who unfortunately have gotten sick and have had their parents get sick and passed.”<sup>80</sup>

News reports and journal articles describe the extreme measures that health care workers

who, knowing that they were at high risk of Covid-19 infection, took to protect their families from being exposed. The *Washington Post* article cited above details “meticulous cleansing rituals” health care workers practice to protect family members from infection from virus on their persons or clothing.<sup>81</sup> An article from the *Journal of Medical Ethics* describes the “highly burdensome measures” one nurse took to protect her family: “stripping naked” and depositing her clothes in the washer, wiping down all the surfaces she’s touched with disinfectant, showering, disinfecting more surfaces — all before greeting her family.<sup>82</sup> Even after taking these precautions, she maintained her distance by staying “6 feet away from everyone [she] love[s.]”<sup>83</sup> Some nurses avoided their families completely by using separate bathrooms; sleeping in spare rooms, attics, tents, or their cars; and eating their meals alone. Those who could afford it opted for hotel rooms or rented RVs.<sup>84</sup>

Regardless of whether they sleep at home, many nurses have been separated from their families for extended periods of time.<sup>85</sup> Talisa Hardin, a nurse working on a unit for persons under investigation for Covid-19, testified about her experience before the Select Subcommittee on the Coronavirus Crisis of the House Oversight Committee:

For me, the lack of protections in my unit have forced me to send my daughter away to live with my mother during the course of the pandemic. I don’t want to pass this virus on to my daughter or my mother. ... It has been more than five weeks since I last saw my daughter in person, and I don’t know when I’ll see her again. It has been deeply devastating for both of us to take these precautions. My daughter is so frustrated by the situation that she consistently asks me to come home and has recently asked me to quit my job. She follows the news, and she knows that I am at a heightened risk of contracting COVID-19 because my hospital is not giving me the protections I need. She is worried, she is scared, and she is experiencing separation anxiety.<sup>86</sup>

Many nurses sent their children away voluntarily to protect them.<sup>87</sup> Others were forced to give up custody of their children, at least temporarily, when noncustodial parents took them to court, fearing their children might become infected with Covid-19.<sup>88</sup>

Similarly, family members frequently experienced their own psychological distress and trauma related to the risks a nurse faces on the job, which in turn may exacerbate nurses' moral distress.<sup>89</sup> In a *New York Times* article titled "What Happens If You and Daddy Die," discussing the effects nurse exposure to the virus has on family members, the author notes that "[C]hildren of doctors and nurses have kept anguished journals, written parents goodbye letters and created detailed plans in case they never see their moms or dads again[.]"<sup>90</sup> Family members — especially children — may ask health care workers to leave their jobs.<sup>91</sup>

In some cases, nurses cannot meet the responsibilities to their families and also care for their patients. When nurses isolate to protect their families or work for weeks without a day off, others must assume the responsibilities they set aside, for example, assisting with childcare, homeschooling, meal preparation, and other household chores. This creates a hardship for both the nurses and their families at a time when the negative psychological impacts of the pandemic increased — particularly among health care workers but also in the general population.<sup>92</sup> More importantly, at a time when family members needed to draw comfort from one another due to the stress and anxiety of the pandemic, extended sheltering in place, and physical distancing, nurses' separation from their families deprived them of this comfort. Additionally, family members have the added worry about their loved ones working on the pandemic's front lines. Thus, entire families have made tremendous sacrifices, even if they have not lost a loved one to Covid-19.

Although conditions have improved for many nurses since the first year of the pandemic, patient surges continue to wax and wane across the country. The pandemic's widespread adverse mental health effects among nurses continue and may persist for years.

Common, interrelated themes in the mental health research among U.S. health care workers include fear of contracting Covid-19, fear of infecting family members, tension between caring for themselves and families versus going to work and taking care of patients, long hours and heavy workloads, lack of knowledge about the virus, and lack of treatment options.<sup>93</sup> A *JAMA Viewpoint* piece published in early April 2020 reported health care worker concerns based on semi-structured "listening sessions" with U.S. nurses, doctors, and other clinicians.<sup>94</sup> Their chief anxieties included access to appropriate PPE, exposure to Covid-19, infecting family members, and clinical knowledge in treating a novel virus along with several related concerns about meeting family responsibilities while working long hours treating patients. A study based on 657 completed surveys of health care workers treating Covid-19 patients in a New York City hospital at the height of its April 2020 surge, April 9 to April 24, quantifies the level of distress they experienced. (Table 1) RNs showed high levels of acute stress (64 percent), depression (53 percent), and anxiety (40 percent). In contrast, attending physicians had lower rates than RNs across the board: acute stress (40 percent), depression (38 percent), and anxiety (15 percent). In sum, RNs experienced much higher levels of distress than attending physicians in all three areas by significant margins: 24 percent, 15 percent, and 25 percent, respectively.

Table 1. **Top Sources of Distress Among All New York City Hospital Survey Respondents, April 2020**

| Top sources of distress                  | Percentage of respondents |
|--|---------------------------|
| Infesting family members with Covid-19   | 74%                       |
| Lack of control in the clinical setting  | 70%                       |
| Lack of PPE and lack of Covid-19 testing | 68%                       |
| Loneliness                               | 65%                       |

Finally, a study based on a small May 2021 survey of RNs and licensed practical nurses who cared for Covid-19 patients, based largely in the upper Midwest, found that 58.7 percent showed a risk of PTSD based on their score on the Trauma Screening Questionnaire.<sup>95</sup> This study did not link these scores to specific work- or home-related experiences.

NNU has been conducting surveys of RNs throughout the pandemic.<sup>96</sup> A survey of nurses during the period Oct. 16 to Nov. 9, 2020 with responses from across the United States (and some responses from U.S. territories) found that 70 percent of hospital RNs feared getting Covid-19 and 80 percent feared that they would infect a family member. (Table 2) Large majorities also reported experiencing higher levels of insomnia, anxiety, stress, and depression than they did before the pandemic.<sup>97</sup> The most recent survey of nurses covers the period June 1 to July 21, 2021 with responses from all 50 states, Washington, D.C., and Puerto Rico. (Table 3) Although their experiences show some improvement, the pandemic clearly continues to negatively affect the mental health of hospital RNs with 42 percent fearing they will contract Covid-19, 50 percent fearing they will infect a family member, and 34 feeling traumatized by their experiences caring for patients. In comparing their current mental state to prior to the pandemic, 35 percent are having more difficulty sleeping, 54 percent feel stressed more often, and 42 percent feel sad or depressed more often.

News reports, particularly during the earlier surges, demonstrate that U.S. health care workers are also experiencing stigmatization which may contribute to adverse mental health issues. The CDC identifies Asian Americans, Pacific Islanders, and Black Americans among those who may be subject to stigmatization and discrimination in the current pandemic.<sup>98</sup> Anti-Asian racism adds another layer of trauma, anxiety, and depression on nurses of Asian and Pacific Islander descent who are overrepresented in the U.S. health care workforce,<sup>99</sup> particularly Filipinx and Filipinx-American nurses.<sup>100</sup> Similarly for Black health care workers, the anti-Black racism and white supremacy espoused by President Trump, and rampant

**Table 2. Large Percentages of RNs Fear Contracting and Passing Covid-19**

| Hospital RN responses                    | Percentage of respondents |
|--|---------------------------|
| Feared contracting Covid-19              | 70%                       |
| Feared they would infect a family member | 80%                       |

**Table 3. Indicators of Distressed Mental Health Condition Among Hospital RNs**

| Hospital RN responses   | Percentage of respondents |
|---|---------------------------|
| Feared contracting Covid-19   | 42%                       |
| Feared they would infect a family member                            | 50%                       |
| Felt traumatized by experiences caring for patients                 | 34%                       |
| Had more difficulty sleeping, compared to prior to the pandemic     | 35%                       |
| Felt stressed more often, compared to prior to the pandemic         | 54%                       |
| Felt sad or depressed more often, compared to prior to the pandemic | 42%                       |

in communities around the country currently, compounds the already substantial detrimental mental health impact of providing patient care during the pandemic. Moreover, this comes on top of higher baseline levels of stress and emotional exhaustion Black health care workers may experience from defending their patients against racist attitudes and treatment from other health care workers.<sup>101</sup> Taken together, the cumulative effects are causing some Black health care workers to experience debilitating depression and trauma.<sup>102</sup>

### CRISIS STANDARDS OF PATIENT CARE, RATIONING, AND UNNECESSARY DEATH CAUSED RNS EXTREME MORAL DISTRESS, INJURING THEM FURTHER

Widespread rationing and crisis standards of care have been in use across the country during patient surges. The negative impact this has on patient care was recently confirmed by a study in *Annals of Internal Medicine* covering the months of March to August 2020. The study found that 23.2 percent of Covid deaths during that time period were likely due to patient surges that stretched resources too thin, despite greater understanding of the Covid-19 disease process and improvements in treatment that should have decreased mortality rates.<sup>103</sup> An increase in the number of patients assigned per nurse was a major factor in the study's calculations of excess mortality.

RNs have experienced extreme moral distress from witnessing the unnecessary death caused by the lack of preparation for surges in Covid-19 cases by the hospital industry, the premature easing of mitigation measures such as masking and social distancing, and the elimination of shelter-in-place orders. Ethics professor Andrew Jameton introduced the concept of *moral distress* in 1984, stating: "*Moral distress* arises when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action."<sup>104</sup> He elaborated on this concept by breaking it down into three components: "(a) the psychological distress of (b) being in a situation in which one is constrained from acting (c) on what one knows to be right."<sup>105</sup> Drawing on the work of Varcoe et al., this report broadens part (b) of the definition to include "influences beyond those that would be considered institutional to broader socio-political contexts[.]"<sup>106</sup>

Large percentages of hospital RN respondents across multiple NNU surveys have reported worsening staffing conditions during the pandemic.<sup>107</sup> Burdened by a heavy patient load, nurses must witness the suffering and needless death of patients who might have been saved

by appropriate nursing care or medical intervention. Thus, working under crisis standards of patient care leads to profound moral distress and moral injury as well as adverse mental health effects.<sup>108</sup> Crisis standards include rationing care — through insufficient numbers of RNs or staffing with RNs outside their scope of practice or areas of competency — and rationing resources such as PPE, ICU beds, ventilators, and medications.<sup>109</sup> The Hastings Center's "Ethical Framework for Health Care Institutions and Guidelines for Institutional Ethics Services Responding to the Coronavirus Pandemic" states:

In a public health emergency featuring severe respiratory illness, triage decisions may have to be made about level of care (ICU vs. medical ward); initiation of life-sustaining treatment (including CPR and ventilation support); withdrawal of life-sustaining treatment; and referral to palliative (comfort-focused) care if life-sustaining treatment will not be initiated or is withdrawn.<sup>110</sup>

These decisions are driven by an insufficient number of RNs with ICU experience as well as shortages of beds, medications, equipment, and other medical resources which, in turn, are driven by the lack of pandemic planning, decades-long underfunding of public health, and a privatized, market-based health care system.

Under crisis standards of patient care, nurses face two challenges around staffing: being assigned far more patients than they can care for safely and working outside their areas of competency. Typically, staffing in an ICU requires one experienced ICU nurse to care for **no more than** two patients. It is well established that patient mortality decreases with higher RN-to-patient ratios.<sup>111</sup> Yet, with staffing for ICUs in short supply during pandemic surges, some hospitals are reassigning nurses who work in other areas of the hospital to the ICU. The Society of Critical Care Medicine has created a crisis ICU staffing model for hospital use that "encourages hospitals to adopt a tiered staffing strategy in pandemic situations such as COVID-19," using one experienced ICU nurse to oversee

three non-ICU nurses who each care for two patients. Thus, by proxy, the experienced ICU nurse is caring for six patients (two patients for each non-ICU nurse).<sup>112</sup>

This attempt to divide the labor between an experienced ICU RN who oversees non-ICU nurses who then carry out nursing “tasks” is untenable and dangerous. The knowledge needed to provide patient care cannot be divorced from the hands-on practice of providing the care — including directly assessing the patient’s needs; determining, planning for, and implementing needed care; and subsequent evaluation. The experienced ICU nurse may experience moral distress because she knows that her patients are at increased risk of death because she has more patients than she can care for safely.<sup>113</sup> In contrast, the non-ICU nurse, lacking the necessary clinical knowledge and experience, may suffer moral distress out of fear of inadvertently harming a patient, thereby violating the most basic ethical principle of medicine and nursing: nonmaleficence (doing no harm).<sup>114</sup> In a first-person essay for the STAT news site, RN Jaclyn O’Halloran describes the effect this had on nurses in the Massachusetts hospital where she works: “We are assigned

to work in unfamiliar units, with patients who are outside our expertise, without any training. We’re lost.”<sup>115</sup> She adds that many nurses “are scared they’ll make a deadly mistake.”<sup>116</sup> Research confirms the detrimental effect working under crisis standards of patient care may have on nurses during the Covid-19 pandemic: “Nurses’ and other professional grief may also be compounded by being unable to care for families and patients as they might wish. Burnout, moral distress and moral injury has been identified as a significant issue in critical care professionals[.]”<sup>117</sup>

Patient surges and crisis standards of patient care continue to be implemented nearly two years after the first case of Covid-19 was identified in the United States. As Covid-19 surges, the number of patients explodes, and nurses increasingly fall ill with the disease and sometimes die.<sup>118</sup> With these overwhelming experiences come moral distress, moral injury, and damaging effects on nurses’ mental health. Although vaccines have eased deaths among RNs, too many are still experiencing avoidable infections, illness, and death because of their employers’ failure to provide necessary safeguards.



## HOSPITAL INDUSTRY TRANSGRESSIONS AND INCOMPREHENSIBLE PATIENT ILLNESS AND DEATH CAUSED RNS PROFOUND MORAL INJURY

In considering the effect the pandemic is having on RNs, it is helpful to view their experiences along a “continuum of morally relevant life experiences and corresponding responses” such that morally relevant life experiences progress from moral frustration to moral distress to moral injury corresponding to moral challenges, moral stressors, and morally injurious events, respectively.<sup>119</sup> Drawing on work by subject matter experts,<sup>120</sup> we use the following definition of *moral injury*: the deleterious long-term, emotional, psychological, behavioral, spiritual, and/or social effects that may result from potentially morally injurious events, such as perpetrating or failing to prevent acts that transgress deeply held moral beliefs and expectations in a high-stakes environment. The discussion in this section will demonstrate that many RNs have experienced profound moral injury during the pandemic.

Note that a person's role in a potentially morally injurious event will affect their emotional response. In unpacking the concept of moral injury, trauma experts Litz and Kerig explain that those who experience moral injury as a perpetrator of an immoral act or from failing to prevent an immoral act typically respond with internalizing emotions such as guilt and shame, whereas those who experience moral injury as a witness who was unable to prevent an immoral act typically respond with externalizing emotions such as anger and resentment.<sup>121</sup> It is crucial for those affected by potentially morally injurious events to ascribe the blame to the responsible party and not inappropriately take responsibility for failing to prevent a transgression if it was not within their power to do so. Although we have demonstrated that nurses are not the perpetrators of moral injury, they may internalize shame and guilt, nevertheless.

It is paramount that RNs learn to process these emotions and ascribe blame to the appropriate institutions and sociopolitical contexts — and then to fight together to change them.<sup>122</sup> It is the role of government to change this paradigm altogether so that neither patients nor nurses are put in this position again and that nurses are given the resources they need to fully heal from their effects.

Based on our definition of moral injury, hospital employers are guilty of “perpetrating or failing to prevent acts that transgress deeply held moral beliefs and expectations in a high-stakes environment.” For example, hospital employers, often through trade associations such as the AHA, were active *perpetrators* in opposing an OSHA emergency temporary standard and *failing* to provide appropriate PPE, to test and isolate patients, or to notify workers of Covid exposures. They violated “deeply held moral beliefs and expectations” such as: human beings have innate value and should be protected from harm, people's health and lives should have priority over making a profit, and it is wrong to lie by commission or omission. Both nurses and patients have “expectations” that the hospital industry will meet moral, legal, and regulatory requirements to maintain a safe and healthy workplace that protects workers and patients. Finally, hospitals are clearly “high-stakes environments,” particularly during the Covid-19 pandemic. As news reports document, too many workers and patients contracted Covid-19 in the hospital, some have died, while others have infected loved ones.<sup>123</sup>

Therefore, we can expect nurses to sustain moral injury at alarming rates. The risk factors identified by Williamson et al., as well as examples of how nurses may experience moral injury as a result are laid out in Table 4 below.<sup>124</sup> Williamson et al. are not alone in their concern about the impact of the Covid-19 pandemic on frontline health care workers. Numerous experts expect significant numbers of these workers to experience moral distress and, potentially, long-term moral injury.<sup>125</sup>

Table 4. Moral Injury Risk Factors Experienced by Nurses

| Moral injury risk factors <sup>126</sup>  | How RN experiences may embody these risk factors   |
|---|--|
| Increased risk of moral injury if there is loss of life to a vulnerable person (e.g., child, woman, elderly)  | <ul style="list-style-type: none"> <li>» A child, vulnerable family member, or friend dies, particularly if infected by the nurse or if the person dies without the nurse being present.</li> <li>» A patient or coworker dies because a nurse wearing contaminated PPE infects them with Covid-19.</li> <li>» A vulnerable patient (e.g., a child or elderly person) under a nurse's care dies. This may be exacerbated if the patient dies alone or if the nurse is:               <ul style="list-style-type: none"> <li>› Working in an area outside of the nurse's competency due to Covid-19-related crisis staffing; or</li> <li>› Working under crisis standards of patient care in which insufficient staffing, medical equipment, or supplies are proximate cause of the death.</li> </ul> </li> </ul> |
| Increased risk of moral injury if leaders are perceived to not take responsibility for the event(s) and are unsupportive of staff                                       | <ul style="list-style-type: none"> <li>» A nurse works without appropriate health and safety protections (e.g., insufficient PPE or poor patient isolation protocols) because:               <ul style="list-style-type: none"> <li>› Employer denies the need for airborne protections; or</li> <li>› Employer prioritizes profits over worker safety.</li> </ul> </li> </ul>   |
| Increased risk of moral injury if staff feel unaware or unprepared for emotional/psychological consequences of decisions  | <ul style="list-style-type: none"> <li>» A nurse working under crisis standards of patient care in which insufficient staffing, medical equipment, or supplies are a proximate cause of a patient's death.</li> <li>» A nurse caring for patients who are separated from their families because of visitor restrictions.</li> </ul>  |
| Increased risk of moral injury if the potentially morally injurious event (PMIE) occurs concurrently with exposure to other traumatic events (e.g., death of loved one) | <ul style="list-style-type: none"> <li>» A nurse, family member, friend, or coworker develops a severe case of Covid-19.</li> <li>» A family member, coworker, or friend dies from Covid-19.</li> <li>» Racism, racial and police violence, or death in the society in which the nurse lives.</li> <li>» A nurse experiences stigma and discrimination.</li> </ul>   |
| Increased risk of moral injury if there is a lack of social support following the PMIE.   | <ul style="list-style-type: none"> <li>» A nurse is isolating from family and friends to avoid transmitting Covid-19.</li> <li>» An excessive workload keeps a nurse from accessing social support.</li> </ul>   |

### PART III. SOLUTIONS: NURSE RETENTION MEASURES

To ensure the ongoing retention of RNs in bedside care jobs, the federal government must adopt enforceable hospital standards on minimum safe RN-to-patient staffing ratios, strong union protections, and safe and healthy working conditions for nurses. There are several concrete legislative and regulatory measures that Congress and the executive branch must support to ensure that hospitals provide good nursing jobs with safe staffing and safe working conditions.

#### **REQUIRE MINIMUM, NUMERICAL, SAFE RN-TO-PATIENT STAFFING RATIOS**

##### **CONGRESSIONAL ACTION »**

*Congress must pass the Nurse Staffing Standards for Hospital Patient Safety and Quality Care Act (S. 1567, H.R. 3165 in the 117<sup>th</sup> Congress), which would establish federally mandated safe RN-to-patient ratios limiting the number of patients a registered nurse can care for at one time in U.S. hospitals.<sup>127</sup>*

##### **EXECUTIVE AND REGULATORY ACTION »**

*The executive branch, through the Centers for Medicare and Medicaid Services (CMS), should require that hospitals meet minimum safe RN-to-patient ratios as a condition of participation in Medicare.*

To support safe staffing at our hospitals, Congress and the executive branch must champion legislative and regulatory measures that would establish minimum, numerical RN-to-patient ratios in hospitals. Hospitals have no excuse for a staffing crisis they have created. The solution that hospitals can start implementing today is to immediately staff up every unit, on every shift, and create a safe, sustainable work environment where nurses are confident about their ability to provide the best nursing care possible for their patients.

California's success with implementation of its mandated minimum RN-to-patient staffing

ratios law belies industry arguments that there are not enough RNs to comply with mandated RN-to-patient ratios. A study of RN patient loads after the implementation of the state's ratios law found that California hospitals were nearly always in compliance with the ratios just two years after the law's effective date and that California RNs had substantially safer patient loads than RNs in comparison states.<sup>128</sup> Additionally, studies have shown that minimum RN-to-patient staffing ratios mean better patient outcomes, safer and healthier RNs, lower rates of burnout (also called moral distress), and higher RN job satisfaction.

- » A study linking staffing levels and mortality rates in medical-surgical units found that New Jersey hospitals would have had 13.9 percent fewer patient deaths and Pennsylvania 10.6 percent fewer deaths if they matched California's staffing ratios in medical-surgical units.<sup>129</sup>
- » After implementation of California's RN staffing ratios law, there were significant increases in RN staffing levels in the state, particularly in hospitals with lower staffing pre-implementation, and RN full-time employment grew significantly faster than 15 comparison states (nearly 8 percent).<sup>130</sup>
- » A 2015 study found that the California RN staffing ratios law was associated with a 31.6 percent reduction in occupational injuries and illnesses among RNs working in hospitals in California.<sup>131</sup>
- » A survey of California nurses after the implementation of California's ratios law also found that California nurses reported significant improvements in working conditions and job satisfaction.<sup>132</sup>
- » In a 2018 survey of more than 50,000 RNs, California RNs reported lower rates of "burnout" [researcher's terminology], a key factor in nurse retention. Among survey respondents who had left a job due to burnout, the most frequently cited the reasons for their burnout were "a stressful work environment [...]" and inadequate staffing.<sup>133</sup>

Together, these and other studies demonstrate that the provision of safe and therapeutic patient care depends on RNs having safe patient workloads. In short, California's safe nurse staffing mandate positively impacts both patient care and the working environment for nurses, improving occupational safety for nurses, and increasing job satisfaction and nurse retention.

Importantly, mandated numerical RN-to-patient ratios should be the preferred government enforcement measure to achieving safe nurse staffing levels at hospitals. A recent study, published in October 2021, compared the impact of California's state law on mandatory numerical RN-to-patient staffing ratios to other state approaches on nurse staffing laws.<sup>134</sup> The study found that California's RN-to-patient ratios mandate resulted in a statistically significant increase in hospital RN staffing while two other approaches — state law requiring reporting of nurse staffing levels and state law requiring hospital staffing committees — had little or no impact on RN staffing levels. In short, mandatory minimum RN-to-patient ratios is the only approach that has been shown to have a positive effect on RN staffing levels.

Finally, as part of CMS' regulatory authority to establish health and safety standards for hospitals that participate in federal health programs, CMS should add minimum, numerical RN-to-patient ratios as part of its nurse staffing adequacy requirements in its Conditions of Participation (CoPs) agreements with Medicare- and Medicaid-certified providers. Medicare-participating hospitals include nearly all hospitals in the United States and must meet CoPs regarding patient health and safety standards as required under § 1891(e) of the Social Security Act, 42 U.S.C. § 1395x. Current hospital CoPs require that nursing service have "adequate numbers of licensed registered nurses, licensed practical (vocational) nurses,

and other personnel to provide nursing care to all patients as needed" and that "[t]here must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for bedside care of any patient."<sup>135</sup> Additionally, CMS hospital certification procedures for evaluating whether hospitals meet CoPs on nurse staffing adequacy currently include a determination of adequate numbers of nurses based on the number of patients.<sup>136</sup> Nonetheless, the "adequacy" requirement in hospital CoPs includes so little specificity as to be almost meaningless. Moreover, CMS relies on the hospital-funded, non-governmental organization The Joint Commission to conduct Medicare and Medicaid accreditation surveys. Consequently, The Joint Commission, which has a clear conflict of interest, is an inappropriate hospital watchdog for CMS.<sup>137</sup>

Updating CoPs to include detailed standards for Medicare- and Medicaid-certified hospitals is not new to CMS. Indeed, CMS exercised such regulatory authority in November 2021 when it issued regulations to add Covid-19 health care staff vaccination requirements for the vast majority of Medicare- and Medicaid-certified providers.<sup>138</sup> (Although as of the publication of this report federal district courts have blocked enforcement of the CMS rule on Covid-19 vaccination of health care staff pending appeal, CMS has long-included nurse staffing requirements in hospital CoPs.) CMS has the authority to mandate numerical RN-to-patient staffing ratios for hospitals through Medicare- and Medicaid-certified hospital provider CoPs on nurse staffing adequacy, and CMS has recent precedent in establishing such detailed standards in CoPs. Thus, NNU urges CMS to amend hospital CoP regulations to include mandated, minimum numerical RN-to-patient staffing ratios for hospitals.

## ISSUE ENFORCEABLE OCCUPATIONAL HEALTH AND SAFETY STANDARDS TO ENSURE THAT NURSES ARE SAFE ON THE JOB

### CONGRESSIONAL ACTION »

*Congress must pass legislation requiring that OSHA issue workplace health and safety standards to protect nurses from preventable injury and illness on the job and increasing funding for OSHA enforcement programs, including:*

- » *Passing the Workplace Violence Prevention for Health Care and Social Service Workers Act (H.R. 1195 in the 117<sup>th</sup> Congress)*
- » *Increasing funding for OSHA enforcement programs and OSHA hiring of health care-sector inspectors*

### EXECUTIVE AND REGULATORY ACTION »

*The executive branch, through OSHA, must issue enforceable workplace health and safety standards to protect nurses from injury and illness on the job, including:*

*Issuing a permanent OSHA standard on Covid-19. A permanent standard on Covid-19, based on the Covid-19 Health Care Emergency Temporary Standard, that follows the precautionary principle and includes requirements on optimal PPE and other precautionary protocols necessary to prevent aerosol transmission of Covid-19.*

- » *Issuing an OSHA standard on infectious disease. An infectious disease standard that includes protections against aerosol-transmissible diseases.*
- » *Issuing an OSHA standard on workplace violence prevention in health care and social service settings. A workplace violence prevention standard.<sup>139</sup>*
- » *Issuing an OSHA standard on safe patient handling. A standard on safe patient handling to prevent back and other musculoskeletal injuries.*

- » *Issuing an OSHA directive to improve enforcement activities in the health care sector.*
- » *Hiring and training more OSHA inspectors with health care sector expertise.*

Nurses and other health care workers experience **preventable** workplace injury and illnesses, which can result in nurses taking time off to recover or leaving the profession altogether because of temporary disability or illness, permanent disability, or even death. The Occupational Safety and Health Administration must issue permanent enforceable standards on Covid-19, infectious disease, workplace violence prevention, musculoskeletal injury, and other workplace hazards. These occupational health and safety standards would provide nurses and other health care workers with enforceable tools to ensure hospitals are protecting them from workplace hazards.

In the absence of enforceable workplace health and safety standards from OSHA, employers have failed to adequately protect nurses and other health care workers from Covid-19, other infectious disease, workplace violence, back injuries, and other occupational hazards in health care settings. Employers have legal obligations under the Occupational Safety and Health Act (OSH Act) to provide workers safe and healthful workplaces and Congress tasked OSHA with ensuring “so far as possible every working man and woman in the Nation safe and healthful working conditions and to preserve our human resources...” including by passing mandatory standards.<sup>140</sup>

Importantly, where serious occupational hazards persist despite voluntary measures, OSHA is **required** under the OSH Act to establish mandatory workplace health and safety standards. Congress envisioned in the passage of the OSH Act that all workplace safety standards promulgated by OSHA be highly protective. It recognized that OSHA’s leadership would be necessary in creating uniform standards across the nation, requiring, where conflicts existed among occupational standards, that “the Secretary [of Labor] promulgate the standard which assures the

greatest protection of the safety or health of the affected employees."<sup>141</sup>

The Covid-19 pandemic is far from over and OSHA should act to make the Covid-19 Health Care Emergency Temporary Standard (Covid-19 Health Care ETS) permanent.<sup>142</sup> NNU has urged OSHA to move expediently to promulgate a final standard on Covid-19 in health care and to update and to reissue the Covid-19 Health Care ETS until such time as a final standard can be issued.<sup>143</sup> Variants of concern continue to emerge and spread around the world. Only 24 percent of the world population and just 1.3 percent of people in low-income countries are fully vaccinated for Covid-19, and governments around the world failed to establish comprehensive public health programs to track, trace, and isolate Covid-19 cases.<sup>144</sup>

As explained in NNU's letter to the U.S. Secretary of Labor and Assistant Secretary of Labor for OSHA, the Covid-19 Health Care ETS has supported nurses and other health care workers in holding their employers accountable to protect them and their patients from Covid-19.<sup>145</sup> Through collectively organizing and communicating directly with their employers regarding the requirements of the Covid-19 Health Care ETS, union nurses have won improvements to Covid-related health and safety hazards in their facilities, including gaining access to the employer's written Covid-19 policies and procedures and Covid-19 logs, getting nurses on Covid-19 units fit-tested for N95 filtering facepiece respirators for the first

time, and returning all PPE to patient care units instead of locking up and rationing this equipment. In order to provide protections to nurses and other health care workers in an ongoing manner, OSHA should issue a permanent Covid-19 standard for health care settings, based on the Covid-19 Health Care ETS.

Additionally, OSHA enforcement efforts must be dramatically scaled up and enhanced to ensure that standards, once issued, can be effectively enforced in both this administration as well as future administrations. While recognizing that the Biden administration has dramatically scaled up OSHA's enforcement program since taking office in January 2021, Congress must increase funding to hire more OSHA inspectors and to improve OSHA enforcement efforts, and the executive branch should issue a directive to improve enforcement activities in the health care sector where OSHA enforcement historically has been lacking, including through inspector training and programs to hire inspectors with particular experience in health care settings. During the Trump administration, OSHA opened inspections for a slim fraction of complaints filed during the pandemic. As of Jan. 20, 2021, federal OSHA had received 12,831 complaints from workers since the beginning of the pandemic and reported opening a mere 357 inspections in response to complaints (2.8 percent). Under the Biden administration, inspections in response to complaints have risen dramatically, nearly five-fold to 13 percent.<sup>146</sup>



## **STRENGTHEN UNION PROTECTIONS AND THE RIGHT TO ORGANIZE FOR NURSES AND OTHER WORKERS**

### **CONGRESSIONAL ACTION »**

*Congress must pass legislation to strengthen the collective bargaining rights of nurses and their rights to collectively organize a union and to engage in protected concerted activity to improve their working conditions, including:*

- » *Passing the Protecting the Right to Organize (PRO) Act (S. 420, H.R. 842 in the 117<sup>th</sup> Congress).*
- » *Passing the VA Employee Fairness Act (S. 771, H.R. 1948 in the 117<sup>th</sup> Congress).*

### **EXECUTIVE AND REGULATORY ACTION »**

*The executive branch, through executive order and through regulatory action, must take steps to strengthen and protect the rights of nurses to collectively organize a union and to engage in protected concerted activity to improve their working conditions, including by:*

- » *Adopting CMS rules to penalize hospitals that cannot ensure labor peace. The Centers for Medicare and Medicaid Services (CMS) should adopt regulations to subject hospital employers that cannot demonstrate that they can ensure labor peace with a 1 percent Medicare payment reduction penalty each year.*
- » *Supporting the PRO Act and VA Employee Fairness Act. The executive branch should provide its full support for the PRO Act and the VA Employee Fairness Act.*

Union advocacy and representation allow RNs to focus on caring for patients. The benefits of unionization for nurses have never been clearer than during the Covid-19 pandemic. Since the pandemic began, unionized nurses have been able win access to PPE and other worker and patient protections through their union, while nurses in non-union hospitals have found it

more challenging to secure the protections they need. Yet current labor law does far too little to protect and allow workers to exercise our right to join a union. To promote retention of nurses at the bedside and on the front lines of the Covid-19 pandemic, Congress must pass the Protecting the Right to Organize (PRO) Act, which would enhance workers' rights to organize a union and act together to advocate for safe working conditions, to improve their wages and benefits, and to protect their workplace rights through collective bargaining and concerted activity.<sup>147</sup> The PRO Act would ensure that nurses can fully exercise their right to act collectively through their union and have a voice on the job to ensure safe working conditions that prevent death, illness, and injury for themselves, their coworkers, and their patients. The PRO Act is an important step to protecting workers' rights to organize a union and to stop employers' attacks so that every worker can organize without fear of retaliation.

Moreover, certain clinical professionals, including registered nurses, who work at the U.S. Department of Veterans Affairs (VA) caring for veterans have limited collective bargaining under Section 7422 of Title 38 of the U.S. Code. This statute restricts the ability of RNs at the VA to speak out about poor working conditions and patient care issues and to resolve disputes with management. As a result, the quality of patient care can deteriorate and problems in VA facilities can go unaddressed. These statutory limitations to VA nurses' rights to organize must be amended to give VA nurses and other clinicians full collective-bargaining rights, ultimately improving both working conditions for nurses and improving patient care in VA hospitals. The 2021 fiscal year report by the VA Office of the Inspector General found that 73 percent of facilities surveyed had a severe shortage of nurses and that a severe shortage of nurses has been identified every year since 2014.<sup>148</sup> Thus, it is crucial to rectify this matter swiftly and ensure VA nurses have full collective bargaining rights.

Finally, the executive branch, through CMS, must take regulatory action to support unionization of nurses and other hospital workers, which not only would strengthen nurses' ability

to advocate for better working conditions but also, as shown through research literature, improve patient outcomes.<sup>149</sup> Hospital employers are the beneficiaries of federal government health care dollars through Medicare and Medicaid and should be required to show they respect workers' organizing rights.<sup>150</sup> Despite the hospital industry's reliance on federal health care dollars for its continued existence,<sup>151</sup> the hospital industry engages in the same kind of union-busting efforts as employers in any other industry, subjecting workers to relentless pressure, fear, and intimidation and spending millions upon millions of dollars in the process — federal health care dollars that should be going to safe patient staffing and care. Thus, to ensure bedside nurses' rights to join together in advocating for safe and healthy working conditions, CMS could impose a 1 percent Medicare payment reduction penalty per year if a hospital engages in conduct deleterious to labor peace, capping penalties at 3 percent, as with other CMS programs that reduce hospital payments for failing to meet certain Medicare standards.



## PROVIDE PAID SICK, FAMILY, AND PRECAUTIONARY LEAVE FOR WORKERS

### **CONGRESSIONAL ACTION »**

*Congress must pass legislation mandating paid sick, family, and precautionary leave for nurses and other workers.*

### **EXECUTIVE AND REGULATORY ACTION »**

*The Biden administration, through executive order and through regulatory action, should ensure that all federal workers and federal contractors are entitled to paid sick and family leave beyond the Covid-19 public health emergency.*

Paid sick, family, and precautionary leave are essential for nurses' and all workers' ability to stay healthy, take care of their families, and avoid spreading infectious diseases in the workplace. The absence of these critical supports for workers has undermined public health efforts during the Covid-19 pandemic and damages workers' health even outside of pandemic conditions.

The importance of paid sick and family leave has become indisputable during the Covid-19 pandemic and so has the need for paid precautionary leave to quarantine and isolate at home. Paid time covering isolation after every work-related exposure is essential to combatting this pandemic. However, federal Covid-19 legislation that Congress passed in 2020 explicitly excluded nurses and other health care workers from mandatory workplace benefits for emergency paid sick and family leave. Congress and the executive branch should ensure that any further legislation on paid sick, family, or precautionary leave includes health care workers. For nurses who are exposed to Covid-19 because of inadequate workplace health and safety protections, their ability to isolate without fear of losing their incomes or their jobs is critical to the safety of their families, patients, communities, and coworkers. No worker should have to use their accrued sick or other paid leave to cover a workplace exposure that occurred because their employer failed to protect them. No nurse should ever have to

choose between their livelihood and the risk of further spreading Covid-19 or other infectious diseases.

Beyond the Covid-19 pandemic, paid sick and family leave are essential to allow workers to recover from illnesses or injuries, prevent the spread of diseases, and care for new children and ill family members while remaining in the workforce. While most union nurses have paid leave guaranteed in their collective bargaining agreements, many workers — including non-union nurses — lack sufficient paid sick and family leave to cover illnesses and injuries that they and their family members may suffer. The Bureau of Labor Statistics (BLS) March 2021 employee benefits survey reported that only 35 percent of RNs in the civilian workforce overall have paid family leave.<sup>152</sup> Additionally, although RNs have high rates of reported access to some form of paid sick leave (93 percent), only 25 percent of RNs have access to paid sick leave with no consolidation of their leave plan with other forms of time off such as vacation or personal leave.<sup>153</sup>

Congress and the executive branch should take steps to guarantee paid leave to all workers. NNU urges Congress to pass legislation requiring paid sick days and paid Family Medical Leave Act (FMLA) leave for all workers and to make any additional appropriations necessary to fund paid FMLA leave for federal workers, extending eligibility for paid FMLA leave permanently beyond the Covid-19 pandemic emergency. The executive branch should build on President Obama's executive order requiring up to seven days of paid leave for federal contractors.<sup>154</sup> The administration must issue similar executive orders requiring paid sick and FMLA leave for federal workers and contractors on a permanent basis, and the Office of Personnel Management and the Office of Federal Contract Compliance Programs must issue rules requiring paid sick and FMLA leave, respectively, for federal employees and for federal contractors.

## **ADOPT PANDEMIC RISK AND EFFECTS MITIGATION MEASURES TO RESPOND TO THE ONGOING COVID-19 PANDEMIC AND TO PREPARE FOR FUTURE PANDEMICS**

### **CONGRESSIONAL ACTION »**

*In addition to the other measures listed in this report, NNU urges Congress to pass legislation on workplace protections that we describe in “Deadly Shame: Redressing the Devaluation of Registered Nurse Labor Through Pandemic Equity.”<sup>155</sup>*

#### **Pandemic Risk Mitigation Measures:**

- » Pass legislation requiring hospitals and government to maintain and report on PPE and medical supply stockpiles
- » Pass legislation expanding Defense Production Act of 1950 powers over PPE and medical supply chains during public health emergencies
- » Pass legislation prohibiting the reuse and extended use of single-use PPE

#### **Pandemic Effects Mitigation Measures:**

- » Pass legislation to establish presumptive eligibility for workers' compensation and disability and death benefits for nurses
- » Pass legislation providing free crisis counselling and mental health services to nurses
- » Pass legislation on educational debt cancellation for nurses
- » Pass legislation establishing social support programs for nurses during public health emergencies (e.g., programs providing free childcare, alternate housing, meals, and transportation)
- » Pass legislation to provide nurses essential worker pay

### **EXECUTIVE AND REGULATORY ACTION »**

*In addition to the other measures listed in this report, NNU urges the executive branch to implement other regulatory policies on workplace protections for nurses that we describe in “Deadly Shame: Redressing the Devaluation of Registered Nurse Labor Through Pandemic Equity.”<sup>156</sup>*

#### **Pandemic Risk Mitigation Measures:**

- » Require hospitals and government to maintain and report on PPE and medical supply stockpiles through CMS regulation
- » Fully invoke and exercise Defense Production Act of 1950 powers to coordinate the manufacture and distribution of PPE and medical supplies
- » Rescind all CDC and other federal agency crisis standards that allow the reuse and extended use of single-use PPE and that do not fully recognize aerosol transmission of Covid-19
- » Require hospitals to adopt Covid-19 infectious disease precautions, including:
  - › Patient isolation, screening, universal masking, and other measures
  - › Free vaccines and testing of workers and patients
  - › Contact tracing and communication about Covid-19 cases

#### **Pandemic Effects Mitigation Measures:**

- » Establish presumptive eligibility for disability and death benefits for nurses and workers' compensation for federally employed nurses
- » Require hospitals to provide free crisis counseling and mental health services of the nurse's choosing
- » Take executive action on nurse educational debt cancellation
- » Provide essential worker pay for nurses who are federal employees or contractors

Congress and the executive branch must take the measures listed above to ensure that hospitals are able to retain nurses by providing nurses good, permanent jobs with safe working conditions and strong enforceable workplace protections. As NNU describes in our white paper “Deadly Shame: Redressing the Devaluation of Nurse Labor Through Pandemic Equity,” there are protective measures that the federal government could adopt and enforce immediately to start mitigating this unequal risk of contracting and transmitting Covid-19 borne by our nurses and their families during the Covid-19 pandemic. These pandemic mitigation policies can be conceptualized into two broad categories — risk mitigation and effects mitigation. Risk mitigation measures are policies that reduce the risk of exposure to Covid-19 and other infectious disease borne by our nurses, other health care workers, and their families. Risk mitigation measures protect workers from exposure in the first place. In contrast, effects mitigation measures are policies that government can implement to redress the impact of nurses’ exposure to or contraction of Covid-19 or other infectious disease. These measures support nurses and their families who are exposed to or contract Covid-19. This framework reflects the fact that valuing and protecting the lives of nurses and other health care workers during this pandemic requires a range of interventions.

Importantly, risk mitigation measures and effects mitigation measures should never be treated as substitutes for one another. Remedying the impact of Covid-19 exposure through additional pay or other compensation and benefits does not excuse an employer or the government from their legal and moral obligations to provide safe workplaces for nurses and other essential workers. Measures that may remedy the physical, mental, financial, or other effects of forced occupational exposure to Covid-19 must not be treated as trade-offs for measures that would prevent workplace exposure at the outset and would protect the lives and health of nurses, patients, and their families and communities. These effects mitigation measures do not excuse government from its legal and moral obligation to establish and

enforce worker protection laws. This is particularly true when infectious disease science has long demonstrated that the risk of occupational exposure to aerosolized diseases, like Covid-19, can be reduced significantly.

### **Pandemic Risk Mitigation Measures**

**Adopting Optimal PPE and Other Medical Supply Chain Measures.** Throughout the pandemic, many nurses across the country have not had the necessary PPE to provide care to their patients safely. This failure to ensure that PPE stock and supply is immediately accessible at each facility leaves nurses exposed to Covid-19, which has had deadly consequences for nurses, their patients, and their families. Hospital employers’ rationing of PPE and other medical supplies left nurses unprotected from Covid-19 and other infectious disease, pushing nurses away from the bedside due to unnecessary exposure and preventable illness and death.

- » **Require Employer and Government Maintenance of PPE and Medical Supply Stockpiles:** To ensure that nurses are never again left unprotected while caring for patients, hospitals and government must always be prepared for potential public health emergencies by maintaining stockpiles of PPE and medical supplies. Congress and the executive branch must end “just-in-time” supply practices for PPE and medical supplies by requiring hospitals and government at all levels to maintain PPE and medical supplies stockpiles.
- » **Fully Exercise Defense Protection Act of 1950 Powers:** The DPA must be fully invoked on day one of public health emergencies to dramatically ramp up production and distribution of medical equipment and PPE in needed quantities to consistently provide optimal protections against Covid-19 or other infectious disease exposures of nurses and other health care workers. The executive branch must use DPA authorities to create a comprehensive medical supply chain management system that is coordinated, efficient, and transparent. The DPA can be used to engage in identification of manufacturing facilities that can increase

their capabilities or can transition manufacturing functions to produce critical medical supplies and PPE.

- » **Rescind all CDC and other federal agency crisis standards that allow the reuse and extended use of single-use PPE and that do not fully recognize aerosol transmission of Covid-19:** Federal guidance and hospital policies during the pandemic have not fully recognized aerosol transmission of Covid-19 or, through crisis standards, allowed for the use of non-protective equipment, the reuse of single-use PPE, and for the extended use of single-use PPE. CDC guidance has allowed hospitals to adopt crisis standards that reuse or extend the use of single-use PPE. Every time that single-use PPE is reused, nurses and patients are put at increased risk of exposure. Congress must pass legislation and federal agencies must issue regulations prohibiting hospitals from the reuse or extended use of single-use PPE. These measures could be enforced through OSHA standards, CMS regulation of Medicare- and Medicaid-certified providers, or FDA PPE and medical product use and certification standards.

**Covid-19 and Other Infectious Disease Control Precautions (Patient Isolation, Testing, Screening, Universal Masking, Contact Tracing, Ventilation, and Additional Measures).** NNU advocates for a comprehensive infection control public health program that practices multiple measures of infection control. As outlined in NNU's scientific brief on Covid-19 infection control measures, research literature has shown that multiple measures in a layered approach are necessary to stop and slow the spread of Covid-19.<sup>157</sup> Patient isolation, testing, screening, masking, contact tracing, ventilation and air filtration, vaccines, and other measures would reduce nurses' exposure to Covid-19. Preventing nurses' exposure to Covid-19 in the first place would ensure that nurses are not pulled away from the bedside because of entirely preventable workplace exposure to and infection, illness, or death from Covid-19. To protect nurses from exposure to Covid-19, hospitals should be required to screen all patients — irrespective of vaccination status — using a combination of

testing, symptom screening, and epidemiologic history. NNU urges that Congress and the executive branch require hospitals have designated Covid-19 units and isolate Covid-19 patients in airborne infection isolation rooms (AIIRs), which reduce the possibility that infectious viral particles will be transported to other areas of the hospital. These kinds of measures to prevent patient or visitor transmission of Covid-19 to nurses can be adopted in future pandemics. Legislative and regulatory measures must be taken to authorize and mandate that OSHA or CMS require that hospitals implement such measures during this and future pandemics.

### **Pandemic Effects Mitigation Measures**

**Establish Presumptive Eligibility for Workers' Compensation Claims and Disability and Death Benefits for Nurses.** Congress and the executive branch should establish programs that would presumptively compensate nurses who are injured on the job or who contract illnesses (including Covid-19) with workers' compensation, disability, and death benefits. These kinds of benefits would mitigate the high risk of injury or illness that nurses face on the job. Presumptive eligibility for such benefits programs would mean that nurses would not bear the legal and evidentiary burden of proving that they were injured on the job or became ill as result of workplace exposures to infectious disease such as Covid-19 or other hazardous materials. NNU urges that Congress and the executive branch establish and enforce programs that provide nurses with presumptive eligibility for workers' compensation claims as well as for short-term disability, long-term disability, and death benefits for issues such as infectious and respiratory disease (including Covid-19), cancer, post-traumatic stress disorder, and musculoskeletal injuries.

For nurses, relief from the burden of proving that an injury or illness was work-related is exceedingly important in the context of the current pandemic. As a matter of public policy, it would recognize that by virtue of being deemed essential during the pandemic, nurses have an undue risk of exposure to Covid-19. Workers' compensation for nurses should include not only payment for medical care but

also for time off during any necessary quarantine and medical treatments, payment for temporary housing if needed to prevent exposure to household members, and necessary PPE.

Importantly, disability and death benefit presumptions as well as state-based workers' compensation presumptions already exist for certain male-dominated professions such as EMTs, paramedics, firefighters, and police officers. Although states manage workers' compensation laws for private sector and state public employees, Congress also has established programs that provide public safety officers with presumptive death and disability benefits for certain injuries and illnesses. In 2020, Congress passed legislation which extended existing federal programs providing public safety officers presumptive death and disability benefits to Covid-19-related claims. Meanwhile, workers in health care settings, such as nurses, are not entitled to workers' compensation presumptions and do not have federal programs that provide disability or death benefits. This is despite the fact that nurses treat the same patients in hospitals that public safety officers are treating in the field. Congress and the executive branch must establish and provide similar workers' compensation, disability, and death benefits programs presumptively for nurses. Additionally, the executive branch must provide nurses employed by the Veterans Health Administration, other federal agencies, or federal contractors with presumptive workers' compensation for Covid-19 as well as other infectious diseases and injuries.

**Provide Free Crisis Counseling and Mental Health Services for Nurses.** Considering the psychological trauma, moral distress, and moral injury that nurses are facing on the front lines of the pandemic, Congress and the executive branch should ensure that employers provide nurses with crisis counseling and mental health services. Congress and the executive branch must also supplement and, in some cases, directly provide crisis counseling and mental health services to nurses. Given that much of the psychological trauma and moral distress is attributable, at least in part, to the actions and inactions of health care industry employers to protect nurses and their

patients, it is exceedingly important that any crisis counseling or mental health services are provided by entities other than the nurses' employer. Employee assistance programs and employer-sponsored wellness programs are not sufficient and, indeed, may contribute to stress and psychological trauma if the very entity that causes stress and trauma is the only option for nurses to receive free counseling or mental health services.

**Cancel Educational Debt for Nurses.** Nurses who work at the bedside providing direct patient care to members of their community put themselves at risk of exposure to infectious disease, including deadly viruses such as SARS-CoV-2. For the risk that nurses bear to illness, injury, and death from their work at the bedside and for their services to their patients and communities, Congress and the executive branch should take legislative and regulatory steps to cancel any educational debt of nurses. In the Higher Education Act (HEA), Congress has granted the U.S. Secretary of Education authority to modify student loan debt owed under federal student loan programs. Congress conferred upon the education secretary general authority to "enforce, pay, compromise, waive, or release any right, title, claim, lien, or demand, however acquired, including any equity or any right of redemption."<sup>158</sup> A reasonable interpretation of the statute provides the executive branch's education secretary with the authority necessary to cancel federal educational loan debt for nurses. No nurse who has risked their own and their families' health and safety due to hospital employer and government failures to protect them from preventable injury and illness, including during the Covid-19 pandemic, should continue to be burdened with educational debt.

**Establish Government Programs On Free Childcare, Alternate Housing, Meals, and Transportation.** To help nurses prevent the spread of infectious disease during public health emergencies to their families and communities, Congress and the executive branch must also establish federal programs to provide nurses and other essential workers with free childcare, alternate housing, meals, and transportation. It has been widely documented

that nurses and other health care workers with vulnerable family members or children paid for their own hotel rooms or other accommodations to protect their family members.<sup>159</sup>

**Provide Essential Worker Pay for Nurses.**

While nurses always deserve fair and equitable wages, an essential worker pay differential is specifically meant to compensate workers who have been excluded from governmental orders and public health guidance to stay at home because their work has been deemed “essential” or “critical” and, thus, are being forced to risk exposure to Covid-19 that is higher than government has prescribed as safe. More simply put, because the labor of nurses and other essential workers is vital to our collective well-being, coupled with the fact that working during a pandemic adds complexity and danger for them and their families compared to those sheltering at home, these workers deserve to be paid more.

Sometimes the term “hazard pay” is mistakenly used to describe this kind of mitigation measure, but using this term to describe an essential worker pay differential or premium is a misnomer. Hazard pay, by regulatory definition of the U.S. Department of Labor, is meant to compensate a worker from exposure to a hazard that cannot be mitigated.<sup>160</sup> But the science of industrial hygiene has known for decades how to protect workers from infectious disease and other occupational injury in health care settings, and, as such, we know how to reduce occupational exposure to Covid-19, other infectious disease, and workplace hazards for nurses. Extra pay to nurses as essential workers should not be treated as trade-off for safe workplaces, especially when we know the risk of exposure can be reduced.

Congress or the executive branch must provide essential worker pay to nurses who are federal workers or federal contractors. The executive branch must issue executive orders requiring essential worker pay for federal employees and federal contractors, and Congress must extend current statute providing pay premiums for some federal workers who are exposed to virulent biologicals to all nurses who work for the federal government or federal contractors.

Certain federal workers are entitled to a pay premium of up to 25 percent for work duty “involving unusual physical hardship or hazard.”<sup>161</sup> This kind of pay differential is available if a federal worker is exposed to or must “work with or in close proximity” to “virulent biologicals[.]”<sup>162</sup> However, the statute providing federal workers with pay premium for hazardous work does not apply to Veterans Health Administration nurses.

Congress must also adopt legislation on essential worker pay for private-sector nurses. For example, a U.S. House of Representatives Covid-19 legislative package in 2020, the HEROES Act (H.R. 6800), would have provided a “pandemic premium pay” to “essential workers.” The legislation would have created a federal fund, called the Covid-19 Heroes Fund, that would provide “essential workers” a \$13 per hour premium on top of regular wages.

**Require Free Covid-19 Testing, Treatments, and Vaccines for All.** With the existence of new Covid-19 treatments or vaccines that are safe and effective, it is critical that our public health infrastructure is improved to allow for the efficient, safe, and equitable rollout of these treatments or vaccines. Any vaccine that is scientifically shown to be safe and effective should be available at no cost to all people who would like to receive the vaccine. The administration must also ensure that the necessary administrative and health care supports are in place to ensure timely follow-up care, if needed, for any patient who has received a vaccine.

The United States must also play a leadership role in ensuring that any treatment or vaccine is made available equitably in the rest of the world. Covid-19 and other infectious diseases do not recognize borders, and our nation has the opportunity to play an important role on the world stage to ensure that low and middle-income countries have access to these treatments and vaccines for free or at a low cost. Ending the pandemic is not only the right thing to do as the wealthiest country in the world, but it is also an essential step in eliminating the patient surges that harm patients and RNs.

## PART IV. SOLUTIONS: MEASURES TO STRENGTHEN AND SUPPORT THE RN WORKFORCE PIPELINE

NNU urges Congress and the executive branch to provide robust funding for the programs discussed below, most of which are funded as Nursing Workforce Development programs under Title VIII of the Public Health Service Act.<sup>163</sup> Moreover, Congress and the executive branch should continue to monitor RN education and employment closely and adjust funding as necessary to ensure that patients receive the care they need from a diverse group of culturally and linguistically competent RNs. NNU strongly urges Congress and the Biden administration to adopt the mutually reinforcing policies detailed below to rapidly increase the number and diversity of RNs providing direct patient care at the bedside.

NNU has long advocated for more funding for public nursing schools and incentives to recruit nursing faculty. To ensure a diverse and sustainable nursing workforce, Congress should increase funding for nursing workforce programs that reduce the financial barriers to becoming a nurse imposed by the exorbitant expense of private programs and the lack of admission slots in public nursing programs. NNU believes that federal nursing workforce funding should be increased dramatically and dedicated to ensuring that the direct-care registered nurse workforce, providing the bulk of inpatient hospital care, remains robust and sustainable. Although current federal funding for nursing workforce development is edging upwards, it remains insufficient — apart from the major one-time boost in funding from the American Rescue Plan Act which added \$200 million for the Nurse Corps Scholarship and Loan Repayment Program. Given the importance of the RN workforce to the health of our nation, increased spending on nursing workforce development above the amounts typically funded should become the norm, not the exception.

### **CONGRESSIONAL ACTION »**

#### **CREATE A LONG-TERM, DEDICATED FUNDING STREAM FOR TUITION-FREE NURSING PROGRAMS AT PUBLIC COMMUNITY COLLEGES**

NNU urges Congress to pass legislation creating long-term dedicated funding streams for tuition-free nursing programs at public community colleges and to give funding priority to public community colleges located in health professional shortage areas (HPSAs) and medically underserved areas and populations (MUAs/MUPs). Tuition-free nursing programs, particularly if coupled with stipends to cover living expenses, diminish the financial and time constraints that are the most common barriers to higher education. With sufficient in-person (not simulated) pre-licensure clinical training, nurses with associate degrees in nursing (ADNs) can be ready for entry-level nursing positions in two years. New RNs then need to be paired with preceptors to make the transition to professional practice.

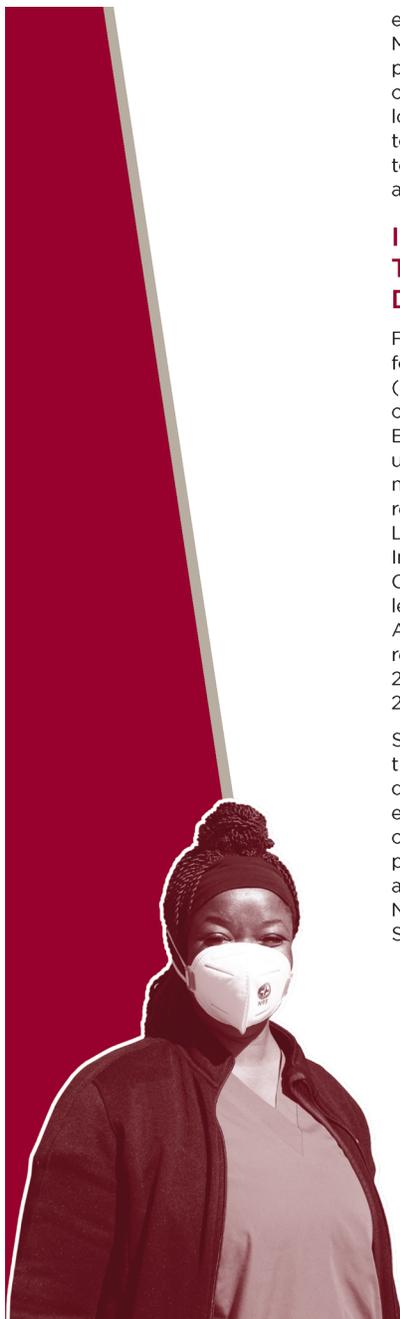
Locating community colleges in HPSAs and MUAs/MUPs will facilitate local nursing students becoming RNs in these areas and populations. Linking community colleges with local pre-licensure clinical training and post-licensure job placement in public hospitals and critical shortage facilities increases the likelihood that RNs working in these areas will be culturally competent and share values that reflect the communities in which they work. Finally, as many HPSAs and MUAs/MUPs have higher percentages of underrepresented BIPOC community members,<sup>164</sup> locating nursing programs in these areas would tend to serve a more racially and ethnically diverse student population. In turn, increasing tuition-free access to nursing programs could lead to greater RN diversity and improve racial, ethnic, and other disparities in health care access, leading to greater health

equity. Additionally, many HPSAs and MUAs/MUPs are in rural areas with lower RN compensation rates.<sup>165</sup> Providing free community college relieves RNs from the burden of student loan debt, thereby reducing financial pressure to avoid hospitals in underserved areas and to seek employment in urban or more affluent areas where RN salaries are higher.

### **INCREASE FUNDING FOR THE NURSING WORKFORCE DIVERSITY PROGRAM**

First, NNU urges Congress to increase funding for the Nursing Workforce Diversity Program (NWDP) as a crucial step to improving health care access and achieving health equity for BIPOC, rural communities, and medically underserved communities. As discussed above, numerous racial and ethnic groups are underrepresented in the RN workforce, particularly Latinx and Black RNs but also Asian, American Indian, and Alaskan Native RNs. NNU urges Congress, at minimum, to adopt the funding levels reported by the House Committee on Appropriations for fiscal year 2022 which reflects a \$6.5 million increase over fiscal year 2021 and an \$8 million increase over fiscal year 2020.<sup>166</sup>

Second, NNU believes it is important to include the voice of labor in the nursing workforce diversity discussion and, as the country's largest union and professional association of direct-care registered nurses, we are well suited to provide that voice. NNU requests that Congress amend 42 U.S.C. § 296m to include National Nurses United in the list of organizations in Section (b).



### INCREASE FUNDING FOR THE NURSE CORPS SCHOLARSHIP AND LOAN REPAYMENT PROGRAMS

As noted above, the American Rescue Plan Act dramatically increased funding by adding \$200 million in fiscal year 2021 for the Nurse Corps Scholarship and Loan Repayment Programs compared to funding ranging \$87-\$89 million since 2018 and in the low \$80 million range prior to that.<sup>167</sup> Yet these programs remain underfunded.

» **Nurse Corps Scholarship Program (NCSP)**

The NCSP has three funding tiers. Tier 1, the highest preference tier, includes students who maintain full-time enrollment in an accredited nursing program leading to an RN license and/or a nurse practitioner program. Tier 2 includes students who maintain full-time enrollment in an accredited graduate nursing program to become a certified registered nurse anesthetist or clinical nurse specialist. Tier 3 includes students accepted or enrolled part-time in an accredited diploma, undergraduate, or graduate nursing program. The NCSP is highly competitive with far more applicants for scholarship awards than available funding.<sup>168</sup> The lack of funding of NCSP historically has limited awards to Tier 1. NNU advocates for increasing NCSP funding to a level that ensures that all eligible applicants applying to the scholarship or loan repayment programs are fully funded until all those residing in the United States have equitable access to high-quality care across the full range of health care services, and then adjusting the funding to a level sufficient to meet ongoing need for health care professionals.

» **Nurse Corps Loan Repayment Program (NCLRP)**

The NCLRP provides RNs and advanced practice RNs up to 85 percent repayment of qualifying educational loans in exchange for full-time employment teaching at an eligible nursing school or working at a critical shortage facility. As with the NCSP, lack of funding for the NCLRP has severely limited the number of awards. The NCLRP is "highly competitive" with more applicants than available funding, with application rates of eight to nine times the number of awards given.<sup>169</sup> For example, in 2020 HRSA received 6,223 applications but only provided 456 initial awards and 291 continuation awards. The high number of nurses who apply for NCLRP support but are turned down due to lack of funding demonstrates that RNs, NPs, and APRNs are ready to fulfill unmet needs in critical shortage facilities and schools of nursing but may need federal support because of their student debt obligations.



## EXECUTIVE AND REGULATORY ACTION »

### IMPROVE THE NURSING WORKFORCE DIVERSITY PROGRAM

The NWDP provides grants “to increase nursing education opportunities for individuals who are from disadvantaged backgrounds (including racial and ethnic minorities underrepresented among registered nurses).”<sup>170</sup> To ensure a representative, culturally and linguistically competent nursing workforce, NNU urges the Health Resources and Services Administration (HRSA), which implements the NWDP, to allocate sufficient funding for research to gather data to better identify racial and ethnic minorities that are underrepresented among registered nurses. This research should include collecting and disaggregating workforce and patient data for Asian, Asian American, and Pacific Islanders and for gender oppressed and gender non-conforming people. Finally, in accordance with Section (b) of 42 U.S.C. § 296m, NNU seeks to work with the Health and Human Services Secretary to ensure a diverse RN workforce by increasing nursing education opportunities. NNU believes it is important for labor to participate in the nursing workforce diversity discussion and that we are well suited to provide that voice.

### IMPROVE THE NURSE CORPS SCHOLARSHIP PROGRAM (NCSP)

- » NNU strongly urges HRSA to simplify and ease the ways in which applicants to the NCSP can adjust the expected family contribution based on their actual financial circumstances, including based on their independent status, if they are not dependents on another’s income tax filings, have supported themselves in the prior year, or based on other relevant circumstances.

The NCSP awards scholarships, based on need, for students to attend an accredited school of nursing in exchange for a minimum two years of employment in a critical shortage facility after graduation.<sup>171</sup>

In addition, as will be required when the FAFSA Simplification Act is fully implemented, HRSA should affirmatively inform applicants that they may pursue adjustments to the expected family contribution based on their individual and family circumstances.

- » NNU urges HRSA to increase NCSP funding, particularly for ADN students, as well as devoting some Tier 1 funding to part-time students to enable those with child or elder care responsibilities to attend school.

In fiscal year 2019, approximately 68 percent of NCSP awards went to bachelor’s degree students, 27 percent to master’s degree students, while only 5 percent went to associate degree students, and no awards were made to diploma students.<sup>172</sup>

- » In addition, NNU strongly urges HRSA to substantially increase funding for NCSP “career pathway” awards which received only \$2 million of the \$89 million in funding in the fiscal year 2021 budget.

Career pathway funding provides scholarships to unlicensed assistive personnel (e.g., certified nursing assistants and home health aides) as well as licensed practical/vocational nurses so that they can become registered nurses. These individuals have both experience and a demonstrated commitment to providing health care which deserves recognition and preferential funding. Moreover, their experience, demonstrated commitment to caring for others, and pursuit of additional education strongly indicates their intention to remain in the health care workforce.<sup>173</sup> Finally, licensed practical/vocational nurses are likely to have completed some of the coursework necessary to becoming a licensed RN, potentially reducing the time from degree completion to entering the workforce.

**IMPROVE THE NURSE CORPS  
LOAN REPAYMENT PROGRAM  
(NCLRP)**

- » In defining funding preference tiers in the NCLRP, NNU advocates that HRSA use HPSA critical shortage facility scores and absolute debt levels rather than a debt-to-salary ratio, as using the debt-to-salary ratio creates an incentive for paying lower wages.  
  
NCLRP’s highest priority should be the placement of nurses in critical shortage areas. Moreover, NNU urges the executive branch to treat NCLRP loan repayment as nontaxable. Finally, NNU urges HRSA to include in NCLRP loan forgiveness all loans that a nurse obtained for training in vocational or practical nursing for coursework required to become an RN as well as loans that have been consolidated/refinanced with ineligible non-qualifying debt or loans of another individual if the eligible qualifying debt can be disaggregated from the ineligible non-qualifying debt.
- » To address the shortage of nursing faculty, NNU urges HRSA to increase NCLRP funding for faculty teaching positions. Funding for faculty teaching positions has been minimal historically and accounted for less

than 10 percent of the NCLRP fiscal year 2021 budget.

According to the American Association of Colleges of Nurses (AACN), a nursing faculty shortage is limiting teaching capacity. The AACN attributes the shortage to budgetary limits, faculty retirements, and competition from clinical jobs with better compensation. Increasing funding for faculty service positions could increase teaching capacity, which is crucial to ensuring that we continue to educate future generations of nurses.<sup>174</sup>

- » NNU also urges HRSA to prioritize placing NCLRP applicants in faculty positions in schools that have at least 50 percent of students from a disadvantaged background, followed by prioritizing the placement of applicants by absolute applicant debt levels rather than debt-to-salary ratio.

For faculty positions, the NCLRP prioritizes applicants with a higher debt-to-salary ratio and placement at a nursing school where 50 percent of students are from a disadvantaged background, as shown in the funding tiers table (Table 5). Insufficient funding has limited awards for teaching to the first three tiers shown. Increasing funding for the NCLRP would also allow awards to fulfill need in all four preference tiers.

Table 5. Funding Tiers for Teaching at a School of Nursing

| Funding Preference Tiers | Debt-to-Salary Ratio | Schools of Nursing (SON)   |
|--------------------------|----------------------|--|
| Tier 1                   | ≥100%                | SON with at least 50 percent of students from a disadvantaged background |
| Tier 2                   |                      | All other SON  |
| Tier 3                   | <100%                | SON with at least 50 percent of students from a disadvantaged background |
| Tier 4                   |                      | All other SON  |

Table 6. Funding Tiers for RNs, NPs, and APRNs

| Funding Preference Tier For RNs, NPs and APRNs | Debt-to-Salary Ratio | CSF Primary Care or Mental Health HPSA Score |
|--|----------------------|--|
| Tier 1   | ≥100%                | 25-14  |
| Tier 2   | <100%                | 25-14  |
| Tier 3   | ≥100%                | 13-0   |
| Tier 4   | <100%                | 13-0   |

- › In addition to increasing funding, NNU urges HRSA to prioritize NCLRP awards by HPSA scores, followed by prioritization based on an applicant's absolute debt levels rather than a debt-to-salary ratio in awarding loan repayment funds.

Similarly, the NCLRP prioritizes those with a higher debt-to-salary ratio and working at a primary or mental health critical shortage facility with a high HPSA score, as shown in the funding tiers table (Table 6). Lack of funding for the NCLRP has limited awards to Tier 1, leaving RNs, NPs, and APRNs with a lower debt-to-salary ratio without student debt support. This is especially troubling with respect to Tier 2, as it funds critical shortage facilities with high HPSA scores.



## CONCLUSION

The hospital industry has long engaged in profit-driven policies that result in unsafe staffing levels and poor working conditions. The industry's ongoing failure to protect the health and safety of nurses and patients during the Covid-19 pandemic is a continuation of these policies. The Covid-19 pandemic has become a convenient excuse to ignore their legal duties as employers to protect the nurses that are the backbone of our health care system.

Nurses have been treated as disposable during the pandemic through the hospital industry's refusal to provide necessary optimal personal protective equipment, imposition of long work hours, refusal of sick or quarantine leave and pay, failure to provide employees Covid-19 tests, demanding that nurses work even if they have been exposed to or are recovering from Covid-19, and disciplining nurses who speak out about unsafe conditions for workers and their patients.<sup>175</sup> Consequently, RNs have experienced high rates of Covid-19 infection, resulting in severe illness, lingering physical health effects, and death. The failure by hospital management to staff appropriately and provide the resources needed to provide safe, therapeutic patient care has caused nurses severe moral distress and moral injury (often incorrectly labeled "burnout"); mental health issues such as stress, anxiety, depression, and post-traumatic stress disorder; and physical exhaustion resulting in many nurses leaving the bedside to protect themselves, their nursing licenses, their families, and their patients.

Additionally, understaffing forces nurses to make morally distressing choices about how to allocate their available time for nursing care, and unsafe working conditions force nurses to make a morally distressing choice to provide patient care or protect their own health and safety. Moreover, crisis standards of patient care implemented during the pandemic have caused profound moral distress and injury for nurses as well as myriad adverse mental health effects<sup>176</sup> and are harmful to patients' health and well-being. The hospital industry's flagrant

disregard for the lives of nurses, their patients, and their families during the pandemic has taken both a physical and psychological toll on nurses, driving them to nursing jobs outside of the hospital setting or to leave the profession entirely.

Even with the widespread availability of Covid-19 vaccines, hospital industry policies continue to create abhorrent working and patient care conditions that drive nurses from the bedside. The pandemic is far from over and multiple infectious disease precautions, in addition to vaccines, are necessary. Although fewer RNs are contracting Covid-19, breakthrough infections continue to occur. Workplace exposure to Covid-19 continues to place nurses and their family members at risk, particularly for nurses who have young children or other family members who cannot yet be vaccinated, immunocompromised family members, or are immunocompromised themselves. Finally, there are regions in the country where hospitals are still operating under crisis standards of patient care.

National Nurses United urges Congress and the executive branch to support bold legislative and regulatory action to retain the current RN workforce and to encourage new nurses to enter the profession. Retaining the current RN workforce requires regulatory and legislative measures to ensure good, permanent, jobs with safe patient staffing, optimal workplace health and safety protections, fair wages, and robust union rights, including conditioning future pandemic relief funding for the hospital industry on implementing nurse retention measures. Encouraging future generations to enter the RN workforce requires vigorously funding nursing education and job placement programs. These actions should also focus on realigning our health care system to meet the needs of patients rather than the aims of the corporate hospital industry, and ensuring that the nursing workforce reflects the racial, ethnic, cultural, and socioeconomic diversity of our patients.

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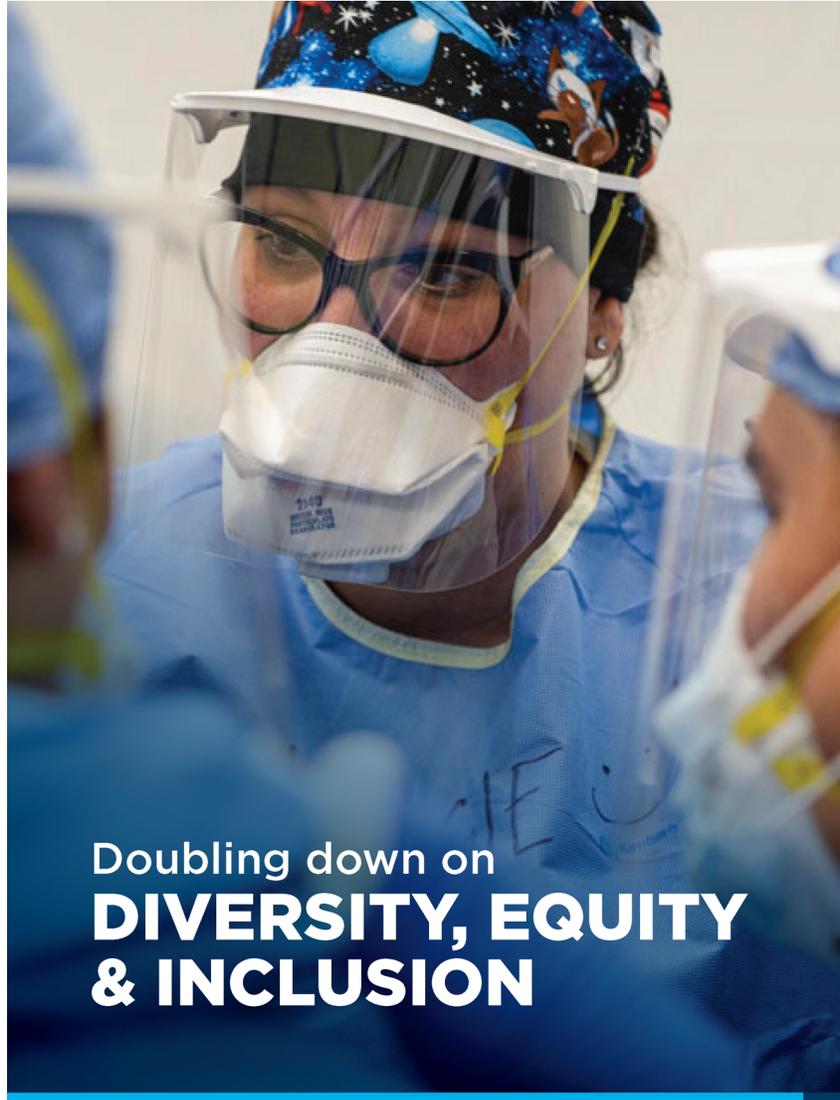




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Doubling down on  
**DIVERSITY, EQUITY  
& INCLUSION**



**Jim Skogsbergh**  
President and CEO  
Advocate Aurora Health

The year 2020 will undoubtedly go down in our nation's history as one of our most difficult years, exacerbated by the pain and suffering experienced by communities of color as our country battled two pandemics: COVID-19 and racism. As a health care leader, I recognize the opportunities Advocate Aurora Health has to make a difference in these areas from our vantage point as one of the top health systems in the country.

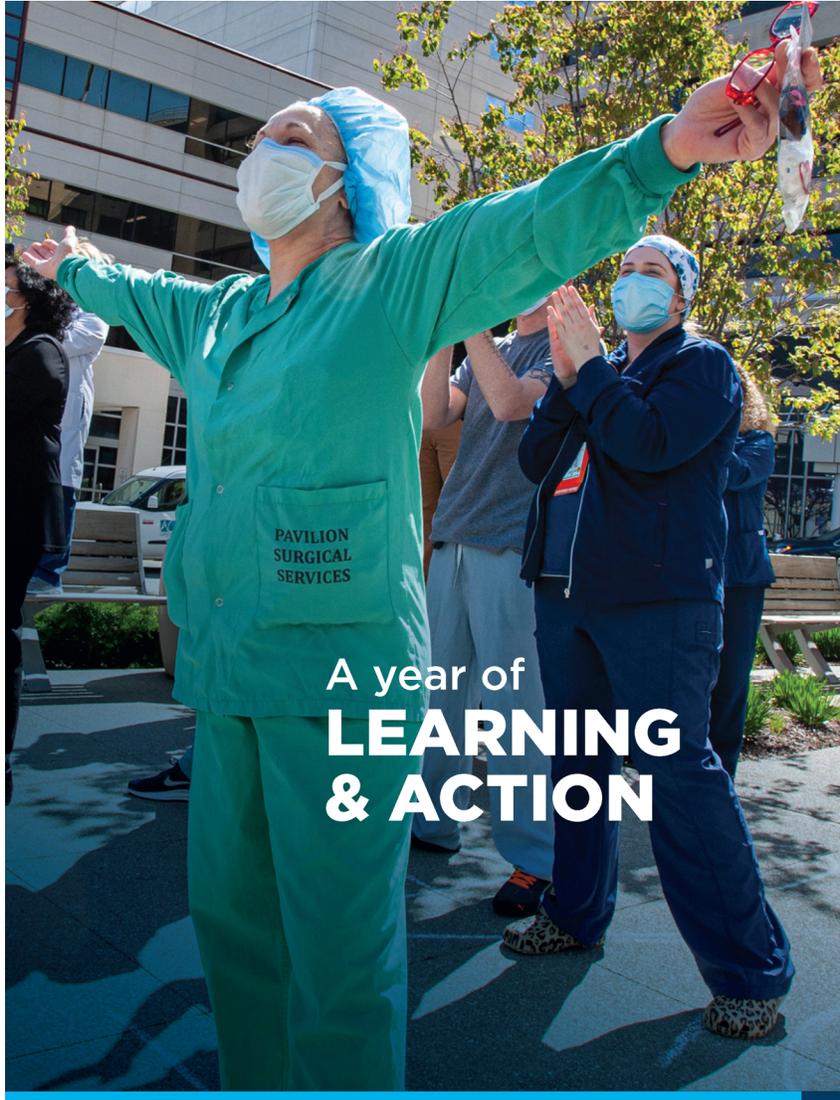
That's why our organization continued to build upon our foundational diversity practices, doubling down on our efforts to build a diverse and inclusive environment and ensure equitable care. We've focused on – and will continue to focus on – taking tangible action to affect real change by:

- Prioritizing health equity to ensure all people have the opportunity to live well
- Working in our communities to eliminate race-based barriers to health care employment
- Denouncing discrimination and racism by identifying and dismantling structural barriers in our organization

This report details the work we undertook to advance those initiatives in 2020. From supporting minority and women-owned businesses through our supply chain purchasing efforts to addressing health inequities by mobilizing free flu shot clinics in under-resourced areas, we answered the call to keep our communities healthy during this challenging year when health care was top of mind for everyone. At the same time, we responded to our nation's outcry for social justice reform by continuing our critical efforts to increase access to care in communities of color.

We recognize the need to evolve and grow as our world also continues to change. We must continue raising the bar to advance how we lead, who we are, who we will become and how we can meet the needs of the communities we are so very privileged to serve.

A handwritten signature in black ink, appearing to be the initials 'J.S.' with a stylized flourish.



A year of  
**LEARNING  
& ACTION**



**Cristy Garcia-Thomas**  
Chief External Affairs Officer  
Advocate Aurora Health

**Cristy Garcia-Thomas oversees diversity, equity and inclusion at Advocate Aurora along with shaping the overall experience for patients, team members and community partners. With a broad landscape to partner with and drive change, she also has oversight of community relations, charitable giving through our foundation, community health and community programs.**

Looking back on 2020, it's clear there were significant lessons to be learned. As we battled the dual pandemics of COVID-19 and racism, the common thread between these two issues is historically marginalized communities and people of color experience serious inequities that need to be addressed. The challenges of 2020 exposed the increasing need for outreach, education, services, technology and innovation to address health care challenges and barriers to improve outcomes across our communities.

Helping people live well is our purpose and delivering consistent, equitable outcomes for our patients, communities and team members is our priority. It's our responsibility to close gaps in the inequities within our control. COVID-19 shined a bright light on the inequities facing our patients, communities and team members, and has challenged us to not only stay true to our purpose but to double down on our Diversity, Equity and Inclusion (DE&I) strategy and connect it to our purpose. To that end, our Advocate Aurora Health Board of Directors has created a DE&I Board Committee, which elevates and supports our strategy at the highest level of the organization and ensures accountability that the strategy is embedded throughout our system.

For 2020 and beyond, we will continue expanding our successful DE&I strategy while developing innovative, new programs to address social determinants of health and work to eliminate health inequities.

*Cristy*



Diversity, Equity & Inclusion:  
**OUR COMMITMENT  
IN ACTION**

Advocate Aurora Health believes that a diverse workforce, in a thriving inclusive environment, delivers a higher level of equitable care, serving all patients across all communities. In this current climate, we must continue to evolve and grow as our world also continues to change. Now is the time to double down on our efforts. Our commitment is focused on three areas – our leaders and team members, patients and communities – to challenge us to raise the bar on how we lead, who we are and whom we serve.



#### **Our leaders and team members**

- Advance DE&I as a strategic organizational priority and enhance policies and processes
- Improve workforce diversity
- Increase engagement with team members of color
- Reduce turnover rate for team members of color
- Increase our representation of people of color in leadership



#### **Our patients and communities**

- Enhance safety, health outcomes and patient experience
- Improve patient-clinician communication and relationships
- Address health inequities across all communities
- Transform communities through strategic partnerships that support health and well-being
- Increase supplier diversity spend to support diverse and inclusive economic development in our communities



#### **Opportunities presented by COVID-19**

- Increased need for language services to meet increased demand for COVID-19 related health services, including testing tents and mobile units
- New technology demands for patient services and everyday operations
- Acknowledgement of racial tension by offering ways to effectively break down barriers
- With many community events cancelled, development of new ways of interacting and providing thought leadership

## OUR 2020 RESPONSE

### Researched

- Monitored real-time COVID-19 data to identify changing health care trends and inform our community focus

### Listened

- Reached high impact communities through listening sessions, focus groups and community meetings to gain insights about COVID-19 challenges and needs
- Hosted and participated in online discussions with community leaders and influencers
- Held internal discussions with more than 1,000 team members about current events and racial tensions

### Enhanced access

- Expanded on-site and remote translation and interpretation services to support research, health services and community outreach for patients who might avoid screening and testing for safety and privacy reasons
- Made changes to current systems and workflows to address unique LGBTQ health challenges

### Garnered support

- Launched new COVID-19 initiatives and programs, prioritized by importance and urgency
- Expanded distribution of multi-language health education resources
- Increased focus on mental health challenges exacerbated by the COVID-19 shelter-in-place and stay-at-home orders and social distancing precautions
- Partnered with other organizations to provide extra support, education and free health care services for new parents and babies affected by the pandemic





We're focused on recruiting and retaining a diverse array of team members because we know we're better when – by empowering diverse perspectives – we inspire creativity that leads to innovative solutions. We aim to cultivate an atmosphere of inclusion and compassion to create a welcoming and safe space for all our team members.

## SPOTLIGHT: REAL TALK CONVERSATIONS

**“It was time to become more comfortable with uncomfortable conversations.”**

***Tiffany Strong-Salaam,***  
*Director, Learning & Development*

We offered our team members a new virtual platform to share how they were feeling about this year's unprecedented world and local events. On top of a global pandemic, George Floyd's murder and the subsequent protests had a significant personal impact on our team members' mental well-being and psychological safety. Our team members needed a safe space to discuss, listen and share their feelings and personal experiences.

We developed a REAL Talk conversation series, creating a facilitator guide and compassionate conversations toolkit to support participants in these difficult conversations.

With more than 1,000 REAL Talk participants across our health care system, we were rewarded not only with appreciation for these sessions, but also an increased interest in DE&I and a new sense of personal responsibility to one another.



## Advocate Workforce Initiative (AWI)

With funding by JPMorgan Chase & Co., we continue to develop a pipeline of diverse talent from the greater Chicagoland area by seeking out individuals who are interested in entry- to mid-skill level health care careers. With the pandemic escalating while our 2019 initiative was concluding, we were able to continue program training, leveraging financial resources for 80% of our partners who were transitioning to virtual training platforms.

| AWI IMPACT TO DATE |   |
|--------------------|---|
| 1,192              | Participants completing the program         |
| 416                | Participants hired into health care careers |
| 114                | Participants hired by Advocate Aurora       |
| 91%                | Participants achieving 90-day job retention |

## Corporate internship program

For the last seven years, we've awarded competitive summer internships to a small group of students to support hard-to-fill corporate positions in our organization. To date we've hired interns from more than 40 colleges across the nation, partnering with local organizations that support underrepresented students.

Despite the pandemic and increased responsibilities on student and mentor participants, we placed eight interns with Advocate Aurora mentors. We provided meaningful projects during one of the most uncertain times in these students' lives – some of whom had family who were sick or died from COVID-19. We conducted online meetings, created team building connections and provided support by text and email during and beyond the internship.

**“I absolutely loved interning with Advocate Aurora and am so proud and blessed to be a permanent member of the Advocate Aurora team! It truly is an amazing organization.”**

*Julie Aspera, 2020 Intern, now part of the Advocate Aurora's Health Information and Technology team*

## Workplace transition policy and practice

In the fall of 2020, we created guidelines to support our transgender, non-binary and gender diverse team members who may be socially, legally or medically transitioning during their employment with Advocate Aurora. Our Human Resources and legal teams, as well as transgender team members, worked to adapt Human Rights Campaign policies specifically for Advocate Aurora and produce guidance sheets for transitioning team members, managers and Human Resources representatives.

## Team member development: LGBTQ cultural awareness

Based on feedback we received from team members participating in the Healthcare Equality Index (HEI) accreditation process, we're expanding our LGBTQ cultural awareness initiative and exploring easily accessible and trackable LGBTQ learning opportunities for our team members.



### **We've developed a personal pronoun information sheet**

to help team members increase their skills and comfort level using various pronouns to introduce themselves and ask others for their pronoun preference. Team members are now better equipped to ask patients sexual orientation and gender identity questions and use these answers to provide individualized patient care. This helps clinicians make more accurate and well-informed health decisions for patients. It also enhances reporting of health outcomes and inequities for this patient population.

## Earn-while-you-learn corporate apprenticeship program

We partnered with the Wisconsin Department of Workforce Development and the Wisconsin Technical College System to offer job seekers the opportunity to earn while they learn and expand their skills for middle-skill positions. Through the apprenticeship program, Advocate Aurora pays an hourly wage for our apprentices to attend the related classroom instruction portion of the apprenticeship. This allows apprentices to receive an income while working toward an industry certification. Apprenticeship allows access for individuals who might not have been previously considered for these roles due to lack of experience and proper certification. Through apprenticeship, we've been able to integrate diverse pipelines of talent for these roles. Eight apprentices have already started or are in the process of starting in the program.





## Inclusion council and core teams

The Advocate Aurora Health Inclusion Council is a newly launched, differentiated model for integrating DE&I into our health system with the support and passion of our team members. This model addresses the challenge of locally executing our system DE&I strategy by deploying 11 inclusion council core teams dedicated to leading DE&I action plans for our patient service areas, corporate functions and select ancillary services. Through this work, we're harnessing the collective strength of more than 150 team members who are trained in our DE&I strategy and key principles and behaviors, such as valuing differences and exhibiting courage. The teams are tasked with locally implementing DE&I efforts that will strengthen our culture of inclusion by improving team member engagement. The system inclusion council reports to our President and CEO Jim Skogsbergh and has involvement from our executive leadership team, patient service area presidents, hospital presidents and other executive leaders.

**“We’re excited to continue our DE&I efforts in our Patient Service Area and even more excited to see the collaboration and support from the system. This new approach brings us all together and aligns our work. Together we’re stronger and will have more meaningful impact at our workplace and in the community we serve.”**

***Paola Velasquez**, Manager, Patient Relations, Guest Services & Switchboard Operators  
Advocate Sherman Hospital*

## NAVIGATE career development program

We created the NAVIGATE career development program to address key obstacles many U.S. frontline workers face – a lack of training and opportunities to advance into higher paying jobs. NAVIGATE provides these marginalized workers with:

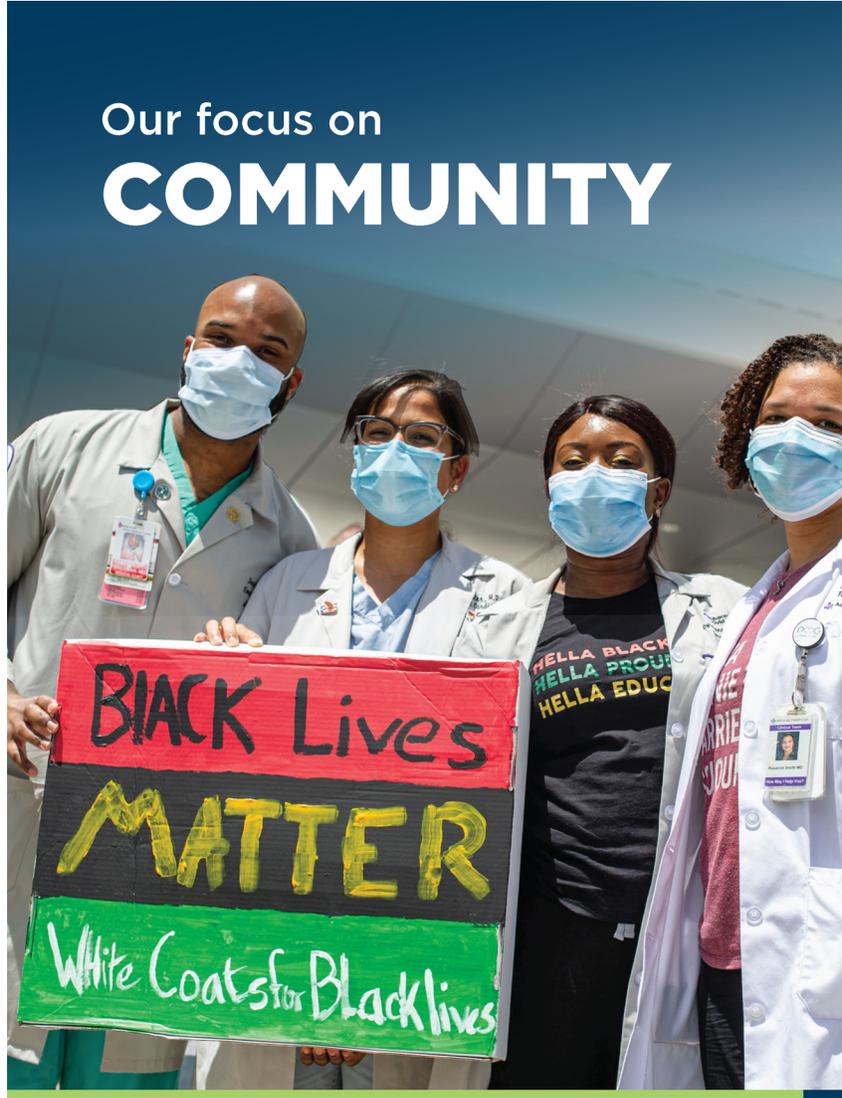
|                            |                               |  |
|----------------------------|-------------------------------|--|
| Essential skills workshops | Career coaching and mentoring | Resume development tips and interview preparations tools |
|----------------------------|-------------------------------|--|

Since starting in the Chicagoland area in 2017, NAVIGATE has expanded to other parts of Illinois and Greater Milwaukee. It's now available at eight Advocate Aurora sites with a goal to expand to our remaining 18 sites by 2024.

| NAVIGATE IMPACT TO DATE |   |
|-------------------------|---|
| 349                     | Total team members in the program             |
| 90%                     | Participants completing the program           |
| 12                      | Illinois participants promoted since Q1 2020  |
| 12                      | Wisconsin participants promoted since Q1 2020 |
| 8                       | Advocate Aurora sites with the program        |



Our focus on  
**COMMUNITY**



**As one of the top health systems in the country, we have an opportunity to be a leader for diversity, equity and inclusion – and it starts in our own communities. Through partnership and collaboration, we help our communities thrive from within.**

## Racial Equity Rapid Response Team



We've signed onto Chicago Mayor Lori Lightfoot's Racial Equity Rapid Response initiative, which is a data-driven and community-based mitigation of COVID-19 illness and death in African American and Hispanic communities. This initiative is a collaborative partnership involving other like-minded health systems and community partners that have a desire to incite real change to achieve racial justice and end health disparities.

Advocate Aurora also serves as a member of the Healthcare Anchor Network, alongside UChicago Medicine, Rush University Medical Center and Sinai Health System. Through this work, we've joined over 80 health care and social service organizations by releasing a joint statement to declare racism as a public health issue.

## Southwest Comprehensive Strategic Partnership Group



Led by Vernard Alsberry, Mayor of Hazel Crest, IL, this collaborative provides long-term solutions for issues impacting the health and vitality of the Southland region beyond the COVID-19 pandemic. Its 40 partners, including the South Suburban Mayors and Managers Association, focus on business and commerce, health care and community engagement. Over \$2 million has been raised, personal protective equipment (PPE) and emergency food was distributed, and community COVID-19 testing was provided. Advocate Aurora provided micro-mobile COVID-19 testing and offers flu shots in this area.

## Chicago's South Side Healthcare Transformation

A collaboration between Advocate Trinity Hospital, UChicago Medicine and St. Bernard Hospital, South Side Healthcare Transformation has engaged federally qualified health centers, faith leaders, community organizations, elected officials and residents to collaborate on a new health transformation plan for Chicago's South Side. Rooted in health equity, the goal is a community-driven process that connects existing health care organizations to maximize their current assets, increase quality of care and address social determinants of health. To date, more than 500 stakeholders have engaged through multiple virtual listening sessions, an online survey and a web-based response form.

## Living Well Community Conversations

To keep our communities informed about the COVID-19 pandemic, we started monthly *Living Well Community Conversations*. To launch this virtual community conversation series, we reached out to community members, faith leaders and businesses for their expertise and insight about COVID-19 related topics such as testing, mental health, flu immunizations and preparing for reopening. To date, we've conducted 11 virtual sessions in dual languages with an average viewership of more than 150 people. New video content is distributed monthly to more than 300 community partners in Illinois and Wisconsin, allowing viewers to tune in to live and recorded events on Advocate Aurora's YouTube and Facebook channels.

### Community conversations in dual languages



- Advocate Aurora virtual Living Well Community Conversation in Spanish with Erika Colón, Dr. Sofia Padilla and Dr. Federico Sanchez
- Roundtable discussions with Hispanic faith leaders in Illinois and Wisconsin, bringing faith leaders together to help us identify ways to partner to address health needs and the impact of COVID-19 in their communities

## Building COVID-19 preparedness for diverse business owners and faith leaders

In 2020, we launched a three-part virtual series to provide diverse businesses and faith organizations with guidance and resources on safely reopening during the pandemic. We developed a prevention plan and hosted virtual conversations for businesses who were looking to reduce the spread of COVID-19 among employees, patrons and the community. Leveraging our partnerships, we touched more than 500 businesses, 25 ZIP codes and 75 faith-based organizations. Similarly, our educational resources and COVID-19 prevention kits impacted more than 150 families.

**“Thank you for providing resources for our most pressing needs. The kits, educational resources and sessions with industry leaders for cleaning and sanitation, legal liability and socially distancing inside were extremely valuable.”**

*Rev. Marilyn Miller, Pastor of Reformation Lutheran Church*

## Healthcare Anchor Network



In 2017, Advocate Aurora was one of the founding members of the Healthcare Anchor Network (HAN), a national consortium of health systems dedicated to driving inclusive anchor strategies to positively impact the

social and economic determinants of health. Last year, Advocate Aurora was among a small group of health systems nationally announcing the HAN Community Investment Commitment, setting a goal to deploy \$50 million by 2025 to provide access to capital for critical needs like affordable housing, small business development and food centers in low income neighborhoods. Investment development is on target, with multiple community development financial institution (CDFI) partnerships established to begin deployment in 2021. In addition, we're again leading the way as one of five leading health systems participating in a new HAN initiative called the Impact Purchasing Commitment, which proposes to spend one billion dollars annually with minority and women-owned businesses by 2025. As part of HAN, we are identifying and committing to specific goals for local impact hiring from underserved communities and spending with local minority and women-owned businesses – with a focus on sustainable projects.

**“By our very nature, health systems are anchor institutions in the neighborhoods we serve. By implementing socially responsible hiring, training, purchasing and investment strategies, health care can help lesson economic, racial and environmental inequities.”**

*Mark Huber, VP, Community Health*

## Chicago Housing Authority health & wellness program

This is the fourth year of our continued partnership with Chicago Housing Authority (CHA). Our objective is to educate senior resident leaders of the CHA Northside Providers Council on how to navigate and assist other residents with resources available through Advocate Illinois Masonic Medical Center. Eleven of 20 senior resident building presidents – each representing an average of 200 senior citizens in their building – took part in the program.



**“Our efforts provide awareness, health and wellness education for a group that is often vulnerable. CHA residents represent a diverse group that Advocate Illinois Masonic’s comprehensive services can help meet their greatest need – a home where they can feel safe during these unprecedented times.”**

*Sandra Arellano, Coordinator, Community Network Development*

## GROWTH IN BUSINESS DIVERSITY SPEND



Despite the challenges of the COVID-19 pandemic, Advocate Aurora focused on strengthening our commitment to support nationally certified enterprises owned by persons of color, women, LGBTQ-identified individuals and veterans. We set our business diversity spend goal to 6% and aim to reach a goal of 6.6% in 2021.

|                                       | 2018                 | 2019                 | 2020                 |
|---------------------------------------|----------------------|----------------------|----------------------|
| Planning, design, construction        | \$36,059,843         | \$59,788,675         | \$90,630,508         |
| Supply chain                          | \$90,975,616         | \$97,759,899         | \$106,425,851        |
| <b>Total business diversity spend</b> | <b>\$127,035,459</b> | <b>\$157,548,574</b> | <b>\$197,056,359</b> |
| Percentage of total AAH spending      | 4.1%                 | 5.4%                 | 6.4%                 |

## Milwaukee Health Care Partnership

### MILWAUKEE HEALTH CARE PARTNERSHIP

In Wisconsin, Advocate Aurora spearheaded an effort with multiple health care organizations to establish a Racial and Health Equity Advisory Council within the Milwaukee Health

Care Partnership. Within this advisory council we have built an interorganizational anti-racism and health equity collaboration that is committed to being part of the solution to racism and injustice, both within our organizations and in partnership with local community groups. We're committed to advancing diversity, equity and inclusion to improve access to care, eliminate biases and address systemic drivers that contribute to poor health outcomes. Through this partnership we share a common purpose in enhancing representation at all levels of governance, creating workplace environments that cultivate belonging and reducing unjust inequities within the communities we serve.

## Health Equity Council community-based flu clinics

To keep our communities healthy, we must address gaps in the number of people receiving flu immunizations. From our research, we found a flu immunization gap of 25% in people of color in high impact ZIP codes who received the flu vaccine compared to non-people of color. To address this significant gap, we went into the community to provide free flu vaccines for our most vulnerable populations. Our data also demonstrated communities with the greatest gaps in flu immunization are among those most severely affected by COVID-19. This makes flu immunizations a viable mitigation strategy to reduce the risk of flu and flu-related hospitalizations while improving the health of the communities already battling COVID-19.

**“People are afraid to leave their homes. They’ve lost loved ones to COVID-19 and are severely affected, personally and financially, by the pandemic. By offering flu vaccines to anyone who presents, we’ve reduced the risk of illness and hospitalization.”**

*Dru Bhattacharya, VP, Diversity, Equity & Inclusion*



### 2020 FLU CLINIC IMPACT

|       |   |
|-------|---|
| 55    | Flu clinics in underserved communities  |
| 15    | Unique community-based partners   |
| 8,000 | Flu vaccines administered through October 2020  |
| 14x   | Increase in Advocate Aurora COVID-19 Virtual Care Program enrollments in Illinois, which was promoted on site via Chicago flu clinics |
| 9     | Media articles and TV news broadcast  |

## COVID-19 consultations and kits

To further mitigate and address COVID-19 among African Americans and Hispanics in Milwaukee and Chicago, we launched the COVID-19 Kit and Call initiative. COVID-19 kits were assembled and distributed upon discharge to all COVID-19 patients and patients under observation within data-identified high impact ZIP codes. About 10,000 kits were assembled and more than 4,000 have been given out. To address Milwaukee's COVID-19 uptick within the 53204 and 53215 ZIP codes, we formed a partnership with the area's Carmen South High School. During Carmen's student orientation, we offered virtual consultations with Advocate Aurora physicians and distributed more than 400 COVID-19 kits including educational materials in English and Spanish, masks, hand sanitizer and other supplies.

## LGBTQ COMMUNITY SUPPORT AND OUTREACH



**Demonstrating PRIDE:** With Illinois and Wisconsin festivals and parades canceled this year because of COVID-19, we found new ways to show pride and support for our LGBTQ communities during Pride Month. From wearing rainbow masks to showcasing our hospitals' health care equality index accreditations, we demonstrated that pride belongs everywhere, not just at parades.

**Cream City Foundation's 12th Annual Business Equality Luncheon:** In October, we sponsored and served as the keynote speakers for this virtual event. Erickajoy Daniels, our Senior VP and Chief Diversity, Equity & Inclusion Officer, and Dr. Michael Otte, an Advocate Aurora physician, spoke about Advocate Aurora's LGBTQ journey and continued commitment to the LGBTQ communities we serve.

## Salvation Army Emergency Lodge community support

The Salvation Army Emergency Lodge experienced serious challenges providing language access for individuals with limited English proficiency – especially for non-scheduled emergency visits requiring on-demand interpreters. As a partner, we provided phone equipment and access to our internal interpreters and telephonic partners to deliver prompt language access. Since the beginning of the year, we've provided interpreters for 37 successful patient appointments, totaling more than 1,150 minutes.



## Diversity investment program

As part of our advocacy efforts, we continue to break down barriers in the historically non-inclusive finance industry by:

|  |  |  |
|--|--|--|
| <p>Identifying, reviewing and working with diverse money managers and banking and investment firms to recruit diverse talent and strengthen their DE&amp;I efforts</p> | <p>Speaking as DE&amp;I experts at financial e-conferences throughout the year</p> | <p>Having 13 diverse vendors in our investment and banking pool to date. These vendors are expected to use and promote diverse talent.</p> |
|--|--|--|

## NBA All-Star Weekend Brunch

As a corporate partner for the Chicago Bulls, Advocate Aurora leveraged the NBA All-Star Game in Chicago to build new partnerships and connections with local and national buyers and diverse suppliers. In highlighting our supplier diversity initiatives in Chicago, the NBA's own supplier diversity effort made them a perfect partner. The Advocate Aurora Health NBA All-Star Weekend Brunch, hosted by our Board of Directors Chairman John Daniels and President and CEO Jim Skogsbergh, included appearances by former NBA players Horace Grant and Wayne Embry. It was attended by more than 100 community and supplier diversity leaders including Aon, Blue Cross Blue Shield, Manpower and others.

## Renewed commitment to Near West Side Partners

In 2020, Advocate Aurora renewed its commitment to serving as an anchor institution for the Near West Side Partners, a non-profit neighborhood collaborative with the mission to revitalize Milwaukee's near west side as a thriving business and residential corridor. By renewing our commitment, we pledged \$500,000 alongside other anchor institutions including Harley-Davidson, Marquette University, MolsonCoors and Potawatomi Business Development Corporation. Through our support, the non-profit has launched several efforts to promote economic development and boost greater safety for residents and businesses in the community.



## Community health care coordination

Advocate Aurora is committed to addressing health inequity while focusing on quality of care, safety and reducing the cost of care. Uninsured and Medicaid patients often present at our hospital emergency departments for low acuity health needs due to lack of access to care. Many experience multiple complex health and social needs that serve as barriers to their ability to live well and manage their chronic health conditions. Advocate Aurora has implemented three unique models to address the social and medical care needs of low-income patients in need of medical home and specialty care follow-up. A cross-functional team is constructing a hybrid model from those pilots, developing recommendations to advance the best practices learned.



### **Primary Care Connection program**

The Primary Care Connection (PCC) program at Advocate Christ Medical Center, Advocate Condell Medical Center, Advocate Sherman Hospital and Advocate Trinity Hospital, deploys Community Health Workers (CHWs) as community resource navigators to serve patients in the emergency department (ED). The program reduces unnecessary ED visits by connecting patients to a primary care home. CHWs educate patients about accessing the appropriate level of care and providing follow-up appointments to a convenient care site for patients during the ED visit. CHWs also conduct a community health assessment to identify social determinants of health and link the patients to social services and community resources that improve patients' overall well-being. From January to September 2020, the program served more than 4,400 patients at an estimated cost avoidance of nearly \$465,000, with a less than 3% 90-day re-admission rate among all patients.



### **Transition Support Program**

In 2020, we provided care coordination and assistance for 4,200 patients through our Transition Support Program (TSP). TSP helps patients navigate health care and social determinants by addressing the needs of our growing uninsured population and patients experiencing significant economic hardship because of the pandemic. Many of our patients have low health and tech literacy and cannot navigate telehealth independently. The TSP successfully reduces readmissions by improving post-discharge appointment scheduling, compliance and patient satisfaction.



#### Coverage to Care program

The Coverage to Care (C2C) program is managed by Aurora Family Service in Wisconsin at three sites – Aurora Medical Center – Kenosha, Aurora Sinai Medical Center and Aurora St. Luke’s Medical Center. Masters-prepared social workers provide intensive transitional care management services for high users of the emergency departments (ED). Patients identified for the program demonstrate frequent ED use driven by social needs that traditional approaches have failed to fully support. The program focuses on reducing avoidable ED utilization and inpatient admissions for patients significantly impacted by social determinants of health. Tailored health care plans are developed with the patients and implemented over three to six months to connect them to primary care and community based social services. On average, C2C demonstrated a decrease in ED visits of 40% and a decrease in associated ED charges of 50% among the patients served.

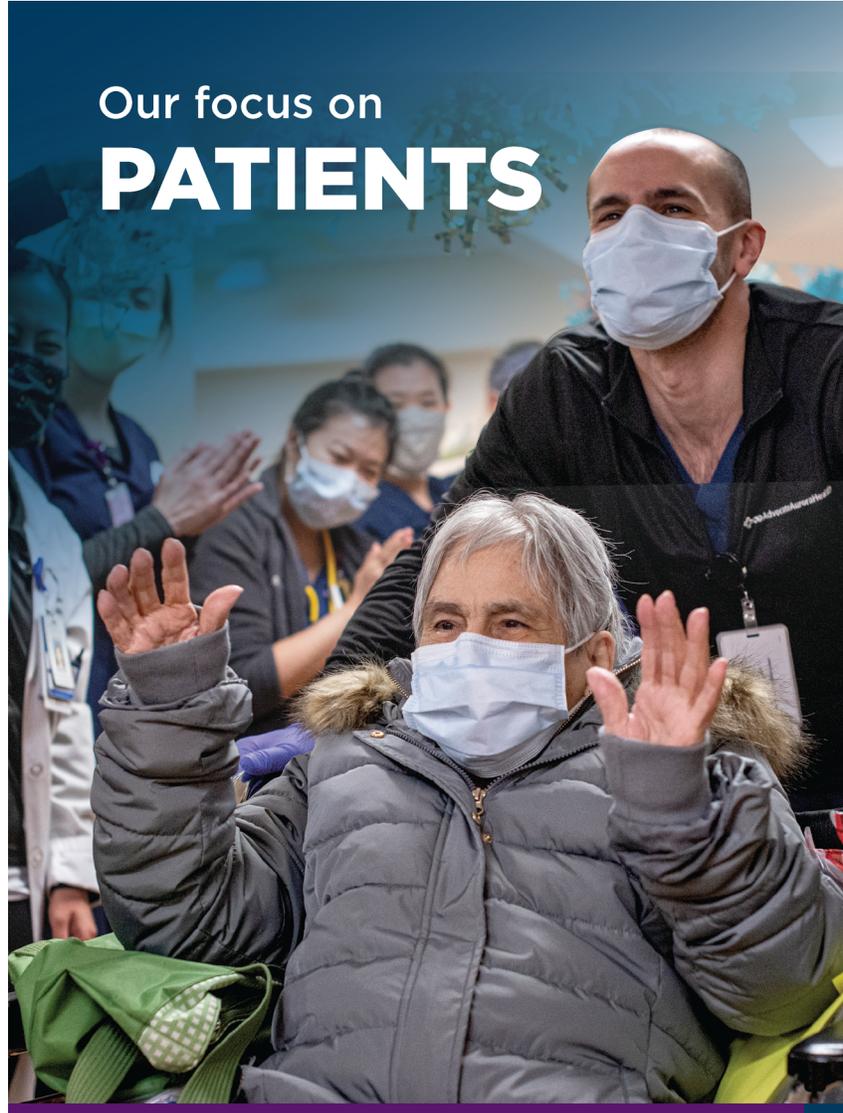
## NowPow

Advocate Aurora is contracted with NowPow, a women-owned and led technology company that provides a multi-sided referral platform including a local community resource directory, social determinants of health (SDOH) screenings, resource matching algorithms and the ability to track referrals. Advocate Aurora uses the program to provide important SDOH resource referrals to our patients. During the pandemic, Advocate Aurora leveraged NowPow to provide team members access to the platform so they can identify resources to meet their needs. A pilot in south Chicagoland showed 25% of patients screened through NowPow demonstrated a need for SDOH support. Food security and affordable housing were the top two needs identified.



## COVID-19 community testing

To combat the spread of COVID-19 in our most vulnerable communities of color, Advocate Aurora was an active provider of micro-mobile COVID-19 testing in high impact areas such as Chicago’s South Side, providing more than 1,500 individuals with free tests. Drive-through testing at Condell and Imani Village provided an additional 5,000 tests in Illinois. In Wisconsin, we partnered with the Division of Health to obtain donated test kits and lab work valued at more than \$6.8 million. Twelve drive-through testing sites were established across the state to deploy those kits. In total, we provided more than 68,000 community COVID-19 tests through drive-through and mobile test sites across our health care system.



Because health care is built upon relationships, it's important for the people we serve to be able to trust us to meet their unique needs. And better understanding our patients' needs allows us to create an environment where our patients can heal – ultimately improving health outcomes.

## LGBTQ Healthcare Equality Index designation

The Human Rights Campaign's Healthcare Equality Index (HEI) is the national benchmarking tool that evaluates health care facilities' policies and practices related to equity and inclusion for LGBTQ patients. To demonstrate our commitment to inclusive health care, all our hospitals underwent the HEI accreditation process and all 26 hospitals were designated LGBTQ healthcare equality leaders – with a perfect HEI score of 100.

**THIS MEANS WE:**

1.
**Ensure foundational protections for patients, visitors and staff in patient and staff policies through cultural competency training**
2.
**Demonstrate progress toward inclusive LGBTQ patient care and support**
3.
**Cultivate an inclusive workforce by providing LGBTQ employee support and benefits**
4.
**Demonstrate public commitment to the LGBTQ community**

We're building on our 2020 HEI successes by directly licensing HEI training for use on our own internal learning management system. This helps us prepare for future accreditation and gives our team members opportunities to continue their LGBTQ health equity and inclusive care education.



**HUMAN  
RIGHTS  
CAMPAIGN  
FOUNDATION**

## Increased collection of sexual orientation and gender identity data

This year, we trained more than 7,000 team members on our new electronic health record system Epic and increased capacity to collect important personal data related to patients' sexual orientation and gender identity (SOGI), preferred pronouns, organ donation preferences and relationship status. All Advocate Aurora teams are trained to help them understand the importance and value of consistently collecting SOGI and inclusive sexual health data from all patients. This helps clinicians make more accurate and well-informed health decisions for patients, while enhancing reporting of health outcomes and disparities.

**“Our work in this area is especially important this year as we saw certain rollbacks of federal health care protections for the LGBTQ community. By showing our commitment to them, our LGBTQ patients can be sure they will continue to receive the same standard of care because our purpose is to help people – ALL people – live well.”**

*Mallory Krumrei, DE&I Clinical Operations*

## LGBTQ clinical care

This year, we enhanced our clinical capacity to treat and care for patients with HIV. This resulted in:

|  |   |  |   |
|--|---|--|---|
| <p>A new clinical screening workflow specific to referrals between primary care, infectious disease and gastroenterology</p> | <p>Adding anal Pap smear to our available LGBTQ clinical services</p> | <p>Designing new clinical training for LGBTQ specialized providers</p> | <p>Adding a new “Service to HIV Clinic” function to our electronic health record system</p> |
|--|---|--|---|

In addition, Advocate Illinois Masonic Medical Center implemented a new pilot policy for the emergency department (ED) using an opt-out rather than opt-in approach to HIV screening as recommended by the CDC to reduce the stigma of HIV testing. Under this approach, ED patients are informed they'll undergo an HIV test as part of ED policy and consent is implied unless the patient specifically declines or opts out of the test.

### THE RATIONALE BEHIND THESE GUIDELINES IS TWOFOLD:

1. **The non-targeted approach lessens stigma and statistical discrimination associated with targeted testing.**
2. **Its psychological framing of the choice (opting out versus opting in) promotes increased test acceptance.**



## TEAM MEMBER SPOTLIGHT: Joelle Espinosa



**As Advocate Aurora's Civil Rights Director with a passion for accessibility and a background in education, restorative justice and conflict resolution, Joelle Espinosa is integral in our pursuit of total health equity.**

Early in the pandemic, the media brought attention to people disproportionately affected by the virus – particularly Black and Hispanic communities – highlighting the same issues she works on every day. “I was happy to see that the media was taking notice and this issue was finally getting the attention it deserved,” Joelle said.

Joelle began partnering with organizations to put communities at ease about testing and teamed up with the Brand, Consumer Experience and Public Affairs team to quickly launch Advocate Aurora's COVID-19-specific website. Joelle recommended translating the website and our COVID-19 symptom tracker into Spanish since Hispanics are the population with the highest number of individuals with limited English proficiency.

During this period, another ongoing issue came to a head – a lot of patients were on halal, kosher or other special diets and needed menu options that followed those dietary preferences. With COVID-19 protocols in place, Joelle helped our system navigate this challenge by partnering with Food & Nutrition Services to develop a kosher and halal menu that was translated into multiple languages and is now available across all Advocate Aurora facilities.

Joelle contributed significant restorative justice insights and tools to help develop our REAL Talk Conversation sessions in response to the deaths of George Floyd and Breonna Taylor and other African Americans across the country this year.

What really stands out to Joelle about the DE&I team's accomplishments is: “Our ability to evolve and grow so quickly, and create an impact. Change never comes rapidly, but we've been able to affect access and shift the culture in how we treat patients. We do this work because we believe in it.”

**“So much about racial inequality has been brought to the forefront this year. George Floyd's killing was traumatic for so many of our team members. It became a point of contention within some teams, departments and locations because it became such a politicized, polarizing topic.”** *Joelle Espinosa, Civil Rights Director*

## New language services strategies

Despite the challenges of the pandemic, we proactively deployed strategies to help provide uninterrupted access to language services for patients and their families.

We expanded our video interpretation capabilities by deploying more than 500 new iPads, bringing our total to 1,400. Phones, iPads and computers helped connect our patients in nearly 850,000 interactions across 98 languages in 2020.

As the use of telehealth increased, we seamlessly integrated interpreters into the telehealth platforms to continue communicating with patients in their preferred language, resulting in nearly 2,000 telehealth visits with an interpreter.

We ensured vital COVID-19 information was provided in languages other than English to help mitigate the spread in at-risk communities of color. In total, 32% translated documents included COVID-19 related content. In a similar vein, our main webpages were upgraded to include Spanish translations with plans to incorporate other key languages.

We added a new multi-language online COVID-19 symptom tracker tool for populations with limited-English proficiency, directing them to appropriate health care resources.

We provided onsite interpreters, equipment and software for COVID-19 testing trailers, screening tents, mobile units and entrance screening tables throughout Illinois and Wisconsin.

**“Our commitment to making sure our patients are able to receive their health information in their native language speaks volumes about our commitment to the community. Providing access to health care through communication is a key component to health equity and healthy living – which everyone deserves.”**

*Emmanuel Chepkwony, System Director, Cultural & Linguistic Services*

**Onsite interpreters at community health care events included:**



**A diabetes outreach event for English class students at the Elgin (IL) YWCA**

**Employee health screenings at Lakeside Foods in Manitowoc, WI**

**An Aurora Sheboygan Memorial Medical Center tour for more than 35 adult English as Second Language students (Spanish, Burmese and Rohingya)**

**Palermo Pizza employee COVID-19 testing in Milwaukee (Spanish and Rohingya)**

**INTERPRETING IMPACT**

|         |   |
|---------|---|
| 518     | Upgraded video devices in Illinois  |
| 1,449   | Total video devices   |
| 189,547 | Calls using Video Remote Interpreting (61% handled by Advocate Aurora team members) |
| 522,754 | Over the Phone Interpreting calls   |
| 1,921   | Telehealth visits with interpreting services  |

## COVID-19 hotspot analysis and reporting

In direct response to the pandemic, we developed an online DE&I dashboard with analysis of data from 26 hospitals across races, ethnicity, age groups, health conditions and ZIP code groups. Our objective was to identify trends and anticipate health care needs across our entire system based on testing, positive diagnoses and deaths. Using Advocate Aurora data and trend identification, we:

Located COVID-19 testing sites in high-risk areas and provided outreach and education activities in those communities

Deployed 10,000 COVID-19 relief kits to discharged patients that included masks, educational materials, healthy recipes and seasoning packets

Reported weekly data trends to community advocacy groups to support messaging, outreach and mask deployment in at-risk communities

Served as panelists for community webinars, discussing how data informs our COVID-19 strategy



## A CONVERSATION ABOUT 2020 with Erickajoy Daniels



As our Chief Diversity, Equity and Inclusion Officer, Erickajoy Daniels is responsible for driving the execution and operations of our DE&I strategy across Advocate Aurora. Within DE&I, she oversees language services, civil rights and business diversity spend. We asked for her insights about the biggest DE&I challenges, lessons and victories this year.

### What do you think was the biggest DE&I takeaway from the events of 2020?

What has really struck me is this year was like a dual pandemic with the spread of COVID-19 and racial protests around the country. The tension mounting on the streets was pouring into our walls and inside our organization. As a health care organization, we had to ask: What was our responsibility for that? What should we do to address it?

### So how did you address it?

We approached it in three ways:

1.

**We had to be vulnerable** enough to honestly acknowledge as a health system that strives to provide a healthy, healing environment, the external fear and racial tension was disrupting healing – not just in our communities, but for our own team members. We needed to help our teams process the confusion, pain and anger they were feeling to encourage healing. We did this by offering REAL Talks, facilitated sessions created to have uncomfortable conversations about race in a safe environment. We also doubled down on our commitment to a safe, diverse and inclusive environment by creating an actionable 2021 plan from what we learned in our REAL Talks and from our communities this year.

2.

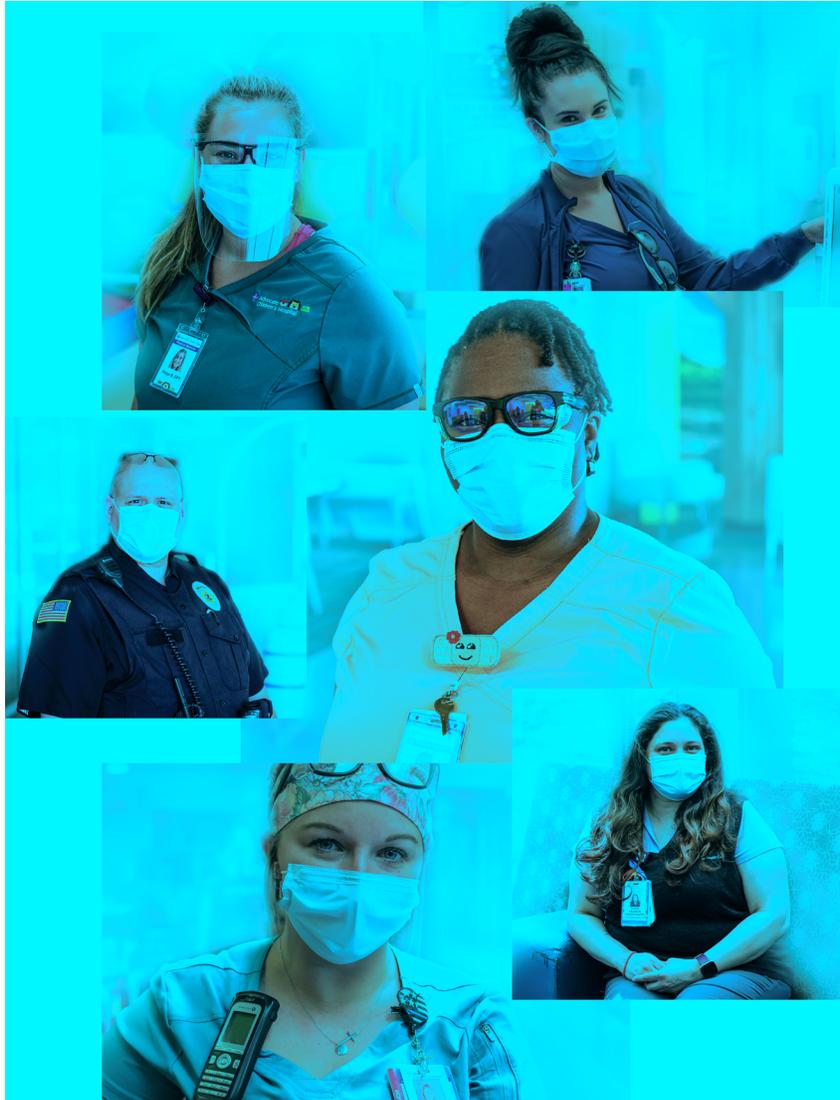
**We had to be connected** enough to our communities to understand how to help them. Our purpose is to help people live well. For us, living well was disrupted by a whole lot of things going on this year. We'd create tools and messaging and education plans for the community, and we'd think they were great. But the community response was, "That's not relevant for us right now. Don't just tell me to go home and throw my things in the washing machine. What if my washing machine is down the street at a laundromat – which I'm now quarantined from? I need guidance that is relevant for me." We had to reach out to people in their own environments, in their own languages, to find out what they needed and how to successfully deliver.

3.

**We had to be agile** enough to continuously assess, shift and ask what is our best course of action right now? As a health care system, we knew it wasn't just about giving people COVID-19 tests and saving lives. We had to act in real time, responding to what was immediately in front of us, but not lose sight of our longer-term strategies to impact change in the future. I praise the work of our language services teams who had to be redeployed remotely but managed to leverage technology to ensure there was no disruption in our ability to offer interpretation services for our patients and their families. Even so, when there were emergent outbreaks, particularly among diverse communities, interpreters were deployed on-site to assist. Whenever and wherever language assistance services were needed, the teams were notified and timely deployed culturally relevant and linguistically appropriate educational materials.

#### **Did we have the impact you'd hoped?**

My hope is that what we delivered this year really improved the lives of our patients, our teams and our communities. Every day people needed to know: "Should I wear a mask or not wear a mask? Am I washing my hands and clothes enough? When I bring groceries home, do I need to spray them down?" That kind of confusion is something we wanted to mitigate. We supported mobile units, patients and teams by providing medical supplies, public service materials, language services and technology. We focused on delivering trusted, practical support to people where and when they needed it. By doing these things, I hope we demonstrated we always question why people aren't able to live well and how we can change that in our patient care and our workplace.





[Whereupon, at 11:39 a.m., the hearing was adjourned.]

○