S. HRG. 118–187

EXAMINING HEALTH CARE WORKFORCE SHORTAGES: WHERE DO WE GO FROM HERE?

HEARING

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED EIGHTEENTH CONGRESS

FIRST SESSION

ON

EXAMINING HEALTH CARE WORKFORCE SHORTAGES

FEBRUARY 16, 2023

Printed for the use of the Committee on Health, Education, Labor, and Pensions

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

U.S. GOVERNMENT PUBLISHING OFFICE

54–460 PDF WASHINGTON : 2024

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

BERNIE SANDERS (I), Vermont, *Chairman*

PATTY MURRAY, Washington
ROBERT P. CASEY, JR., Pennsylvania
TAMMY BALDWIN, Wisconsin
CHRISTOPHER S. MURPHY, Connecticut
TIM KAINE, Virginia
MAGGIE HASSAN, New Hampshire
TINA SMITH, Minnesota
BEN RAY LUJÁN, New Mexico
JOHN HICKENLOOPER, Colorado
ED MARKEY, Massachusetts

BILL CASSIDY, M.D., Louisiana, *Ranking Member*
RAND PAUL, Kentucky
SUSAN M. COLLINS, Maine
LISA MURKOWSKI, Alaska
MIKE BRAUN, Indiana
ROGER MARSHALL, M.D., Kansas
MITT ROMNEY, Utah
TOMMY TUBERVILLE, Alabama
MARKWAYNE MULLIN, Oklahoma
TED BUDD, North Carolina

WARREN GUNNELS, *Majority Staff Director*
BILL DAUSTER, *Majority Deputy Staff Director*
AMANDA LINCOLN, *Minority Staff Director*
DANIELLE JANOWSKI, *Minority Deputy Staff Director*

C O N T E N T S

STATEMENTS

THURSDAY, FEBRUARY 16, 2023

EXAMINING HEALTH CARE WORKFORCE SHORTAGES: WHERE DO WE GO FROM HERE?

Thursday, February 16, 2023

U.S. SENATE,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The Committee met, pursuant to notice, at 10 a.m., in room 430, Dirksen Senate Office Building, Hon. Bernard Sanders, Chairman of the Committee, presiding.

Present: Senators Sanders [presiding], Murray, Baldwin, Murphy, Kaine, Hassan, Smith, Luj̀an, Hickenlooper, Markey, Cassidy, Paul, Collins, Murkowski, Braun, Marshall, Romney, Tuberville, and Budd.

OPENING STATEMENT OF SENATOR SANDERS

The CHAIR. The Senate Committee on Health, Education, Labor, and Pensions will come to order. As I have mentioned before, and as everybody knows, this Committee covers a huge gamut of issues that impact the American people. And the reality is, as everybody knows, that there are going to be some issues where there are going to be very strong disagreements, and we will simply agree to disagree and hopefully do that in a respectful way.

There are going to be other issues, however, that impact every state in this country where in fact there should be strong bipartisan support. And the issue we are discussing today is one of those issues. Let me just start off my remarks, then I'm going to give the mic over to Senator Cassidy, and we will have questions, and everybody will have their time.

But let me start off by telling you what the panelists certainly know, and we thank all of them for being here today, and every Member here knows, and that is the United States will face a shortage of up to 124,000 physicians by 2034, including 48,000 primary care physicians. By 2025, the United States will have a shortage of up to 450,000 nurses.

Right now, and this is an issue we don't discuss much as a Nation, and I intend to see this Committee discuss it, we need approximately 100,000 more dentists across the United States. We have a major crisis in terms of access to dental care in Vermont, and I expect every state in this country.

The number of people who live in areas without enough health care providers, I think will use the word health care deserts since

it is the common term used, 99 million primary, 70 million dental, 156 mental health, which everybody in this Committee knows is a horrendous crisis in America.

Here is my hope, my hope that we can do what the pundits tell us that we can't do, and that is actually deal with the issues facing the American people in a serious, nonpartisan way because these issues impact every state in America. I want to thank our excellent panelists. I read the testimony and I thank you all for being here.

Let me begin by saying that it is no secret to anyone that our Country faces many health care crises. Despite spending almost twice as much per capita on health care as any other major country, we spend $13,000 per person, man, woman, and child on health care, we have massive shortages in health care providers.

Today, we are going to focus on that crisis. And that is that we simply do not have in our Nation enough doctors, nurses, nurse practitioners, dentists, dental hygienists, pharmacists, mental health providers, among other medical professions. And what is the impact of those health provider shortages? What does it mean to ordinary people?

It means that nearly 100 million of our people live in a primary care desert, where they are unable to gain timely access to a doctor when they need it. It means that nearly 70 million people live in a dental care desert, unable to get dental care while teeth in their mouths are rotting.

It means that some 158 million Americans, nearly half our population, live in a mental health care desert at a time when this country is facing an unprecedented mental health crisis. Simply put, it means that a significant percentage of our population live in places where they cannot access the health care they desperately need in a timely manner.

Got to tell you, bumped into some people in Vermont, and we do better than most states, I think. A guy goes in, he wants a, just a checkup. Four months later, he will get that checkup. That is in Vermont. In my view, the reality is, this reality is a contributing factor to the declining life expectancy we are seeing in many parts of our Country and the fact that our overall life expectancy is lower than many, many other countries.

Life expectancy, as I think we all know, is not simply a factor of access to health care. Deals with economics, a lot of other things. But access to health care is an important part of why people are living shorter lives.

Here is a point that you are going to hear me make over and over again, and that is that not only does the lack of medical professionals in many parts of this country lead to increased human suffering and unnecessary death, it is incredibly wasteful from a financial perspective.

If people cannot access a primary care doctor, they may end up in an emergency room, which is the most expensive form of primary health care. Somebody goes to a community health center, somebody goes to an emergency room. Going to the community health center is 1/10th the cost to Medicaid than going to the emergency room.

If their illnesses continue because they don't go to a doctor when they should, they may end up in a hospital running up tens of thousands or hundreds of thousands of dollars of unnecessary expenses if they got the treatment that they needed when they needed it.

Study after study shows that disease prevention saves money. If people are able to access care when they need it, if there are enough medical professionals to provide that care in every part of this country, our health care costs go down.

A shortage of health care personnel was a problem before the pandemic, and now it has gotten much worse. Health care jobs have gotten more challenging and in some cases more dangerous. Many thousands of our health care workers have died from COVID, we all know that doctors, nurses, others, taking care of the American people.

These are genuine heroes and heroines, and we owe them more than we can ever pay back. According to the best estimates, over the next decade, our Country faces a shortage of over 120,000 doctors, including a huge shortage of primary care physicians. And our goal, as long as we get more doctors, is to get them to the places where they are needed, often in rural areas, in urban areas.

We don't need more folks on Park Avenue in New York City. We need them in rural areas where people can't access a doctor, in urban areas where the waiting lines are too long. Over the next 2 years, it is estimated we will need up to 450,000 more nurses. Today it is estimated we need 100,000 more dentists.

In America today, there is a massive shortage and we will discuss this at length in another occasion, in terms of mental health providers. and that is psychiatrists, psychologists, social workers, counselors, addiction specialist, and many more. In addition to our overall crisis in health care providers, that problem is especially acute in minority communities, and we are going to be discussing that today.

We desperately need more African American, Latino, and Native American health care personnel who are way, way underrepresented in the health care profession. How we address these crises is the subject of today's hearing and of a lot more future discussions that we will all be having.

But talk and hearings, frankly, are not good enough. Our job is to get the best information we can as quickly as we can, put that information into good legislation and to pass that legislation. Let me very briefly talk about some of the thoughts that I have, others who will have different thoughts.

First, it is a no brainer to understand that when over 100—over 10,000 medical school graduates are unable to fill residency slots every year, we must significantly expand and improve the graduate medical education program. That is not within our jurisdiction. It is in the Finance Committee. But it is something that we have got to look at.

Further, and in the jurisdiction of this Committee, we must also greatly expand the teaching health center program, another really

good program that allows residents to work in community health centers and in primary care. Very important.

Further, at a time when young people are graduating from medical school, dental school, and nursing school deeply in debt, everybody here has talked to graduates, doctors leaving $400,000, $500,000 in debt.

It is pretty obvious that those people graduating with huge debts are not going to go to rural America, not going to go to urban America. They are going to go to places where they can make a lot of money. And that is why we must substantially, in my view, increase student loan debt forgiveness and scholarships through the National Health Service Corps Program.

We have expanded that in recent years. We have got to do more. Further in terms of nursing, boy, that is an issue that I think impacts everybody. Despite a major nursing shortage, and I will tell you in my own State of Vermont, and I talked to Senator Collins about it, I think it is true all over this country.

We in our hospital in Vermont are spending $125 million on traveling nurses, an insane amount of money, and yet we have young people in Vermont who want to become nurses. Our nursing schools can't accommodate them because we don't have enough teaching personnel or the kind of equipment that we need.

Totally crazy, and that is an issue I look forward to us addressing. Well, that is about it for me. And you know, I want to say also a word about emergency medical services. I know in Vermont, rural areas, you got great people, often volunteers. They have to pay for their own training. I hope that that is an issue we deal with as well.

Bottom line is, look, we have an issue that the American people want us to resolve. It should be a bipartisan issue. I intend to work with Republicans and Democrats to make sure that we get good legislation through. Senator Cassidy.

OPENING STATEMENT OF SENATOR CASSIDY

Senator CASSIDY. Thank you, Mr. Chairman. The COVID–19 pandemic has strained our health care system. It has placed a huge burden on health care workers. So, as we come out of the pandemic, this hearing is to address workforce issues. Why are there still shortages post-pandemic? Which are most pressing? And how do we get the understanding to address it? There is an old saying in internal medicine, don't just do something, think.

We must first think about what we should do. Now, physicians in hospitals in Louisiana tell me they need nurses. And speaking as a physician who had the great fortune to work with many incredibly talented nurses, they are essential. Goes without saying. There are different things we can do.

I am going to use an example of a woman I once worked with to explain the concept of upskilling. Linda started off in the clinic as a Medical Assistant. She kept going to school and got her LPN. Kept going to school and got her BSN. Kept going to school and got her masters, and at the end was the Nurse Manager in the clinic in which she had begun as a Medical Assistant. That is upskilling.

Along the way she improves her family, helps patients, but demonstrates for her children the power of education and the power of delayed gratification. There is a lot in that story that can inform what we should be doing on national policy. And Linda, you know who you are, wherever you are, I am talking about you.

Now, something that is—by the way, this is not all Federal. We know that there is a shortage of nurse educators. But when you look at the requirements in some states, mine included, you have to have a master's of nursing to be a nurse educator. Now, I have worked with certificate nurses who have been by the bedside for 20 years who knew nursing. The idea that we cannot use someone such as she in order to educate others, I think doesn't acknowledge how much she knows.

This is a way to remove a choke point which is preventing all these applicants from having more slots in which to go to fill our nursing shortage. Now, I agree with the Chair. We can and should work in a bipartisan way to address nursing shortage and other shortages aside from nursing.

My hope for this hearing is to identify those other providers and those areas, as the Chair mentioned, such as rural areas that have critical workforce needs. But why don't we use the workforce we have more efficiently? I say that because there was a recent study, just before the pandemic, in the Annals of Internal Medicine that found that physicians spend as much as 16 minutes per patient filling out the electronic health record.

Now speaking to my colleagues, many of them retire early because they are sick of that. It is a major cause of burnout. So that which has been implemented by the urging of the Federal Government is creating the problem of physician workforce shortage.

For the patient, it is a difference between having a physician type on a screen as he tells you that you have cancer or looking into your eyes and telling you that you have hope. We need to give that physician the ability to communicate hope. This is something this Committee can look into, understand, and address.

On a larger scale, the Federal Government invests billions toward health care workforce programs. We need to continue to support what is working, understand what is not, and fix that which is broken.

We have to be good stewards of the taxpayers' dollars, not wasting money. We have to be productive. This year, the Committee is tasked with extending mandatory funding for programs like the National Health Service Corps, which offers loan repayment and scholarships to health care providers in exchange for working in a health professional shortage area. And the Teaching Health Centers Graduate Medical Education Program, which supports the cost of training medical and dental residents in outpatient settings.

Additionally, we are tasked with reauthorizing the Children's Hospital Graduate Medical Education Program set to expire this year. This program, this legislation supports training of pediatrician and pediatric subspecialists, noting that nearly half of all pediatric residents train at a children's hospital.

It is important that the funding for these programs is extended on time, in a bipartisan fashion, and that it be paid for. Finally, I know today's witnesses have innovative ideas on how hospitals and academic institutions can support the pipeline of health professionals.

One of my witnesses will speak directly to that. The Federal Government does not play the only role in seeking a solution to workforce shortage. We need to hear the perspective of these experts as we bolster America's health care workforce moving forward, and while doing so, just like Linda, create more opportunity for the individual. Thank you.

The CHAIR. Thank you, Senator Cassidy. We have a great panel of witnesses, and I thank them all for coming.

Our first witness will be Dr. James Herbert, and I first met Dr. Herbert when Senator Collins brought him to a hearing that we did. I would like Senator Collins to introduce him. Senator Collins.

Senator COLLINS. Thank you so much, Mr. Chairman. I am delighted to introduce Dr. James Herbert, President of the University of New England, located in Biddeford and Portland, Maine.

Dr. Herbert has served as President of UNE since 2017. As the Chairman has indicated, he offered extraordinarily insightful testimony before the Primary Health Subcommittee in 2021, and I thank the Chairman and the Ranking Member for inviting Dr. Herbert back to testify today.

UNE is one of a handful of private universities with a comprehensive health education mission, including medicine, pharmacy, dental, nursing, and an array of allied health professions. UNE ranks in the top 20 of medical schools nationally for educating primary care physicians, particularly those trained in rural medicine.

UNE is the largest provider of health professionals to the State of Maine, the only medical school in our state, and offers Northern New England's only dental college. Dr. Herbert holds a doctorate and master's in clinical psychology from the University of North Carolina at Greensboro, and a B.A. in Psychology at the University of Texas at Austin.

Dr. Herbert, welcome back. I have appreciated your many insights that you have shared with me, and I am delighted that the Chairman and Ranking Member have invited you to return and share those insights with the Full Committee. Thank you, Mr. Chairman.

STATEMENT OF JAMES HERBERT PH.D., PRESIDENT, UNIVERSITY OF NEW ENGLAND, BIDDEFORD, ME

Dr. HERBERT. Thank you so much, Senator Collins. Thank you very much, Chairman Sanders and Ranking Member Cassidy, and other Members of the Committee for inviting me to speak with you today.

As the Senator said, my name is James Herbert. I am from the University of New England in Maine. I won't repeat who we are because Senator Collins just told you. Thank you very much. I

would stress that we consider ourselves a private university with a public mission, and we are very proud of that public mission.

As you probably all know, Maine is the oldest state in the Nation. We have one of the oldest health care workforces, and we are tied with Vermont being the most rural state in the Nation. The challenges that we face today in Maine are harbingers of what the rest of the country will increasingly confront as our Nation ages and as urbanization creates pockets of underserved populations, not only in our cities, but also in our vast rural areas.

I won't detail the shortage of health care professionals. Senator Sanders has done that very nicely, and I know you all appreciate the scope of the problem. What I would like to do today is to briefly outline six specific strategies that I believe can go a long way to address this crisis.

At UNE, we are attempting to address each of these strategies. I don't pretend that we have all the answers, but we have found that what is critical to moving the needle are strategic partnerships between higher education, Government, business, nonprofits, and philanthropy. And it is that partnership that allows us to move forward.

First and most fundamentally, we must increase the number of doctors, nurses, and other health care professionals that we educate. But educating more professionals is not as straightforward as it might seem. The biggest challenge is the limited availability of clinical training opportunities.

As financial margins have tightened and clinician workloads have increased over the past three decades, practicing clinicians have less time to train students. The single most important thing we can do to increase the number of health care providers is to support partnerships between universities, and community, and health care entities to develop additional clinical training opportunities.

This includes revision of the Center for Medicare and Medicaid Services' antiquated policies around funding graduate medical education, which Senator Sanders touched on. Tuition for many healthcare professional programs is high and can be an impediment to many students. I assure you this is not because greedy universities are trying to get rich on the backs of students.

Rather, the cost of educating students has skyrocketed. Just for example, in our case, the costs of training third-and fourth-year medical students has increased fivefold since I assumed this position in 2017. Scholarship and loan repayment programs are critical to make health care education more accessible to those who would otherwise find it out of reach.

As Senator Sanders mentioned, the National Health Service Corps is one example of such a program, but it is simply inadequate in many ways to meet current needs. Another barrier that has been mentioned is the difficulty in hiring and retaining qualified faculty members who can typically earn more in the private sector in direct or indirect clinical settings than at universities.

Support such as that displayed by Senator Collins and Sanders and others for a strategic health care faculty loan repayment pro-

grams is critical to ensuring the future of the health care workforce. So, the second thing we must do is to intentionally recruit more students who look like the communities that they serve.

It is well-established that individuals from underrepresented groups are more likely to seek needed health care services from practitioners who share their identities and backgrounds.

Third, it is not enough merely to train more professionals. As Senator Sanders mentioned, we must address their maldistribution in society. That is, we must encourage them to practice in underserved areas following graduation, such as in tribal and rural and medically underserved communities.

Like Maine, most states have vast rural areas of distributed population, and these communities have far less access to health care. Financial support in terms of loan repayment programs, strategic loan repayment programs to practice in underserved areas is critical, and I thank Congressional leadership for their ongoing support.

But these programs are currently insufficient. In the case of physicians, for example, the loan repayment subsidies don't compensate for the typical salary gap between rich urban and suburban communities on the one hand and underserved urban and rural communities on the other.

Fourth, we must leverage the power of technology to reach underserved communities. Telehealth and digital medicine have tremendous potential to help in this regard. Fifth, we need changes to state level regulations to allow health professionals to practice at the top of their scope of practice.

Across the U.S., many states have laws that prevent some health care professionals from providing services that they are perfectly trained and able to provide. Many states made temporary changes to increase the flexibility during the pandemic, and such flexibility should be continued.

The focus of scope of practice regulation should be on what level of regulation results in the best outcomes in terms of health care safety of the population, and not managing guild driven turf wars between professionals. Sixth, and finally, the most fundamental change. We must fundamentally change the prevailing educational model in two ways.

First, accrediting bodies need to allow training programs to be more creative and innovative and flexible, without sacrificing educational quality, to adopt new models. This includes so-called career laddering, opportunities that don't completely remove professionals from the workplace as they are training to upskill.

Accrediting bodies should also accept more high-quality clinical simulation hours in place of hours physically spent in clinical settings, and that reduces the burden on hospitals that I touched on earlier. The second educational reform, and I will conclude, involves breaking down the traditional silos that characterize health care training and practice.

Anyone who has recently been in a hospital or has cared for a loved one in a hospital understands how siloed the practice of health care tends to be. In response, an educational model has

emerged in which students are trained to work together in multidisciplinary teams, and this is known as interprofessional education.

This model is shown to improve outcomes, improve patient satisfaction, decrease medical errors, and decrease provider burnout. So, in conclusion, successfully addressing America's health care workforce crisis will require not merely acting on each of these individual initiatives in isolation, but in strategically combining them.

I am grateful for your time and consideration. Thank you.

[The prepared statement of Dr. Herbert follows:]

PREPARED STATEMENT OF JAMES HERBERT

Thank you, Chairman Sanders, Ranking Member Cassidy, and other Members of the Committee for the opportunity to speak with you today. It's an honor to share some thoughts on strategies for addressing our Nation's healthcare workforce crisis.

My name is James Herbert, and I am the president of the University of New England (UNE). UNE is Maine's largest private university, with campuses in Biddeford and Portland Maine and in Tangier Morocco. We are a comprehensive university that houses Maine's only medical school and only physician assistant program, and northern New England's only dental school. We're the largest provider of healthcare professionals to the State of Maine, [1] and we take great pride in being a private university with a public mission.

As you probably know, Maine's population is the oldest in the nation [2] and is tied with Vermont as being the most rural [3] state. Our healthcare workers are also among the oldest in the country, with many practitioners approaching, or even practicing beyond, retirement age. [4] The challenges we face are in some sense harbingers of what the rest of the country will increasingly confront as our Nation ages and as urbanization creates pockets underserved populations in our cities as well as in our vast remote rural areas.

I won't detail the growing shortage of healthcare professionals across our Country, as I'm sure you already appreciate the scope of the problem. Rather, I will offer ***six specific strategies*** that I believe can go a long way to addressing the crisis (these are summarized briefly in Appendix A). I will also offer some examples of how we at UNE are attempting to implement each of these strategies. This is not to imply that we've figured out all the best solutions, but rather to provide some specific examples of how higher education can partner productively with the government, business, and nonprofit sectors to move the needle in important ways on this critical problem.

First, and most obviously, ***we must increase the number of doctors, nurses, and other healthcare professionals we educate*** to address our growing population, aging workforce, and many underserved communities. But educating more professionals is not as straightforward as it may seem; we at universities face a number of barriers in doing so. I will briefly touch on the three most important of these challenges.

By far the most important impediment to training more healthcare providers is the availability of clinical training experiences in hospitals and clinics, which has been well documented by the Department of Health and Human Services Health Resources and Services Administration (HRSA). [5] As financial margins have tightened and clinician workloads have increased over the past three decades, healthcare facilities and practicing clinicians have fewer resources and less time to devote to

---

[1] UNE offers programs in 14 health professions, including osteopathic medicine, dental medicine, pharmacy, physician assistant, nursing, nurse anesthesia, dental hygiene, occupational therapy, physical therapy, social work, nutrition, athletic training, applied exercise science, and public health.

[2] Maine has the highest median age in the U.S.: 44.7 years relative to the national average of 38.8 (U.S. Census Bureau, 2022). At 21.3 percent Maine also has the highest percentage of citizens over 65 in the U.S. (U.S. Census Bureau, 2019b).

[3] U.S. Census Bureau, 2019b

[4] At 39.3 percent, Maine ranks first in the Nation for the percentage of active physicians who are age 60 or older (AAMC, 2021). In 9 of16 Maine counties, 50 percent or more of physicians are 55 or older (Skillman & Stover, 2018). Over 50 percent of Maine's registered nurses are 50 or older (Maine Nursing Action Coalition, Center for Health Affairs NEONI, 2017).

[5] U.S. Congress: Advisory Committee on Interdisciplinary, Community-Based Linkages. (2018).

training students.[6] *The single most important thing we can do to increase the number of healthcare providers is to support and expand partnerships between universities and community healthcare settings to develop additional residencies, clerkships, practica, and other training opportunities*. In medicine in particular, the Center for Medicare and Medicaid Services' (CMS) payment system for graduate medical education (GME; i.e., physician residencies) favors academic medical centers, places caps on successful rural residency programs making expansion difficult, and penalizes community hospitals that may have previously partnered with other institutions. In other words, CMS policy is antiquated and makes it very difficult to grow more residency placements.[7]

At UNE, one way we have expanded clinical training opportunities is by working with partners in rural and underserved primary care sites and federally Qualified Health Centers. One advantage of such placements is that students learn how to deliver compassionate care to Maine's most vulnerable residents, many of whom are uninsured and also navigate chronic physical and mental health conditions. The precepting clinicians in these settings are dedicated to treating underserved patients, sometimes with limited access to specialized professional support.[8] These settings afford students exposure to a broad range of conditions and allow them to perform and assist with a wide variety of procedures.

Clinical training opportunities are not the only infrastructure limitation to producing more healthcare professionals. Cost, both to educational institutions and to students themselves, is also a factor. Standing up new educational facilities, or expanding existing ones, involves considerable startup costs. One-time governmental support is often needed to supplement institutional investments and philanthropy.[9]

Tuition for many programs is high and can be an impediment for many students, especially those from poor, working class, or even middle-class backgrounds. Contrary to certain narratives, this is not because greedy universities are trying to get rich on the backs of students.[10] Rather, the costs to educate students have risen considerably. For example, the cost of training third-and fourth-year medical students has increased fivefold since 2017. Scholarship and loan repayment programs can make healthcare education accessible to those who would otherwise find it out of reach. The National Health Service Corps is one example of such a program; however, it is inadequate to meet current needs in many ways. Only a limited number of professions are covered, the competition is high with many applicants being turned down, the scholarship or loan reimbursement amounts are inadequate, and the kinds of eligible sites (FQHCs, tribal clinics, etc.) are too limited.

A third barrier to training more healthcare professionals is the difficulty hiring and retaining qualified faculty members, who can typically earn more in direct care clinical settings and yet require a higher level of training and credentialing than those working clinically.[11] Support such as that displayed by Senators Sanders, Collins, and others for strategic loan repayment programs targeting those assuming faculty positions in health professions is critical to ensuring the future of the healthcare workforce. Loan repayment programs improve access to graduate/doctoral education by encouraging qualified individuals to advance their education and subsequently become employed as faculty.[12] Title VIII programs, such as the Nurs-

---

[6] Benbassat, 2020; Cox & Desai, 2019; Hanna, 2019; Hatfield et al., 2022; Graziano et al., 2018; Konrad et al., 2010; Krehnbrink et al, 2020; de Villiers et al., 2018; Rodriguez, 2013

[7] CMS policies for GME have established caps on most existing residency programs and although CMS created a somewhat circuitous pathway for rural hospitals to expand beyond their cap, the criteria of the review committees of the Accreditation Council on Graduate Medical Education (ACGME) create significant obstacles to accredited expansion and the creation of new rural residency programs.

[8] Hempel et al., 2015; Lee et al., 2016.

[9] An example of an effective public-private partnership is UNE's establishment of our College of Dental Medicine. Recognizing the region's significant unmet oral healthcare needs and the fact that there was no dental school in all of northern New England, in 2013 we partnered with both Federal and state governments, regional industry, non-profits, and philanthropists to establish a dental school. Senator Collins was critical in helping to secure Federal support for that project. And the people of Maine passed a $3.5 million bond to support not only creation of the school itself, but also community dental clinics around the state to help them increase their capacity to provide dental care and to take our students on rotation. The school was created with an explicit focus on addressing underserved populations.

[10] An exception being certain predatory foreign medical schools, particularly in the Caribbean, that cater to American students who cannot gain entry into domestic medical schools and which charge exorbitant tuition.

[11] Christmas et al., 2010; Feldman et al., 2015; Girod et al., 2017; Nauseen et al., 2018

[12] The case of dentistry is illustrative of the problem. The number of dental school graduates entering an academic career immediately following graduation is quite low. For the Class of

ing Workforce Development Programs, are an example of an important step in addressing this issue.

In addition, in some cases practicing clinicians can be recruited to serve as faculty instructors in their existing workplaces. For example, we have developed a new accelerated nursing program, in which existing employees of Maine's largest healthcare system are trained onsite by a combination of our own faculty and hospital clinicians.

Despite these challenges, at UNE we continuously seek to increase the number of health profession students we educate. For example, we have increased the size of our nursing program 300 percent over the last decade, and we have a grant under review with the U.S. DOL to further bolster our nursing training. We are currently in the process of increasing the class size of our medical students from 165 to 200 per year, our dental students from 64 to 72 per year, and our graduate registered dietician program from 80 to 100 per year. And with these increases we remain focused on quality training, as evidenced by the fact that our students routinely score above the state and national means on clinical board exams, and our medical students have among the highest residency match rates in the Nation.

The second strategy for addressing the Nation's healthcare workforce involves ***intentionally recruiting and training more students who look like the communities we need to serve***. It is well established that individuals from underrepresented groups are more likely to seek out practitioners who share their identities and backgrounds.[13] Studies have found that minority patients who are treated by race/ethnic-concordant clinicians are more likely to use needed health services and are less likely to delay seeking care.[14]

In Maine, we have a growing immigrant population, especially from Central and Eastern Africa, and not surprisingly, this community experiences significant healthcare discrepancies relative to the broader population.[15] To address this issue, not only has UNE increased recruitment efforts targeting students of color across the entire university, we recently expanded our "Advanced Standing" programs in dentistry and pharmacy, which are designed to accelerate the time it takes for foreign-trained immigrant professionals to achieve a U.S. degree and become eligible for licensure. We have also developed partnerships with local community colleges to matriculate students from our immigrant communities into certain healthcare programs (e.g., dental hygiene).[16]

Third, it's not enough merely to train more healthcare professionals, ***we must address their maldistribution within our society. That is, we must encourage healthcare providers to practice in underserved areas, including rural, tribal, and medically underserved urban communities***. Like Maine, most states have vast rural areas with highly distributed populations, and these communities have far less access to healthcare.[17] The U.S. Government has invested in programs, administered through the Health Resources and Services Administration, that provide financial support in the form of loan repayment to graduates who serve in disadvantaged areas. These programs are absolutely critical, and we thank Congressional leadership for their ongoing support. However, they are insufficient. For example, in the case of physicians, the loan repay-

---

2022 graduates responding to the American Dental Education Association Senior Survey, 0.7 percent (13 of the 1,757 respondents) indicated they plan to work as a faculty/staff member at a dental school after graduation (Istrate et al., 2022). An additional consideration is that most dental schools provide little exposure to academic careers. At UNE's College of Dental Medicine (CDM), dental students may participate as teaching assistants, tutors, peer mentors in the simulation and patient care clinic, or conduct research with faculty to be exposed to elements of an academic career. To date, out of six graduating classes, five alumni have returned to teach as part-time adjunct faculty in the CDM, one is an adjunct faculty in UNE's dental hygiene program, one recently joined the CDM as a full-time faculty member, and eight serve as preceptor faculty at CDM clinical affiliation sites where fourth-year students complete community-based externship rotations.

[13] LaVeist et al., 2003; Shen et al., 2018; Takeshita et al., 2020

[14] Handtke et al., 2019; LaVeist & Nuru-Jeter, 2002; Saha et al., 2000;

[15] Drewniak et al., 2017

[16] National Academies of Sciences, Engineering and Medicine, 2021.

[17] The U.S. Department of Health and Human Services has designated nearly 248 geographic areas in Maine as health professional shortage areas for primary care, dental health, and mental health, as of December 31, 2022 (Maine Center for Disease Control & Prevention, 2023). Maine also has 51 medically underserved areas/populations, defined as areas having too few primary care providers, high infant mortality, high poverty, and/or a high elderly population. Nearly all of Maine's medically underserved areas are in Maine's Congressional District Two, the second most rural congressional district in the country (U.S. DHHS, 2019).

ment subsidies do not compensate enough for the typical salary gap between rich urban and suburban communities and underserved urban and rural areas.[18]

The paucity of physicians and other healthcare providers practicing in rural areas is particularly acute, fueled in part by the decline of students from rural backgrounds pursuing healthcare education.[19] At UNE, we have successfully used a three-prong strategy to encourage our graduates to practice in rural areas. We intentionally recruit students from rural areas, both from Maine and around the country. Students from small towns and other nonurban areas are more likely to return to such communities after graduation.[20] Regardless of where they come from, we place students in clinical training sites in underserved rural areas as part of their education to give them a taste of rural practice and lifestyle. Each year, many graduates exposed to these crucial settings during rotations return for employment, inspired by the commitment to quality patient care they witnessed, as well as their love of small-town life.[21] For example, between 2013 and 2019 up to 53 percent of our medical students who completed a rotation in a rural community hospital in Maine returned to those areas to practice regardless of where they did their residency or where they were originally from. Our experience is consistent with research demonstrating a direct relationship between exposure to rural settings in physician residency training and subsequent work in rural communities.[22]

Finally, in concert with state and philanthropic partners, we have developed loan repayment and scholarship programs to incentivize practice in rural settings. These efforts have paid off; over the past decade we have made dramatic inroads in addressing the needs of rural communities. For example, 40 percent of UNE medical school graduates who practice in Maine do so in health profession shortage areas (HPSAs) designated by the U.S. Government, positively impacting the HPSA designation of five counties.[23] And in our dental school's first six graduating classes (2017—2022), we educated 377 dentists, 27 percent of whom are currently practicing in Maine. Of those practicing in Maine, 57 percent are practicing in a Dental Health Professional Shortage Area (HPSA), 47 percent are enrolled as MaineCare providers or are in a practice that accepts MaineCare, and 17 percent practice in a FQHC or non-profit clinic.[24] Nearly one in five is employed in a federally Qualified Health Center, a non-profit community clinic, or the Veteran's Administration, and four in ten are practicing in Maine's most disadvantaged areas.[25]

The fourth strategy for addressing the healthcare workforce crisis involves technology. Specifically, ***we must leverage the power of technology to reach underserved communities***. The COVID–19 pandemic introduced many Americans for the first time to the value of telehealth, as we all learned to access healthcare providers via videoconferencing.[26] Telehealth and digital medicine have enormous potential to transform healthcare delivery, particularly in underserved areas.[27] In addition to patients accessing their providers through secure videoconferencing platforms, primary care providers in remote locations can themselves access specialist colleagues in urban tertiary care hospitals and university health centers for expert consultation. And emerging digital medicine and artificial

---

[18] In addition to scholarship and loan repayment programs, revisions to Medicaid reimbursement schedules are needed to meet the needs of rural populations and to incentivize clinicians to practice in these areas. Rural populations tend to be more reliant on Medicaid to pay for healthcare. In the case of dentistry, for example, coverage and reimbursement rates vary by state. The low reimbursement rates and cumbersome preauthorization and claims processes deter many practitioners from accepting Medicaid insurance.

[19] Shipman, S. (2019)

[20] American Academy of Family Physicians, 2016; Hu et al., 2022; Lee et al., 2021; University of Wisconsin, 2020;

[21] UNE's dental school clinical model is an excellent example of success in this regard. UNE places students in up to two 12-week clinical rotations in settings throughout northern New England, working in collaboration with a network of FQHCs, non-profit clinics, and private dental offices. Students provide billable services while receiving supervision from the preceptor and most importantly, learning about the community they serve. We are grateful for the U.S. Department of Health and Human Services' on-going funding to Maine's network of health centers providing access to many of our marginalized residents, while also offering much-needed clinical placements to students.

[22] Russell et al., 2022.

[23] NCAHD's Enhanced State Licensure Data, 2016; The Robert Graham Center, 2012.

[24] Department of Professional and Financial Regulations, Maine Board of Dental Practice: Provider directory; Maine Care Services, Provider directory; Health Resources & Services Administration, Find shortage areas; National Plan Provider and Provider Enumeration System, NPPES NPI registry.

[25] This is particularly noteworthy given that Maine has the second fewest (just ahead of New Hampshire) dental providers participating in Medicaid or CHIP in the entire country, according to the American Dental Association's Health Policy Institute (2019).

[26] Wosik et al., 2020

[27] Kichloo et al., 2020

intelligence technologies will increasingly allow clinicians to monitor patient symptoms and even deliver certain treatments remotely over the internet. These technologies can also enhance the education of students in health profession programs but also the reach and effectiveness of continuing medical education programs. At UNE, we are integrating robust telehealth training for all of our health profession students in close partnership with our various training sites.

Fifth, ***changes to state level regulations that allow health professionals to practice at the top of their scope could help address health care workforce shortages***. ''Scope of practice'' defines what services or procedures a particular type of health professional is trained for and is legally permitted to provide. Across the U.S., many states have scope of practice laws that prevent some health professionals from providing certain services even though they are trained and prepared to do so. Temporary changes to increase flexibility of such regulatory practices were made in many states around the country during the pandemic to help address the pandemic related workforce crisis. Continuing such flexibility should be seriously considered. The focus when it comes to developing scope of practice regulation should be on what level of regulation results in the best outcomes in terms of health and safety of the population, not on managing guild-driven turf wars between professions at the ''edges'' of their scope of practice. Overlap and redundancy between professions is a good thing, especially during times of workforce shortages.

Sixth and finally, ***we must fundamentally change the prevailing educational model in two ways***. First, accrediting bodies need to allow training programs to be more creative and flexible—without sacrificing educational quality of course—to develop novel training models. This would include so-called ''career laddering'' opportunities that do not completely remove the individual from the workforce while they are pursuing an advanced degree, such as a physician assistant or nurse practitioner becoming a physician, a dental hygienist becoming a dentist, or a certified nursing assistant becoming a registered nurse. In addition, accrediting bodies should accept more high-quality clinical simulation hours in place of hours physically spent at clinical sites, thereby reducing the burden on clinical sites.

The second educational reform involves breaking down the traditional siloes that characterize healthcare training and practice. Anyone who has recently been a patient in a hospital, or who has cared for a hospitalized loved one, understands how siloed the practice of healthcare tends to be. Far too often, healthcare professionals are all practicing their respective crafts with scant communication and coordination among themselves. This siloed practice is a result, at least in part, of the traditional discipline-centered model of educating healthcare professionals. In 2001, the Institute of Medicine issued a groundbreaking report, Crossing the Quality Chasm: A New Health System for the 21st Century, which laid out the case for dramatic, systemic changes to health care organization and delivery. In response, stakeholders from academia, health systems, and government convened to determine how best to address the Institute's recommendations. In 2012, these efforts led to the development of a new educational model in which students from diverse disciplines are explicitly trained to work together, across traditional boundaries, in multi-disciplinary teams. Known as "interprofessional education"[28] or "IPE" for short, this training model prepares students with team-based competencies, attitudes, and skills that complement distinctive disciplinary knowledge. Interprofessional health care teams offer more than any one discipline can achieve alone, and this is especially critical as patients' health conditions are becoming increasingly complex.[29] Growing evidence suggests that interprofessional collaborative practice[30] improves clinical outcomes,[31] reduces medical errors,[32] increases patient satisfaction,[33] and decreases provider burnout.[34]

The IPE training model, especially when paired with digital health technologies, can be instrumental in meeting the needs of underserved communities.[35] The com-

---

[28] Interprofessional Education occurs when two or more professions learn about, from, and with each other to improve collaboration and the quality of patient care.

[29] Mayo & Williams-Woolley, 2016

[30] According to the World Health Organization, interprofessional collaborative practice happens when multiple health workers from different professional backgrounds work together with patients, families, care givers, and communities to deliver the highest quality of care (World Health Organization, 2010)

[31] Lutfiyya et al., 2019

[32] Anderson & Lakhan, 2016; Hardisty et al., 2014; Irajpour et al, 2019; Lygre et al., 2017; Wilson et al., 2016

[33] Will et al, 2019

[34] Cain et al., 2017; Dow et al., 2019

[35] One particular area of healthcare that exemplifies the value of this kind of collaborative approach is geriatrics. Diseases of aging often encompass a broad scope of conditions and disciplines: heart disease and diabetes treated by primary care practitioners; mobility issues by physical and occupational therapists; isolation by social workers; oral health by dentists and hygienists, and so on. At UNE, we weave training in geriatrics throughout all of our health profes-

Continued

bination of IPE and telehealth allows doctors, mid-level clinicians, and other primary care practitioners to effectively expand their scope of practice, while also extending specialist care to those for whom it is otherwise out of reach.

At UNE, we have been pioneers in IPE over the past decade for all our healthcare programs. We are currently constructing a new health sciences training facility on our Portland campus, which will serve as the new home of our medical school. By co-locating all of our health profession programs on a single site, we will be able enhance our training of students in this collaborative, team-based model.

In conclusion, successfully addressing America's healthcare workforce crisis will require not merely acting on each of these six strategies in isolation, but seamlessly integrating them. Although strategic investment of resources will be required, much of the work we confront reflects cultural changes that will require strong leadership, a willingness to innovate, and coordinated partnership between academia, government, industry, and the nonprofit sector.

I am grateful for the Committee's time and attention, and appreciate your efforts to address our Nation's healthcare workforce crisis. Thank you.

References

American Academy of Family Physicians. (2016). *Rural practice, keeping physicians in (position paper). https://www.aafp.org/about/policies/all/rural-practicekeeping-physicians.html*

American Dental Association. (2021). *Supply of dentists in the U.S.: 2001–2021. https://www.ada.org/resources/research/health-policy-institute/dentist-workforce*

Anderson, E., & Lakhani, N. (2016). Interprofessional learning on polypharmacy. *The Clinical Teacher,* 13(4), 291—297. *https://doi.org/10.1111/tct.12485*

Association of American Medical Colleges. (2019). *Maine physician workforce profile. https://www.aamc.org/media/37931/download*

Benbassat, J. (2020). Managing time-constrained doctor-patient encounters: A proposal for a teaching program by a former doctor and present patient. *Journal of Primary Care and General Practice,* 3(1), 1–3. *https://www.alliedacademies.org/articles/managing-timeconstrained-doctorpatient-encounters-a-proposal-for-ateaching-program-by-a-former-doctor-and-present-patien.pdf*

Cain, C. L., Taborda-Whitt, C., Frazer, M., Schellinger, S., White, K. M., Kaasovic, J. Nelson, B., & Chant, A. (2017). A mixed methods study of emotional exhaustion: Energizing and depleting work within an innovative healthcare team. *ournal of Interprofessional Care,* 31(6), 714–724. *https://doi.org/10.1080/13561820.2017.1356809*

Center for Health Affairs NEONI. (2017). *Maine Nursing Forecaster. https://usm.maine.edu/sites/default/files/nursing/Maine percent20Nursing percent20Forecaster percent—Public percent—Access percent—Information.pdf*

Christmas, C., Durso, S. C., Kravet, S. J., & Wright, S. M. (2010). Advantages and challenges of working as a clinician in an academic department of medicine: academic clinicians' perspectives. *Journal of Graduate Medical Education,* 2(3), 478–484. *https://doi.org/10.4300/JGME-D–10–00100.1*

Cox, W. J., & Desai, G. J. (2019). The crisis of clinical education for physicians in training. *Missouri Medicine,* 116(5), 389—391.

de Villiers, M., Conradie, H., & van Schalkwyk, S. (2018). Teaching medical students in a new rural longitudinal clerkship: Opportunities and constraints. *Annals of Global Health,* 84(1), 58—65. *https://doi.org/10.29024/aogh.17*

Department of Professional and Financial Regulations. (n.d.) *Maine Board of Dental Practice: Provider directory. https://www.maine.gov/dental/licensure/license-verification.html*

Dow, A. W., Baernholdt, M., Santenhttps, S. A., Baker, K., & Sessle, C. N. (2019). Practitioner well-being as an interprofessional imperative. *Journal of Interprofessional Care.*33(6), 603–607. *https://doi.org/10.1080/13561820.2019.1673705*

Drewniak, D., Krones, T., Wild, V. (2017). Do attitudes and behavior of health care professionals exacerbate health care disparities among immigrant and ethnic

---

sion programs. Thanks to legislation sponsored by Senator Collins and supported by Maine's Junior Senator Angus King, and working closely the University of Maine and multiple statewide partners, UNE is one of 48 organizations nationally to have received funding through HRSA's Geriatrics Workforce Education Program, which aims to create a more age-friendly health system by transforming primary care practices and engaging and empowering older adults.

minority groups? An integrative literature review. *International Journal of Nursing Studies,* 70, 89–98. *https://doi.org/10.1016/j.ijnurstu.2017.02.015*

Feldman, H. R., Greenberg, M. J., Jaffe-Ruiz, M., Kaufman, S. R., & Cignarale, S. (2015). Hitting the nursing faculty shortage head on: Strategies to recruit, retain, and develop nursing faculty. *Journal of Professional Nursing,* 31(3), 170–178. *https://doi.org/10.1016/j.profnurs.2015.01.007*

Girod, S. C., Fassiotto, M., Menorca, R., Etzkowitz, H., & Wren, S. M. (2017). Reasons for faculty departures from an academic medical center: a survey and comparison across faculty lines. *BMC Medical Education,* 17(1), 8–17. *https://doi.org/10.1186/s12909–016–0830-y*

Graziano, S. C., McKenzie, M. L., Abbott, J. F., Buery-Joyner, S. D., Craig, L. B., Dalrymple, J. L., Forstein, D. A., Hampton, B. S., Page-Ramsey, S. M., Pradhan, A., Wolf, A., & Hopkins, L. (2018). Barriers and strategies to engaging our community-based preceptors. *Teaching and Learning in Medicine,* 30(4), 444–450. *https://doi.org/10.1080/10401334.2018.1444994*

Handtke, O., Schilgen, B., & Msko, M. (2019). Culturally competent healthcare—A scoping review of strategies implemented in healthcare organizations and a model of culturally competent healthcare provision. *PloS one 14* (7). *https://doi.org/10.1371/journal.pone.0219971*

Hanna, M. (2019). The patient vs. the clock: time constraints are damaging progress in medicine. *In-Training*. *https://in-training.org/the-patient-vs-the-clock-time-constraints-are-damaging-progress-in-medicine–18623*

Hardisty, J., Scott, L., Chandler, S., Pearson, P., & Powell, S. (2014). Interprofessional learning for medication safety. *The Clinical Teacher,* 11(4), 290–296. *https://doi.org/10.1111/tct.13430*

Hatfield, J., Neal, G., Isbell, T., & Dickey, D. (2022). The effect of a medical student on community preceptor productivity. *Medical Education 56* (7), 747–753. *https://doi.org/10.1111/medu.14733*

Health Resources & Services Administration. (n.d.). *Find shortage areas. https://data.hrsa.gov/tools/shortage-area/by-address*

Hempel, S., Gibbons, M. M., Ulloa, J. G., Macqueen, I. T., Miake-Lye, I. M., Beroes, J. M., & Shekelle, P. (2017). Rural healthcare workforce: a systematic review. Department of Veterans Affairs (U.S.). *https://www.ncbi-nlm-nih-gov.une.idm.oclc.org/books/NBK409505/*

Hu, X., Dill, M.J., & Conrad, S.S. (2022). What moves physicians to work in rural areas? An in-depth examination of physician practice location decisions. *Economic Development Quarterly, 36* (3) 245–260. *https://doi.org/10.1177/08912424211046600*

Irajpour, A., Farzi, S., Saghaei, M., & Ravaghi, H. (2019). Effect of interprofessional education of medication safety program on the medication error of physicians and nurses in the intensive care units. *Journal of Education and Health Promotion, 8(1). https://doi.org/10.4103/jehp.jehp—200—19*

Istrate, E.C., Cooper, B.C., & West, K.P. (2022, Sept.). Dentists of tomorrow 2022: An analysis of the results from the ADEA 2022 survey of U.S. dental school seniors. *American Dental Education Association (ADEA) Education Research Series,* 4. *https://www.adea.org/Seniors2022/*

Kichloo, A., Albosta, M., Dettloff, K., Wani, F., El-Amir, Z., Singh, J., & Chugh, S. (2020). Telemedicine, the current COVID–19 pandemic and the future: A narrative review and perspectives moving forward in the USA. *Family Medicine and Community Health, 8*(3). *https://doi.org/10.1136/fmch—2020–000530*

Konrad, T. R., Link, C. L., Shackelton, R. J., Marceau, L. D., von Dem Knesebeck, O., Siegrist, J., & McKinlay, J. B. (2010). It's about time: physicians' perceptions of time constraints in primary care medical practice in three national healthcare systems. *Medical Care, 48*(2), 95 –100. *https://doi.org/10.1097/MLR.0b013e3181c12e6a*

Krehnbrink, M., Patel, K., Byerley, J., Tarantino, H., Peyser, B., Payne, L., Foley, K., & Latessa, R. (2020). Physician preceptor satisfaction and productivity across curricula: A comparison between longitudinal integrated clerkships and traditional block rotations. *Teaching and Learning in Medicine, 32*(2), 176—183. *https://doi.org/10.1080/10401334.2019.1687304*

LaVeist, T. A., & Nuru-Jeter, A. (2002). Is doctor-patient race concordance associated with greater satisfaction with care? *Journal of Health and Social Behavior, 43*(3), 296–306. *https://www.jstor-org.une.idm.oclc.org/stable/3090205*

LaVeist, T. A., Nuru-Jeter, A., Jones, K. E. (2003). The association of doctor-patient race concordance with health services utilization. *Journal of Public Health Policy, 24*(3–4), 312–323. *https://doi.org/10.2307/3343378*

Lee, M., Newton, H., Smith, T., Crawford, M., Kepley, H., Regenstein, M., Chen, C. (2016). The benefits of physician training programs for rural communities: Lessons learned from the teaching health center graduate medical education program. *Journal of Health Care for the Poor and Underserved 27*(4), 83–90. *https://doi.org/10.1353/hpu.2016.0184*

Lee, J. K., McCutcheon, L. R. M., Fazel, M. T., Cooley, J. H., & Slack, M. K. (2021). Assessment of interprofessional collaborative practices and outcomes in adults with diabetes and hypertension in primary care. *AMA Network Open, 4*(2). *https://doi.org/10.1001/jamanetworkopen.2020.36725*

Lygre, H., Kjome, R., Choi, H., & Stewart, A. L. (2017). Dental providers and pharmacists: A call for enhanced interprofessional collaboration. *International Dental Journal, 67*(6), 329—331. *https://doi.org/10.1111/idj.12304*

Lutfiyya, M. N., Chang, L. F., McGrath, C., Dana, C., & Lipsky, M. S. (2019). The state of the science of interprofessional collaborative practice: A scoping review of the patient health-related outcomes based literature published between 2010 and 2018. *PloS one, 14*(6), e0218578. *https://doi.org/10.1371/journal.pone.0218578*

Maine Care Services. (n.d.) Provider directory. *https://mainecare.maine.gov/mhpviewer.aspx'FID=PDIR*

Maine Center for Disease Control & Prevention (2023). Health professional shortage areas (HPSAs) and medically underserved areas/populations (MUA/Ps). *https://www.maine.gov/dhhs/mecdc/public-health-systems/rhpc/hpsa.shtml*

Maine Senior Guide (2019). *https://maineseniorguide.com/*

Mayo, A. T. & Williams-Woolley, A. (2016). Teamwork in health care: Maximizing collective intelligence via inclusive collaboration and open communication. *AMA Journal of Ethics, 18*(9), 933–940. *https://doi.org/10.1001/journalofethic?.2016.18.9.ta2—1609*

McAndrew, M., Brunson, W. D., & Kamboj, K. (2011). A survey of U.S. dental school programs that help students consider academic careers. *Critical Issues in Dental Education,* 75(11), 1458–1464. *https://doi.org/10.1002/j.0022—0337.2011.75.11.tb05203*

National Academies of Sciences, Engineering and Medicine. (2021). *The Future of Nursing 2020–2030: Charting a Path to Achieve Health Equity*. The National Academies Press. *https://doi.org/10.17226/25982.*

Nausheen, F., Agarwal, M. M., Estrada, J. J., & Atapattu, D. N. (2018). A survey of retaining faculty at a new medical school: opportunities, challenges and solutions. *BMC medical education,* 18(1), 1–8. *https://doi.org/10.1186/s12909—018—1330*

National Center for the Analysis of Health Care Data. (2016). *Enhanced state licensure data*. *https://www.ncahd.org/esl-data/*

National Plan Provider and Provider Enumeration System. (n.d.). NPPES NPI registry. *https://npiregistry.cms.hhs.gov/search*

The Robert Graham Center (2012). *Projecting U.S. primary care physician workforce needs (2010–2025). http://www.annfammed.org/content/10/6/503.full.pdf*

Rodriguez, S. M. (2013). The impact of limited clinical sites on prelicensure nursing education programs: Current issues and recommendations for the future. *Sophia, the St. Catherine University Repository*. *https://sophia.stkate.edu/ma—nursing/73*

Russell, D. J., Wilkinson, E., Petterson, S., Chen, C., & Bazemore, A. (2022). Family Medicine Residencies: How Rural Training Exposure in GME Is Associated with Subsequent Rural Practice. *Journal of Graduate Medical Education, 14*(4), 441–450. *https://doi.org/10.4300/JGME-D—21—1143.1*

Saha, S., Taggart, S. H., Komaromy, M., & Bindman, A. B. (2000). Do patients choose physicians of their own race? To provide the kind of care consumers want, medical schools might be able to justify using race as an admissions criterion. *Health affairs,* 19(4), 76–83. *https://doi.org/10.1377/hlthaff.19.4.76*

Shen, M. J., Peterson, E. B., Costas-Muiz, R., Hernandez, M. H., Jewell, S. T., Matsoukas, K., & Bylund, C. L. (2018). The effects of race and racial concordance on patient-physician communication: A systematic review of the literature. *Journal of Racial and Ethnic Health Disparities,* 5(1), 117—140. *https://doi.org/10.1007/s40615—017—0350—4*

Shipman, S. A., Wendling, A., Jones, K. C., Kovar-Gough, I., Orlowski, J. M., & Phillips, J. (2019). The decline in rural medical students: A growing gap in geographic diversity threatens the rural physician workforce. Health Affairs, 38(12). *https://doi.org/10.1377/hlthaff.2019.00924*

Skillman, S. M., & Stover, B. (2014). Maine's physician, nurse practitioner and physician assistant workforce in 2014. *Seattle, WA: WWAMI Center for Health Workforce Studies, University of Washington. https://www.familymedicine.uw.edu/chws/wp-content/uploads/sites/5/2018/08/maines—physicians—nps—and—pas—2018.pdf*

State Board of Maine Dental Practice. (2019). *https://www.maine.gov/dental/*

Takeshita, J., Wang, S., Loren, A.W., Mitra, N., Shults, J., Shin, D.B., & Sawinski, D.L. (2020). Association of racial/ethnic and gender concordance between patients and physicians with patient experience ratings. *JAMA network open 3,* (11). *https://doi.org/10.1001/jamanetworkopen.2020.24583*

University of Wisconsin. (2020). Neighborhood Atlas. *https://www.neighborhoodatlas.medicine.wisc.edu*

U.S. Census Bureau. (2019a). *Maine. https://data.census.gov/cedsci/profile—0400000US23*

Health Resources and Services Administration. *HU.S. DHHS HPSAs and MUAs in Maine.* Retrieved June, 2019 from *https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation.*

U.S. Census Bureau. (2019b) *American Fact Finder. https://www.census.gov/programs-surveys/acs/data.html*

U.S. Congress: Advisory Committee on Interdisciplinary, Community-Based Linkages. (2018). *Enhancing Community-Based Clinical Training Sites: Challenges and Opportunities*.

Will, K. K., Johnson, M. L., & Lamb, G. (2019). Team-based care and patient satisfaction in the hospital setting: a systematic review. *Journal of Patient-Centered Research and Reviews, 6*(2), 158. *https://doi.org/10.17294/2330—698.1695*

Wilson, A. J., Palmer, L., Levett-Jones, T., Gilligan, C., & Outram, S. (2016). Interprofessional collaborative practice for medication safety: Nursing, pharmacy, and medical graduates' experiences and perspectives. *Journal of Interprofessional Care, 30*(5), 649—654. *https://doi.org/10.1080/13561820.2016.1191450*

World Health Organization. (2010). *Framework for action on interprofessional education and collaborative practice* (No. WHO/HRH/HPN/10.3). *https://www.who.int/publications/i/item/framework-for-action-on-interprofessional-education-collaborative-practice*

Wosik, J., Fudim, M., Cameron, B., Gellad, Z. F., Cho, A., Phinney, D., & Tcheng, J. (2020). Telehealth transformation: COVID–19 and the rise of virtual care. *Journal of the American Medical Informatics Association*.

Appendix A

Table 1

Summary of Recommendations

Increase the number of healthcare professionals	Increase the number of doctors, nurses, dentists, and other healthcare professionals we educate by: (1) expanding partnerships between universities and community healthcare settings to develop additional training opportunities; (2) revise antiquated CMS policies for funding GME; (3) providing targeted one-time investments in expanding healthcare training infrastructure; and (4) strategic scholarship and loan-repayment programs, including those supporting clinical educators to increase faculty.
Representation	1ntentionally recruit and train more students who look like the communities they serve.
Maldistribution of providers	Use a variety of tools to encourage healthcare providers to practice in underserved areas, including rural, tribal, and medically underserved urban communities.

Appendix A—Continued

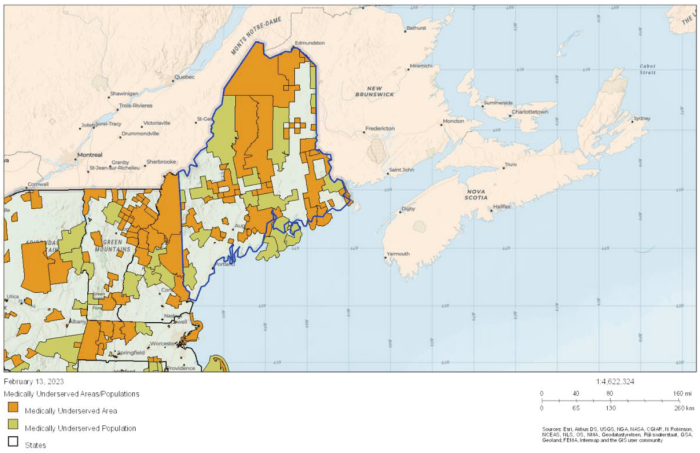
Table 1

Summary of Recommendations

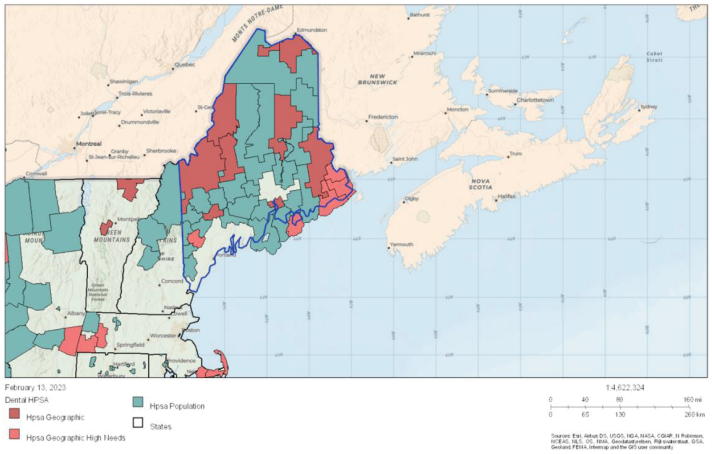
Technology	Leverage the power of technology, including telehealth and digital medicine, to reach underserved communities.
Scope of practice	Modify state level regulations to allow health professionals to practice at the top of their scope.
Flexibility of educational models	Encourage accrediting bodies to allow training programs to be more creative and flexible (without sacrificing educational quality) to develop novel training models including ''career laddering'' opportunities that do not completely remove the individual from the workforce while they are pursuing an advanced degree.
Interprofessional Education	Promote Interprofessional Education (IPE) training models to break down traditional healthcare training and practice siloes.

Appendix B

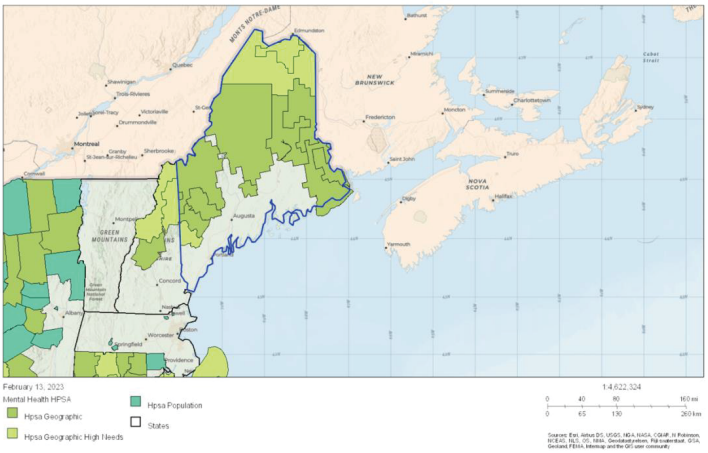
Map 1
Medically Underserved Areas (2023)



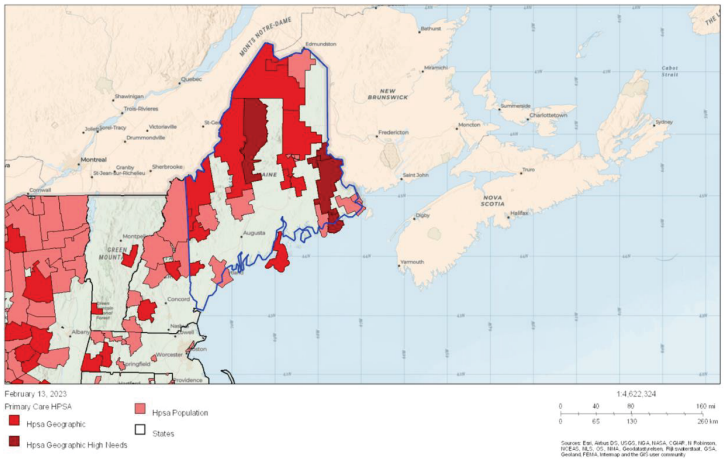
Map 2
Dental: Health Professional Shortage Area (2023)



Map 3
Mental Health: Health Professional Shortage Area (2023)



Map 4
Primary Care: Health Professional Shortage Area (2023)



The CHAIR. Dr. Herbert, thank you very much. Our next witness is Dr. James Hildreth, who is President and CEO of Meharry Medical College, the largest private, independent, historically black academic health sciences center.

Dr. Hildreth was the first African American Rhodes Scholar from Arkansas, and he holds a Ph.D. in Immunology from Oxford University. Dr. Hildreth, thanks so much for being with us.

STATEMENT OF JAMES E.K. HILDRETH SR., PH.D., M.D., PRESIDENT AND CEO, MEHARRY MEDICAL COLLEGE, NASHVILLE, TN

Dr. HILDRETH. Thank you, Chairman Sanders, Ranking Member Cassidy, and Members of the Committee for inviting me to give testimony today about our Nation's shortage of health care providers where we need the most, in the field of primary care, especially in communities without a doctor or nurse or physician to treat the sick in those communities.

There are many reasons we—our Country is full of medical specialists but woefully lacking in primary care professionals. But in the time allotted me today, I would like to talk about ways to solve the problem and perhaps to solve it very quickly. I am the proud President of Meharry Medical College, as you heard.

We are the Nation's four historically black academic health science centers. We were originally founded to train students that the white medical system refused to train in order that those students might treat patients that the white medical establishment refused to treat.

Our purpose remains essentially the same today. A majority of the students that we attract come to us to learn primary care, and they intend to serve in places often ignored by mainstream medicine.

I am proud to say that 80 percent of our graduates do go on to serve the underserved. In other words, we already trained exactly the professionals this country so desperately needs. The majority of our students do not have to be incentivized to switch from lucrative subspecialties to practice primary care.

They are fully committed to working in rural communities and urban health care deserts. In many cases, their determination is borne out of personal experience. They have watched a family member die of untreated diabetes or some other chronic disease.

They have suffered themselves from a lack of access to wellness checks, common in American communities. I know what drives them, I am one of them. I was born in rural Arkansas in the 1950's and watched my father die of cancer because no one would or could care for him.

I have been trained at the world's most elite institutions, Harvard, Oxford, Johns Hopkins, yet I choose to lead Meharry Medical College because Meharry graduates and their counterparts at Howard, Morehouse, and Drew choose to care for people like my father, poor blacks, poor whites, poor Hispanics, poor Native American people who deserve to be healthy just like the rest of us.

I submit to you that the Consortium of Black Medical Schools already has the necessary history, structure, deep relationships for community organizations dedicated to eradicate health disparities, and we have the credibility within disenfranchised communities to help alleviate the shortage.

We have been working for decades to increase the pipeline of minority health care workers in our Country. We are already partnering with industries to support the education of minority physicians, dentists, nurses, researchers, and public health professionals. We work with neighborhood, middle, and high school students to introduce them to science and medicine.

At Meharry, we are grateful to Governor Bill Lee and the leadership of the State of Tennessee for supporting a program we put in place to fast-track undergraduate students in the medical school who are committed to serving in rural areas in the State of Tennessee. But there is no simple solution to the health care shortage, and it is going to take a variety of initiatives to solve the problem.

The HBCU Medical School Consortium is well poised to lead the effort, but we need your help. We have done this work for generations, even though we have been woefully underfunded. Because of my 30 plus years at prestigious majority institutions, I am fully aware of how the Federal Government sometimes choose to allocate funds to institutions that are deemed uniquely qualified to solve certain problems facing the Nation.

Today, I submit to you that HBCU medical schools are uniquely poised to solve this problem. We ask your help in doing so. Specifically, we ask for $5 billion over the next 5 years to improve our infrastructure, the labs, the simulation centers, the study spaces, the classrooms at our institutions that have been egregiously underfunded for decades.

This would also allow us to dramatically expand our pipeline programs that are meant to get more minorities in health care profes-

sions. These funds, while they are certainly significant, are a mere drop in the bucket compared to other budget items and will pay media dividends to quickly expand the pipeline and close to health disparity gap.

We also ask that Medicare's GME policy be amended to give expanded consideration to hospitals that train a large share of graduates from black medical schools. Finally, we ask for your support to ease the debt burden of students coming from poor, working-class families whose hard-earned health care, especially primary care.

Our students who come from lower income households often graduate with hundreds of thousands of dollars of debt. This debt burden can be a deterrent from entering primary care, and we need those folks in the game and we need them right away.

Our graduates are ready. They are willing. They are desperately needed. Our nation's HBCU medical schools have trained them well. We know how to reach others who want to serve just like they do.

Let's do everything in our power to break down barriers standing in their way so that America can benefit from the care they will provide and reduce the barriers to care in the United States. Thank you, Mr. Chairman.

[The prepared statement of Dr. Hildreth follow:]

PREPARED STATEMENT OF JAMES E.K. HILDRETH

Chairman Sanders, Ranking Member Cassidy, and Members of the Committee, thank you for the invitation to discuss the implications, both immediate and long-term, that the health care workforce shortage has on our Nation and, in particular, to communities of color and growing segments of the population located in rural and underserved areas.

Before I begin, I'd like to thank Chairman Sanders for his work to significantly expand the National Health Service Corps, Community Health Centers, and Teaching Health Centers to hire more doctors and nurses of color to underserved areas and boost the Teaching Health Center Graduate Medical Education program to help train more African American primary care physicians. We have a number of Meharry students who are participants in the National Health Service Corps. I'd also like to thank Senator Cassidy and other Members of the Senate for passing the John Lewis National Institute on Minority Health and Health Disparities Research Endowment Revitalization Act. This important legislation will provide critical funds to Historically Black Colleges and Universities (HBCUs) to conduct research into and to address minority health disparities.

This important conversation about the effects that the health care workforce shortage has on health care, health outcomes, and thus life opportunities of a growing segment of the U.S. population could not be coming at a more appropriate time. It is certainly not lost on me that we are addressing this critical topic both during Black History Month as well on the 20th anniversary of the National Academy of Medicine's landmark report, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care", a report that highlighted the startling fact that across similar income and education levels, insurance status, age and even disease type and severity, racial and ethnic minorities, when compared to their white counterparts, often are diagnosed later, and consistently have less access to the most advanced care and treatments, suffer worse health outcomes, and die prematurely. What a fitting time to draw attention to and call for action on the effects of our health care workforce shortage on inequities in health care and on health outcomes.

I have been trained at—and served on the faculty of—some of the world's most prestigious institutions of higher learning. I chose to take the helm at Meharry because of the populations it exists to serve. The reason is because my life—like the lives of so many trained by Meharry and other HBCU academic health science centers—was shaped by health care disparities.

Meharry was founded in 1876, made possible by a donation from a young trader of Scots-Irish descent who was traveling one night through rough terrain in Tennessee when his wagon became mired in a swamp. A Black family came to his aid, giving him food and a place to sleep, and helping him rescue his wagon the next morning. The man said, "I have no money, but when I can, I shall do something for your race." He was as good as his word. In 1876, he and his brothers donated $15,000—a significant sum at that time—to establish a medical school in Nashville to train Black doctors the white medical establishment would not train, in order to care for former slaves the white medical establishment would not care for. The man's name was Samuel Meharry. The name of the family that helped him remains unknown.

Meharry is the oldest and largest historically Black academic health science institution in the Nation, dedicated to educating and training exemplary primary care physicians, dentists, researchers, public health professionals, and health policy experts. As times began to change for the better in the mid–20th century and the American medical establishment began accepting people of color into its ranks, Meharry expanded and amplified its mission across its schools and programs to train medical professionals to serve all of the underserved—those in urban centers where the population is mostly Black, in rural towns where the population is mostly white, in Latino and immigrant communities, and on native American reservations. In fact, four out of every five Meharry physicians and dentists work in underserved rural and urban communities.

The Present Persistent Problem

Meharry has made major contributions to bolstering the medical, dental, scientific, and public health workforce in America. Approximately 14 percent of Black medical doctors, 27 percent of Black dentists, and 15 percent of Black biomedical scientists in America graduated from Meharry Medical College. Collectively, with other historically Black health professions institutions across the United States, we have educated and trained half of the Black physicians in the country, half of the Black dentists, and 75 percent of the Nation's Black pharmacists and veterinarians. No other set of institutions has such an impressive legacy of accomplishment that is consistent with the national goal of improving the health status of all population groups. As we strive to continue to be the leading producer of diverse health professionals committed to bolstering access to primary care, eliminating health disparities in rural and urban communities, and improving health care quality for all, it is not lost on me that we have a long way to go to close the gaps in our health professions workforce.

A 2021 article in the Journal of the American Medical Association highlighted the dearth of underrepresented minorities in many of our health diagnosing and treating professions. Consider, for example, that while White Americans account for 68.7 percent of Dentists, Black, Native American, and Hispanic Americans account for 4.4 percent, 0.1 percent, and 5.7 percent respectively. Comparatively, Black Americans account for just 5.2 percent of physicians, with Native Americans accounting, once again, for 0.1 percent and Hispanic Americans accounting for 6.9 percent. This is in comparison to the 62.4 percent of physicians that identify as White Americans. The lack of diversity continues even when considering the other professions at a patient's bedside. For example, while Black Americans account for 4.5 percent of Physician Assistants, and Native and Hispanic Americans each account for 0.5 percent and 7.3 percent respectively, the overwhelming majority of Physician Assistants are White Americans, as represented by the fact that they account for 75.9 percent.

The dearth of diverse health providers is associated with significant disparities in health care access, quality, and treatments, along with access to critical public health resources. According to the Association of American Medical Colleges, "If underserved populations were to experience the same health care use patterns as populations with fewer barriers to access, the United States would need an additional 102,400 to 180,400 physicians." In addition, a recent research brief by the de Beaumont Foundation found that in the wake of the Covid–19

pandemic, in order to provide a minimum set of public health services to the Nation, state and local governmental public health departments need an 80 percent increase in their workforce. What this percentage equates to in raw numbers, is a minimum of 80,000 more full-time equivalent positions being required to provide adequate infrastructure and a minimum package of public health services. This reality is exacerbated by the fact that in the past decade alone, state, and local health departments lost 15 percent of their essential staff. Even further, while approximately 54,000 of the additional positions that are needed should be deployed to local

health departments, and the remaining 26,000 to state health departments, it is worth noting that the most acute needs are in local health departments that specifically serve fewer than 100,000 people (de Beaumont Foundation, 2021).

The Worsening Future Problem if We Don't Act Now

The United States is in the midst of a moment of heightened awareness where greater attention is being paid to health inequities. And so, I look forward to working with the Members of this Committee to leverage this unique time in history to achieve health equity in a very real and meaningful way, which requires our serious efforts to address the health workforce shortage and the lack of diversity in the health care and public health arena before things get worse. It is important to remember that most of the recent statistics I just mentioned happened against the backdrop of the ongoing COVID–19 pandemic and its stark, disproportionate, and disparate impact on Black, Latino, American Indian, Asian, Native Hawaiian, and Pacific Islander individuals and communities. In general, low-income Latino families had the highest numbers of full families in poor health, followed by Black/African American low-income families (Braveman & Barclay, 2009).

It is hard for me to overstate the reality that these disparities were brought to light as racial and ethnic minorities continued to suffer from less access to affordable, quality health care, and disproportionately higher rates of incidence and prevalence, as well as premature death, across every chronic and acute disease and condition. This includes cancers, diabetes, hypertension, heart disease, asthma, depression and anxiety, and obesity, just to name a few. During the pandemic, adults reporting symptoms of mental illness quadrupled, from one in ten prior to four in ten. COVID exacerbated isolation and stress for millions during a time when families and communities continued to grapple with social justice issues and economic stress. This impact affected Black, Latino, Native Americans, Native Hawaiians, Alaska Natives, and Asian American adults at a much higher rate than Whites in the United States owing to structural barriers to health care, public health, family leave, and economic opportunity.

For example, today, the maternal mortality rate among Black women is two to three times higher than that among White women. In fact, a Black woman with an advanced degree is more likely to die from pregnancy-related complications in the United States than a White woman with only a high school degree. Unfortunately, their babies do not fare much better: African American newborns, overall, are three times more likely than White newborns to die. In some communities, the number is even higher. Study after study confirms that racial and ethnic health disparities and inequities are so pervasive that they have—in some cases—widened over time and become the norm in the United States. Further adding insult to injury is a report from the Commonwealth Fund that found that racial and ethnic health inequities not only are pervasive in this country, but some of the starkest and widest disparities are actually in states known for having high performing health care systems. However, according to a ground-breaking study, in situations where the physician was Black, the infant mortality rates dropped significantly.

These disparities carry a hefty economic cost. Research shows that health disparities amount to nearly $93 billion in excess medical care costs and another $42 billion in lost productivity each year (Laveist, et al.., 2009). In a study led by one of our researchers at Meharry to determine the economic burden of mental health inequities, the study showed that over a 4-year period, $278 billion could have been saved and reinvested into the economy, and over 116,770 lives could have been saved had mental health inequities become more equitable—and this is a conservative estimate (Dawes, et.al., 2022). Han & Ku (2019) reported that over two-thirds of rural counties had no psychiatrists and almost half of rural counties had no psychologists. Additionally, Deloitte also released a major study showing that if we do not address health disparities in the U.S. by 2040, the top five costly chronic diseases today will cost us $1 trillion.

Consortium of Black Medical Schools Partnership

The historic halls of Meharry and its fellow HBCU medical schools are replete with professionals who have experienced the systemic problem of health disparities, have dedicated their careers to treating this systemic problem, and are prepared to solve the systemic problems relative to our national health care workforce shortage.

All four HBCU medical schools, including Meharry Medical College, Howard University College of Medicine, Morehouse School of Medicine and Charles R. Drew Medical School established the Consortium of Black Medical Schools (CBMS) initially to address the COVID–19 crisis, by providing expanded testing, contact trac-

ing, surveillance, training of front-line health workers, research & drug development, and policy recommendations to address the unique needs of vulnerable, low income, African American, and other underrepresented communities that experienced disproportionate adverse outcomes due to the pandemic.

Meharry and the other HBCU medical schools are uniquely qualified to address the shortage of health care professionals for this population in a way that no others are. The Consortium brings together the cumulative expertise of the four HBCU academic health science centers in primary care and subspecialties which treat diseases that account for the disparities heavily impacting disenfranchised communities of all races and ethnicities. Together we have worked with the White House, the Centers for Disease Control and Prevention, the Department of Health and Human Services, state and local legislatures, local health departments, faith-based organizations, and other community stakeholders to reduce areas of disparity in vulnerable and marginalized communities across the Nation.

The CBMS has the necessary history, organizational structure, deep relationships with national and international organizations dedicated to eradicating health care disparities, and credibility within disenfranchised communities to scale up immediately and rapidly. Crucially, Black health professionals are trusted in these communities—trusted because we have always been there when others have failed them, forgotten them, or, with the best of intentions, misunderstood them and their needs.

As we have done this work, we also have been woefully underfunded for generations. Because of my 30+ years of experience at prestigious, majority institutions, I am aware of how Federal funding is allocated to those who are deemed "uniquely qualified" to address a critical national need. This is entirely appropriate when it makes the best use of resources. And especially when and where a crisis is afoot.

We, the four HBCU medical schools, are asking for those same rules to apply to our work. We are without a doubt "uniquely qualified" to address this growing national health crisis.

We already are our Country's most reliable source for a well-trained, diverse health care workforce. And the value of a diverse workforce cannot be underestimated. Trust, cultural competency, and a strong background in social determinants of health are as crucial during these times as medical training. We must accept that, in order to successfully treat at-risk African Americans and other vulnerable populations, we must hire and deploy a workforce that is trained to implement a care plan for individuals and communities that addresses the social forces impacting and undermining their well-being.

Yet currently, HBCU medical schools—the most adept at training such a workforce—face the challenge of expanding our number of graduates in light of insufficient funding, an increasingly detrimental predicament for everyone, especially in a country whose population is ever-expanding and diversifying. A truly sustainable response to the shortage of diverse health care workers must include strategies to support HBCU medical schools.

To do this work, the CBMS requires an immediate infusion of significant resources in order to scale up quickly, efficiently, and comprehensively. The CBMS anticipates the cost to develop and implement our plan will be $5 billion dollars over the next 5 years. We are well-prepared and well-positioned to offer enormous benefit to the Nation at comparatively little cost. We plan to use the infrastructure we build to begin addressing the structural barriers to health in minority communities. Our plan will therefore have benefits that should reduce the overall cost of health care for the Nation.

Major Consortium Pipeline Initiatives

The Consortium is now leading the national drive for greater pipeline diversity and is engaged in multiple initiatives to ensure a more equitable health care workforce in the future. It has attracted the interest and investment of $100+ million in public and private funding to support current students, as well as longer term efforts to educate, train and employ more Black health care workers. Notable funders include the National Institutes of Health, Bloomberg Philanthropies and Mackenzie Scott.

- The Consortium convened a gathering of 166 representatives from 54 of the 99 HBCUs with undergraduate programs to develop a cohesive and aggressive program to increase the number of Black or African American health science professionals and improve educational outcomes for both

STEM and humanities students to ensure health science workforce diversity.

- NFL Diversity in Sports Medicine Pipeline Project to increase diversity in sports medicine by providing HBCU medical schools the opportunity to complete a clinical rotation with NFL club medical staff.
- Chan Zuckerberg Initiative to advance genomics research at the four medical schools by contributing $11.5 million per institution over the next 5 years.
- Two-year $100 million award to the Consortium from NIH's Advance Health Equity and Researcher Diversity (AIM-AHEAD) program.
- American Cancer Society's $12 million Diversity in Cancer Research institutional advancement grants to fund a 4-year program to increase the pool of minority cancer researchers at the four HBCU medical schools.
- Partnership between the Consortium, the Organ Donation Advocacy Group and the Association of Organ Procurement Organizations to initiate programs to increase the number of U.S. Black organ donation and transplant professionals across the Nation.
- Beacon of Hope Partnership, a 10-year collaboration of the Consortium, Novartis, Sanofi, and Merck, to create programs that address the root causes of disparities in health and education.

As I testify today, I think of Samuel Meharry. His gift in 1875 was nominal relative to his total wealth. But he had been the beneficiary of selfless compassion from an African American family. He gave in order to allow that compassion to exert the maximum influence possible during that time and in that world, where slavery had been abolished in name only. I also think of my father, who—generations later—would succumb to health care disparities as much as he succumbed to cancer. I think of my mother, who urged me to respond by serving those who are perennially left out and left behind. I think of Black physicians and other professionals from the past who because of redlining and structural racism could not build wealth for their families and communities. I think of my colleagues across the Nation who could share similar stories with you of family members and friends locked into legacies of poor health.

For more than a century, the responsibility for educating Black doctors, dentists, researchers, and health care professionals in the U.S. has largely rested on the institutions dedicated to that purpose: our Nation's four HBCU Medical Schools. Charles R. Drew University of Medicine and Science in Los Angeles, Howard University College of Medicine in Washington, DC, Meharry Medical College in Nashville, and Morehouse School of Medicine in Atlanta have long prioritized the need for more diversity in medical careers while other colleges and universities ignored the issue. For years, we have worked individually in our own communities and together, as a Consortium, on larger initiatives in the United States and Africa to advance the diversity of the workforce and the health of the patients they served.

We, the Consortium of Black Medical Schools, are ready. We only need your endorsement and a modicum of the Nation's resources to make a profound difference. Let us take our place in this fight. We already are well-prepared and well-trained. But we must be well-armed. Please arm us by supporting the policy recommendations outlined below. Thank you for your time.

Policy Recommendations

- $5 billion for infrastructure for Improving Research and Development Infrastructure for academic health science centers at Historically Black Graduate Institutions as defined under Section 326(e) of Title III of the Higher Education Act.
- $500 million to maintain and expand programs to increase research capacity at minority-serving institutions (as described in sections 371(a) and 326(e)(1) of the Higher Education Act.
- Amend/Expand the Medicare GME policy to add a priority criterion for hospitals that have a sponsoring institution for their GME programs that is a Minority-Serving Institution (to include Historically Black Graduate Institutions), as well as add "non-contiguous area" to the "rural" criterion.

[SUMMARY STATEMENT OF JAMES E.K. HILDRETH]

Meharry Background

Meharry is the oldest and largest historically Black academic health science institution in the Nation, dedicated to educating and training exemplary primary care physicians, dentists, researchers, public health professionals, and health policy experts.

Meharry has made major contributions to bolstering the medical, dental, scientific, and public health workforce in America. Approximately 14 percent of Black medical doctors, 27 percent of Black dentists, and 15 percent of Black biomedical scientists in America graduated from Meharry Medical College.

Focus of Testimony

A 2021 article in the Journal of the American Medical Association highlighted the dearth of underrepresented minorities in many of our health diagnosing and treating professions. Consider, for example, that while White Americans account for 68.7 percent of Dentists, Black, Native American, and Hispanic Americans account for 4.4 percent, 0.1 percent, and 5.7 percent respectively. Comparatively, Black Americans account for just 5.2 percent of physicians, with Native Americans accounting, once again, for 0.1 percent and Hispanic Americans accounting for 6.9 percent. This is in comparison to the 62.4 percent of physicians that identify as White Americans.

These disparities carry a hefty economic cost. Research shows that health disparities amount to nearly $93 billion in excess medical care costs and another $42 billion in lost productivity each year (Laveist, et al.., 2009). In a study led by one of our researchers at Meharry to determine the economic burden of mental health inequities, the study showed that over a 4-year period, $278 billion could have been saved and reinvested into the economy, and over 116,770 lives could have been saved had mental health inequities become more equitable. Han & Ku (2019) reported that over two-thirds of rural counties had no psychiatrists and almost half of rural counties had no psychologists. Additionally, Deloitte also released a major study showing that if we do not address health disparities in the U.S. by 2040, the top five costly chronic diseases today will cost us $1 trillion.

Consortium of Black Medical Schools Partnership

For more than a century, the responsibility for educating Black doctors, dentists, researchers, and health care professionals in the U.S. has largely rested on the institutions dedicated to that purpose: our Nation's four HBCU Medical Schools. Charles R. Drew University of Medicine and Science in Los Angeles, Howard University College of Medicine in Washington, DC, Meharry Medical College in Nashville, and Morehouse School of Medicine in Atlanta have long prioritized the need for more diversity in medical careers.

Meharry and the other HBCU medical schools are uniquely qualified to address the shortage of healthcare professionals for this population in a way that no others are. The Consortium brings together the cumulative expertise of the four HBCU academic health science centers in primary care and subspecialties which treat diseases that account for the disparities heavily impacting disenfranchised communities of all races and ethnicities.

Recommendations to Senate Help Committee

$5 billion for infrastructure for Improving Research and Development Infrastructure for academic health science centers at Historically Black Graduate Institutions as defined under Section 326(e) of Title III of the Higher Education Act.

$500 million to maintain and expand programs to increase research capacity at minority-serving institutions (as described in sections 371(a) and 326(e)(1) of the Higher Education Act.

Amend/Expand the Medicare GME policy to add a priority criterion for hospitals that have a sponsoring institution for their GME program/s that is a Minority-Serving Institution (to include Historically Black Graduate Institutions), as well as add "non-contiguous area" to the "rural" criterion.

The CHAIR. Well, thank you very much, Dr. Hildreth. Our next witness is Dr. Sarah Szanton. She is dean of the John Hopkins School of Nursing and an Advanced Nurse Practitioner and has

published more than 200 papers. Dr. Szanton, thanks so much for being with us.

STATEMENT OF SARAH SZANTON PH.D., RN, FAAN, DEAN, JOHNS HOPKINS SCHOOL OF NURSING, BALTIMORE, MD

Dr. SZANTON. Chairman Sanders, Ranking Member Cassidy, and Members of the Committee, thank you for the opportunity to describe some of the factors contributing to our national nursing crisis and to offer some solutions for your consideration.

As you mentioned, I am a Professor, a Nurse, and the Dean of the Johns Hopkins School of Nursing. I have spent 25 years at Johns Hopkins teaching nurses, nurse scientists, making house calls in the community, and conducting research.

I state for the record the opinions expressed here today are my own and do not necessarily reflect the views of the Johns Hopkins University or the Johns Hopkins health system. As we have discussed, our Country is perilously short of nurses, and those we do have are often not working in the settings that could provide the most value. This was true before the pandemic, as you mentioned, and has become more acute.

One thing that has not been mentioned is the average age of nurses today is 54 years old, and 19 percent of them are 65 or older. So, you can imagine we are worried about the future as well. And that, coupled with an aging population that has more and more chronic conditions as well.

There are 4.5 million nurses and nurses are often considered the oxygen of any health care setting. So as a country, we need people to become new nurses and we need to retain current nurses, and there are many steps to both.

To become a nurse, one needs to first be able to imagine oneself as a nurse, to apply and be accepted to a nursing school, and have the resources to pay tuition, food, housing, and perhaps childcare while in the program.

One needs to have dedicated time and space to learn and then pass the nursing boards. For the school to be able to admit that student, it needs enough faculty, adequate facilities, clinical settings in which to place nursing students for experience, and scholarships to offer. And then to stay in nursing, nurses need supportive, safe work environments, a career ladder, and for some, the ability to return to school to develop the science behind prevention and care.

If we take each factor separately, as a field, nursing has historically been composed of predominantly women, so men have a hard time seeing themselves in the role. Another misperception is that nursing is all hospital based, when the reality is that only 60 percent is.

Turning to nursing schools, 90,000 qualified applications are turned down from nursing schools each year, as you mentioned in Vermont, due to lack of space. There is not enough scholarship and loan repayment money to support nursing students. And as was mentioned, the nursing shortage is in large part a nurse faculty shortage.

The country is shy about 2,100 nurse faculty. We need to increase the number of highly educated nurses who can be faculty and retain them by paying them as much as their clinical counterparts would receive.

I mentioned the schools also struggle to find nurses outside of school willing to precept nurses in training, and this has been mentioned across the board. Like medical school, nursing education combines classroom learning with hands on clinical training, and that clinical training relies on established nurses willing to precept students. And it has been mentioned about graduate medical education.

There is nothing similar for graduate nursing education. There is a small pilot that has ended that was successful. So, at a time when nurse shortages are glaring, nurses with a full clinical workload, who are often overtaxed, struggle to take on students on top of that. Finally, some schools have offices, classrooms, practice spaces, and simulation areas that are arcane. So as leaders in nursing, we prepare for both current and future challenges.

The current we have discussed. But we also need to prepare people for the health system of the future in which most encounters will happen at home, online, in clinics, in schools, and in businesses.

As you consider solutions to the crisis, I want to acknowledge the vital work Congress has done to strengthen and grow the Title VIII Nursing Workforce Development Programs and the CARES Act of 2020. I urge the Committee to support the Future Advancement of Academic Nursing Act, or FAAN Act, when it is reintroduced by Senator Merkley, and Congresswoman Underwood, and co-sponsors.

It would address all of the areas that I have mentioned, solving barriers for students, preceptors, faculty, and enhancing infrastructure. And in closing, I would like to highlight two additional principles to guide this body's deliberations. First, as a Nation, we must strive to make nursing more disability inclusive.

27 percent of our Country has a disability, both ethically and practically. We should tap the strengths and skills of people with disabilities. Second, robust support for preventive health care approaches could also save money, reduce poor health outcomes, and thus require fewer nurses. With a more deliberate emphasis on a preventive health care system, we might no longer have a nursing shortage.

Models delivered at home, like the capable program I spearheaded, for instance, would allow older adults to age in the community. Today, nurse scientists are developing many models that may soon provide health care for a nation that is both better and less expensive. Thank you. I would be pleased to answer any questions that you have.

[The prepared statement of Dr. Szanton follows:]

PREPARED STATEMENT OF SARAH SZANTON

Chairman Sanders, Ranking Member Cassidy and Members of the Committee.

Thank you for the opportunity to describe some factors contributing to our national nursing crisis—and to offer some solutions for consideration.

My name is Sarah Szanton. I am a professor, a nurse and the dean of the Johns Hopkins School of Nursing. I have spent 25 years at Johns Hopkins, teaching nurses and nurse scientists, making house calls in the community, and conducting research. I now lead the Nursing school.

I state for the record that the opinions expressed here today are my own and do not necessarily reflect the views of The Johns Hopkins University or the Johns Hopkins Health System.

Our country is perilously short of nurses, and those we do have are often not working in the settings that could provide the most value. This was true before the COVID pandemic, and has become more acute since COVID struck. According to the McKinsey Institute, the Nation needs at least 200,000 more nurses—and perhaps closer to a half million.

The average age of U.S. nurses today is 54 years old. Fully one fifth of working nurses are at least 65 years old! The nurse shortage will only grow more severe over time, as these nurses approach retirement at the same time as COVID's long-term disabilities become clearer, and the aging population encounters more chronic diseases.

Nurses are the largest component of the health care workforce—4.5 million strong. Nurses are often considered the oxygen of any health care setting.

As a country, we need people to become new nurses and to retain current nurses. And there are many steps to both.

To become a nurse, one needs to be able to imagine oneself as a nurse, to apply and be accepted by a nursing school, to have the resources to pay tuition, food, housing and perhaps childcare while in the program. One needs to have dedicated time and space to learn. And then pass the nursing boards. For the school to be able to admit that student, it needs: enough faculty; adequate facilities; clinical settings in which to place nursing students for experience; and scholarships to offer.

To stay in nursing, nurses need: supportive, safe work environments, a career ladder and, for some, the ability to return to school to develop the science behind prevention and care.

Let's take each factor separately—As a field, nursing has historically been composed of predominantly women, so men have a hard time seeing themselves in the role. Another misperception is that nursing is all hospital-based, when the reality is that only 60 percent is.

As for nursing schools, about 90,000 qualified applications are turned down from nursing schools each year due to lack of space, and there is not enough scholarship and loan repayment money to support nursing students. The nursing shortage is, in large part, a nurse faculty shortage. This country is shy about 2,100 nurse faculty. We need to increase the number of highly educated nurses who can be faculty in the U.S. To retain them, we need to pay them on par with what they can earn clinically.

I mentioned that schools also struggle to find nurses outside of school willing to precept nursing students-in-training. Like medical school, nursing education combines classroom learning with hands-on clinical training in hospitals and clinics. That clinical training relies on established nurses willing to precept students. In medicine, there's a paid mechanism through Medicare to support medical education, but not so in nursing. At a time when nurse shortages are glaring, nurses with a full clinical workload are often overtaxed and struggle to take on students, too.

Finally, some schools have offices, classrooms, practice spaces, and/or simulation areas that are arcane or inadequate.

As leaders in nursing, at Johns Hopkins, we prepare for both current and future challenges. We prepare nursing students for today's acute care-focused medical system, and we must prepare them for the health system of the future, in which most encounters will happen at home, online, in clinics, at schools, or in businesses.

As you consider solutions to the crisis, I want to acknowledge the vital work Congress has done to strengthen and grow the Title VIII nursing workforce development programs through annual appropriations and the CARES Act of 2020.

I urge the Committee to support the Future Advancement of Academic Nursing Act (Or FAAN Act) when it is reintroduced by Senator Merkley and Congresswoman Underwood, and cosponsors. It would address all the areas I have mentioned, specifically, solving barriers for students, preceptors, faculty, and enhancing infrastructure.

In closing, I highlight two additional principles to guide this body's deliberations.

First, as a Nation, we must strive to make nursing more disability-inclusive. Twenty 7 percent of the country has a disability. Both ethically and practically, we should tap the strengths and skills of people with disabilities.

Second robust support for preventive health care approaches could also save money, reduce poor health outcomes and, thus, require fewer nurses. With a more deliberate emphasis on a preventive healthcare system, we might no longer have a nursing shortage. Models delivered at home, like the CAPABLE program I spearheaded, for instance, would allow older adults to age in the community. Today, nurse scientists are developing many models that may soon provide health care for our Nation that is both better AND less expensive.

Thank you and I would be pleased to answer any questions you may have.

[SUMMARY STATEMENT OF SARAH SZANTON]

Johns Hopkins School of Nursing and Its Dean

- Johns Hopkins School of Nursing, in Baltimore, MD, is a leading school of nursing that educates nurses from all over the country to become nurses as well as nurse practitioners, nurse anesthetists, and PhD level nurse scientists.
- Sarah Szanton is a professor, nurse and dean of the Johns Hopkins School of Nursing, where she has spent 25 years teaching nurses and nurse scientists, making house calls in the community, and conducting research.

Testimony Focus

- The nursing shortage has been exacerbated by COVID with likely 200,000–400,000 RNs short by 2025.
- The average age of the 4.5 million U.S. nurses is54.Twenty percent of working nurses are at least65 years old.
- The nurse shortage will grow more severe as these nurses approach retirement, and the aging population encounters more chronic diseases.
- There are barriers to becoming a nurse both from the student perspective and the school perspective.
- Schools turn down over 90,000 qualified applications each year due to shortage of both faculty and clinical preceptors who provide hands on training, inadequate facilities, and financial aid shortages.
- To stay in nursing, nurses need supportive work environments, career ladders and for some—opportunity to return for advanced education.
- It's important to simultaneously prepare nursing students for today's acute care-focused medical system, and the health system of the future, in which most encounters will happen at home, online, in clinics, at schools, or in businesses.
- We acknowledge the vital work Congress has done to strengthen and grow the Title VIII nursing workforce development programs through annual appropriations and the CARES Act of 2020.

Recommendations to Senate Help Committee

- Support the Future Advancement of Academic Nursing Act (FAAN Act) when reintroduced which would address student enrollment and retention, support modernization of curricula including mental health of patients and communities, address faculty and precept or shortage while diversifying the field, enhance outdated infrastructure and train more nurse scientists.
- Improve recruitment and retention of people with disabilities to be nurses and doctors; this can improve health care and decrease workforce shortage.
- Consider preventive healthcare approaches to improve health outcomes, save money and possibly require fewer nurses.

The CHAIR. Dr. Szanton, thank you very much. Senator Cassidy is going to introduce our next witness. Senator Cassidy.

Senator CASSIDY. Dr. Szanton, first let me compliment you. You finished just at—your time ran out. It was just like a gymnast getting her feet down perfectly.

[Laughter.]

Senator CASSIDY. My pleasure to introduce Dr. Leo Seoane. And on a note of personal pride, this is, I think, the fifth or sixth time one of my former students has testified. I think the first time I have actually invited. So, you have done very well, Dr. Seoane.

I think you would say your success is despite your instructor, not because of. But anyway, my pleasure to introduce Dr. Leo Seoane, the Executive Vice President and Chief Academic Officer of Ochsner Health System.

He is a graduate of LSU Medical School, and he joined Ochsner in 2001 and has served in a variety of leadership roles, overseeing both medical care and medical education. As Chief Academic Officer, Dr. Seoane leads Ochsner's partnership with Loyola regarding nursing, Loyola of New Orleans, and Xavier of New Orleans, which is soon to join Meharry, becoming the sixth historically black college and university in the Nation to have a medical school. He is also currently serving as interim Chief Executive Officer at Ochsner System, North Louisiana, which has a wide rural catchment area.

For decades, Dr. Seoane has worked to improve the quality of care for Louisiana families, including partnering with other academic institutions for workforce development initiatives within Ochsner, so that future Louisiana health care providers have access to the best education possible.

As a doctor and educator in Louisiana, Dr. Seoane understands the challenges that rural and underserved communities face when it comes to health care shortages. He also understands the importance of having an educated and diverse health care workforce to close the health gap and provide quality care. I look forward to Dr. Seoane's insights on how to address these issues.

STATEMENT OF LEONARDO SEOANE M.D., FACP, CHIEF ACADEMIC OFFICER, OCHSNER HEALTH, NEW ORLEANS, LA

Dr. SEOANE.

[Technical problems]—Chairman Sanders, and thank you, Senator Cassidy. I am almost as nervous as I was on rounds with you when I was——

[Laughter.]

Dr. SEOANE [continuing]. and distinguished Members of the Committee. I am the lead of the medical education programs at Ochsner in my role as Chief Academic Officer. As Senator Cassidy said, I lead the partnerships with our universities and colleges. Headquartered in New Orleans, Ochsner is one of the Nation's leading nonprofit, clinically integrated academic health centers.

We deliver care to urban, suburban, and rural communities throughout the Gulf Coast. Over the last 14 years, in partnership with the University of Queensland, we have helped train 800 new physicians for the United States. We also annually train more than 330 residents and fellows through our 31 ACGME accredited residency programs.

Today's hearing comes at a critical time for us. Like providers across the Nation, Ochsner faces an alarming shortage of nurses,

doctors, and health professionals. As Senator Cassidy knows very well, we face a significant challenge in that Ochsner serves patients who come from low income, rural, and historically underserved communities.

Ochsner has undertaken dozens of proactive and innovative initiatives to recruit and develop a pipeline of doctors, nurses, and allied health professionals. But despite these efforts, today, we have 1,200 open nursing positions throughout our system. In addition, we are also experiencing a physician shortage.

Last year, the American Association of Medical Colleges projected that over the next decade, as Senator Sanders pointed out, Louisiana will be the third worst in physician shortages of all 50 states. And our neighbor Mississippi will be the worst.

During the past 6 months, these shortages have forced us to close more than 100 beds across the health system, resulting in the need to hold more patients in the emergency departments that are already constrained. There are two main causes for our nursing shortages in our region.

First, a lack of training and educational capacity that is preventing us from developing the adequate pipelines needed to fill our current nursing positions. Second, these shortages are putting an enormous strain on our current workforce and in turn leading to loss of our bedside clinical nurses. This has been exacerbated by the pandemic.

Moreover, these shortages have led to rising costs and increased competition for qualified health professionals. Since 2019, our nonagency labor costs have grown just under 60 percent. In comparison, over the same period, our contracted staffing costs for nurses and allied health has increased nearly 900 percent.

Ochsner is committed to addressing the workforce shortages today and developing the next generation of health care providers. We know solutions are multifaceted and require partnerships with Government, and universities and colleges. We are trying to do our part. In 2022, we invested more than $5 million to operate dozens of different workforce programs, impacting more than 1,200 individuals.

We are seeking to grow the pipeline of high school and college students entering health care careers and provide career advancement opportunities for existing employees by offering earn as you learn programs. We in the Gulf Coast regularly experience and survive hurricanes. This makes us resilient and innovative. And we have brought these traits to solving our workforce shortages.

My written testimony provides greater details, but here are two examples. In 2021, Ochsner invested $20 million to launch a partnership with the Delgado Community College in New Orleans to train the next generation of nurses and allied health professionals. The resources cover a new training facility and full-time tuition for Ochsner employees pursuing a nursing or allied health career.

We also provide tuition support for physicians that are committed to working in primary care and behavioral health, as well as tuition support for nurses that are committed to working throughout the Gulf Coast at the Ochsner system post-graduation.

We take—we understand and take real responsibility that we need to train a more diverse workforce that represent the diverse communities of Louisiana and Mississippi.

To that end, in January, Ochsner partnered with the Xavier University, one of our premiere HBCUs, to announce plans to create the Xavier Ochsner College of Medicine, with the explicit mission to increase the number of underrepresented physicians in the U.S. We appreciate that Congress has taken several steps to address health care workforce gaps. However, additional efforts are needed to bolster local efforts like the ones we have undertaken.

My written testimony provides a range of ideas, including investments to help scale our proven local solutions, increasing the number of GME slots, and providing more stable Medicare and Medicaid reimbursement climate for our physicians.

In conclusion, on behalf of Ochsner and all the communities we have the privilege of serving, thank you again for this opportunity. We stand ready to work with you and your colleagues through public, private partnerships to ensure access to quality care for the patients across the Gulf Coast and our Nation.

[The prepared statement of Dr. Seoane follows:]

PREPARED STATEMENT OF LEONARDO SEOANE

Chairman Sanders and Ranking Member Cassidy, I am Dr. Leonardo (Leo) Seoane of Ochsner Health, where I serve as Executive Vice President and Chief Academic Officer; Associate Vice-Chancellor of Academics for LSU Health Shreveport; and Professor of Medicine for University of Queensland. On behalf of Ochsner Health (Ochsner) and our nurses, physicians, and other professionals who provide comprehensive, quality care to families and communities throughout Louisiana and Mississippi, thank you for the opportunity to present testimony to you and your colleagues on the Senate Health, Education, Labor, and Pensions Committee.

Since joining Ochsner in 2001, I have supported Ochsner's continuum of education, including undergraduate, graduate and continuing medical education programs, as well as all research initiatives. Additionally, I oversee Ochsner's partnerships with the University of Queensland Ochsner Clinical School, Xavier University of Louisiana (Xavier), and Loyola University of New Orleans. I am particularly proud to serve as our executive champion for Healthy State by 2030, Ochsner's commitment to building a healthier Louisiana for all people. As a Cuban American, this vision and our efforts to create health equity for the diverse communities we serve are professionally and personally meaningful to me. I graduated from Loyola University in New Orleans with a Bachelor of Science in Biological Sciences and earned my Doctor of Medicine degree at Louisiana State University School of Medicine. I am certified by the American Board of Internal Medicine in internal medicine, pulmonary care, critical care, and palliative medicine.

Over the last several years, Congress has taken meaningful steps to address health care workforce gaps and improve patient access to care. This includes the support and expansion of various graduate medical education programs, Health Resources and Services Administration (HRSA) grants provided to strengthen and expand access to care in rural and underserved areas, and resources to enhance and facilitate the use of telehealth. Moreover, substantial resources were provided temporarily to a wide range of health care providers during the COVID–19 public health emergency (PHE). However, although the Federal PHE will soon expire, we know that the pandemic has had a lasting impact on the U.S. health care system. As I will discuss in greater detail, Ochsner has undertaken numerous initiatives to retain health care workers and expand the future pipeline for doctors, nurses, and other allied health professionals. However, it is clear that additional efforts are needed in both the public and private sectors. This hearing—the first for the HELP Committee this Congress—could not be happening at a better time. We thank the Committee for its leadership and look forward to contributing to this important examination of policies and programs that can help improve patient access to care by addressing current and anticipated workforce challenges.

We are honored to have this opportunity to share with you our experience with the current health care workforce shortage and discuss several initiatives to develop and retain existing health professionals and build a pipeline of the next generation of caregivers. Ochsner stands ready to be a resource for the Committee and your colleagues in Congress as you explore ways in which the Federal Government may help address the current and anticipated shortage of nurses, physicians, and other health professionals. Working together, we can ensure the patients of today and tomorrow receive the primary, specialty, urgent, and emergency care they need and deserve.

About Ochsner

Ochsner, headquartered in New Orleans, is one of the Nation's leading clinically integrated not-for-profit academic health systems. Ochsner's mission is to Serve, Heal, Lead, Educate and Innovate. As a leader in value-based care and delivery system innovation, we provide a comprehensive range of services across 90 specialties and subspecialties. This is done through our clinically integrated network of 4,600 affiliated and employed physicians and 47 owned, managed, and affiliated hospitals. Of these hospitals, eight are critical access hospitals located in medically underserved rural areas in Louisiana, Mississippi, and Alabama. We are proud that our innovative partnership model through the Ochsner Health Network (OHN) allows many communities to maintain local ownership and control of their hospitals, while bringing to bear the benefit of experience and breadth of the Ochsner clinical and operational teams. Each year we serve more than one million individual patients who come from every state in the Nation and more than 70 countries. Ochsner educates thousands of health care professionals annually. With our partner, LSU Health Shreveport, we are the leading educator of physicians in Louisiana. For the past 14 years, Ochsner has been training medical students through a partnership with University of Queensland, resulting in more than 800 new physicians for America. In addition, Ochsner is a leader in graduate medical education (GME) programs with 31 ACGME accredited residency and fellowship programs, through which we train more than 330 residents and fellows each year.

Louisiana's Health Care Workforce Shortages

Louisiana and Mississippi historically are the lowest-performing states for health outcomes in the U.S. Illustrating the myriad challenges facing the states that we serve, the United Health Foundation's America's Health Rankings 2022 Annual Report ranked Louisiana as 50th and Mississippi 49th.[1] The leading drivers of poor health for both states are economic hardship, high rates of chronic disease and premature death, and low high school graduation rates as compared to other states. Moreover, while Louisiana has expanded Medicaid and overall numbers of uninsured have decreased, a significant proportion of the individuals and families we serve are underinsured. According to the American Community Survey reflecting 2016–2020, Mississippi and Louisiana are among the top five states and territories with the highest percentage of the population living in poverty. The COVID–19 pandemic has had disproportionately large impacts on minority communities, uninsured populations, and rural communities—all of which are found in Louisiana and Mississippi. Ochsner was the first to document the disproportionate impact of COVID–19 on African American communities in the New England Journal of Medicine in May 2020.

Louisiana has been especially hard hit by the pandemic. The Louisiana Department of Health's COVID–19 dashboard reports over 1.55 million cases to date in Louisiana and more than 18,600 deaths. This impact has been further exacerbated by the five named hurricanes that have made landfall in Louisiana since the pandemic began. Louisiana's health care workforce has played a critical role in the delivery of life-saving clinical care throughout the pandemic, but it has placed a tremendous strain on the entire health care delivery system and our workforce.

Ochsner, like other health care providers throughout Louisiana and the Nation, continues to face an alarming shortage of nurses practicing in our communities. Despite multiple efforts to address these shortages, we currently have nearly 1,200 open registered nurse positions to fill. Unfortunately, the pipeline of available nurses being educated in Louisiana is not keeping pace with demand. The 2022 Louisiana State Board of Nursing's Education Capacity Report shows that more than 1,200 qualified students were denied admission to the pre-RN licensure schools in 2021 due to insufficient training capacity.

---

[1] *https://assets.americashealthrankings.org/app/uploads/allstatesummaries-ahr22.pdf*

A 2017 study by the U.S. Department of Health and Human Services (HHS) estimated that the Nation would need 3.6 million nurses by 2030—or approximately 50,000 new registered nurses each year from 2017 through 2030.[2] More recently, in September 2022, the U.S. Bureau of Labor Statistics reported that the Nation will have approximately 203,000 annual openings for new registered nurses through 2026, due to nurses retiring or otherwise leave the nursing field.[3] The nursing shortage was once due to a lack of individuals interested in the field, but the challenge now is there is lack of nursing school capacity to support the matriculation of all interested and qualified students. Inadequate nursing school capacity is due to several factors, including lack of qualified and available faculty, insufficient funding to support enough faculty positions, and faculty salaries that are significantly lower than bedside, management, or administrative nursing positions. Without numerous interventions to address these issues, Louisiana will continue to lose interested and qualified nursing students.

In addition to the severe shortage of nurses, we also face a shortfall in physicians—both in Louisiana and across the Nation. In a 2021 report, the American Association of Medical Colleges projected that "physician demand will grow faster than supply, leading to a projected total physician shortage of between 37,800 and 124,000 physicians by 2034."[4] AAMC estimates that Louisiana will rank third in the Nation for shortage of physicians by 2030. Louisiana's population estimate for 2030 is 4.6 million. Therefore, the estimated shortage of physicians comes to 100 per every 100,000 people. Neighboring Mississippi is projected to have the worst physician shortage in the Nation by 2030, with 120 physicians needed for every 100,000 people. Rural and underserved communities throughout Louisiana and Mississippi are expected to be the hardest hit.

Impact of the Nursing Shortage on Ochsner and Our Patients

The ongoing nursing workforce challenge has created a nationwide reliance on agency nurses, which significantly drives the cost of delivering care. The number of unique job postings in the U.S. for travel nurses more than doubled from January 2019 to January 2022 and the average amount staffing agencies charge hospitals and pay their nurses has increased from 15 percent in January 2019 to 62 percent.[5]

The operational and financial impact of staff shortages and nursing and allied health staff agency costs on the Ochsner system pre-pandemic to today has been dramatic. Our contract staffing costs alone increased by 892 percent since 2019. During the same period, non-agency labor costs grew 59 percent. Ochsner currently contracts with approximately 600 agency registered nurses. In addition to the increased costs, relying on high numbers of agency nurses can impact the effectiveness of care delivery teams. Hospital-based health care delivery is centered on a team-based approach and high functioning teams require consistency among the team members and iterative practice to assure highly reliable, safe care.

While we have worked hard to reduce this number and convert these positions to full time roles, the latest report from the Louisiana Nursing Supply and Demand Council indicates that nursing shortages will continue to grip the state unless we remove barriers to meet the demand and undertake more significant interventions.

Of serious concern is that these staffing shortages and the rising costs, coupled with a growing senior population with multiple chronic conditions, are impacting our ability to meet current and anticipated demand for primary, specialty, preventative, urgent, and emergency care. For example, across our system, we have closed 100 beds, resulting in the need to hold patients in non-traditional care settings like emergency departments that are already constrained. While Ochsner has a very advanced patient flow center that manages transfers across the state, over the past several months nearly all our 47 locations have been on inpatient and specialty diversion.

Ochsner's Efforts to Address Workforce Shortages

Ochsner is committed to addressing the workforce shortages of today and developing the next generation of health care providers and front-line staff for tomorrow. We know that the solution to this statewide and national problem is multi-faceted

---

[2] *https://www.usnews.com/news/health-news/articles/2022—11—01/the-state-of-the-nations-nursing-shortage*
[3] *https://www.bls.gov/ooh/health care/registered-nurses*
[4] *https://www.aamc.org/media/54681/download*
[5] *https://www.fiercehealth care.com/providers/aha-Federal-funds-needed-offset—20-patient-increase-hospital-expenses—2019*

and requires efforts from all stakeholders, including providers and state and local government. To that end, we have developed several programs and partnerships dedicated to workforce development in New Orleans and across Louisiana.

We are proud that last year we invested more than $5 million to operate more than 29 different workforce programs, serving over 1,200 individuals. We have focused efforts on increasing the supply of nurses, growing the pipeline of high school and college students entering health care training programs, and advancing existing employees by offering "earn as you learn" programs to incumbent employees. The following provides several examples of our current offerings and strategies.

- ***Delgado Community College Investment***. In February 2021, Ochsner launched a partnership with Delgado Community College (Delgado) to train the next generation of nurses and allied health professionals, forming the Ochsner Center for Nursing and Allied Health. Delgado is the largest educator of nurses and allied health professionals in Louisiana. Together, Delgado and Ochsner will meet critical workforce demands, providing more opportunities for local graduates in high-wage careers, and proactively pursue the career development of minority and disadvantaged students. Ochsner's $20 million investment in the center covers full-time tuition for Ochsner employees pursuing a nursing or allied health certificate or degree at Delgado and matching funds for a new state-of-the-art facility on its City Park Campus. In addition to RN and LPN programs, the facility will host Radiologic Technologist, Respiratory Therapy, Physical Therapy Assistant, Occupational Therapy Assistant, Surgical Technologist, Medical Laboratory Technologist, and Pharmacy Technologist programs.
- ***Ochsner Nurse Scholars*** offers a tangible solution to growing a diverse nursing workforce in Louisiana and Mississippi by providing funding support and professional development for current LPN, ADN, BSN, MSN nursing students attending accredited Louisiana and select Mississippi nursing schools full-time. In exchange for the funding, students are required to work at Ochsner as a nurse upon graduation for 1–3 years, depending on which degree they are pursuing. There are currently 364 active nurse scholars and an additional 44 who have already graduated and joined Ochsner. Over 65 percent of Ochsner's nurse scholars are demographically diverse with a 90 percent retention rate of program participants. Students are attending one of 35 academic partners across Louisiana (28) and Mississippi (7).
- ***Ochsner Nursing Pre-Apprenticeship*** launched in 2021 in partnership with Delgado Community College and the Louisiana Department of Education (LDOE). It provides high school sophomores and community college students an opportunity to apprentice as nurses. This LDOE-approved Fast Forward Pathway serves high school students across Jefferson, Orleans, St. Bernard and the River Parishes and also supports students in St. Bernard in partnership with Nunez Community College. The program will soon expand to students in Shreveport, Lafayette, Monroe and Baton Rouge. With more than 350 students currently, the program seeks serve more than 600 students over the next 2 years.
- ***Ochsner Facilities Pathway Pre-Apprenticeship*** launched in 2022 in partnership with Delgado Community College and includes a high school pathway for the skilled trades (plumbing, light electrical, etc.) as well as an incumbent apprenticeship pathway. While the high school pathway is new in 2023, in partnership with Jefferson Parish Public Schools, the incumbent pathway has seven apprentices who will graduate in May 2023 from Delgado. This pathway has been submitted for recognition as a registered apprenticeship.
- ***The Ochsner Catalyst Summer Internship Program (Catalyst)*** build awareness of career opportunities in the health care industry. In its 3d year, Catalyst draws college students pursing an undergraduate or graduate degree for an 8-week paid summer internship. The program provides 1:1 mentorship, hands-on experience, peer networking and developmental training sessions and assists students in identifying non-clinical health care career opportunities, while providing economic security. More than 500 students applied for the 100 opportunities.
- ***Ochsner's Medical Assistant to Licensed Practical Nurse (LPN) Apprenticeship*** recently celebrated the pinning of 31 LPNs. In partnership with LCTCS colleges, North Shore Technical Community College, and Delgado Community College, the registered apprenticeship offers tuition-free career growth to current Ochsner Medical Assistants. Plans are underway to scale the program into the Shreveport and Lafayette areas.
- ***Ochsner's LPN to Registered Nurse Apprenticeship*** celebrated its first cohort in 2022–23. This earn as you learn registered apprenticeship provides an opportunity for LPN to advance in the nursing profession to ADN while sustaining their living. While in an Ochsner apprenticeship, benefits are subsidized allowing the apprentice to pursue education while continuing to earn a living wage. Seven students were part of the inaugural cohort.
- ***IMPACT Essential Skills Builder*** trained over 200 incumbent environmental services, patient escort, supply chain dock workers and certified nursing assistants in ethical decisionmaking, interpersonal communication, and critical thinking skills. Participants are given opportunity to meet with a career coach to shape a personal career development plan

that aligns them to opportunities ranging from apprenticeship pathways to nurse scholars to tuition reimbursement for college.

- ***MA Now,*** first launched in 2013, is our signature community-facing program that links unemployed and underemployed to a nursing pathway. Students earn several industry-aligned credentials including the certified clinical medical assistant, phlebotomy, ED Tech Monitor, and EEG pathways. More than 250 MA Now graduates have been trained and employed by Ochsner. Graduates regularly move into leadership, LPN, and RN positions as they advance their careers.
- ***PAR Now,*** modeled on the highly successful MA Now, is Ochsner's community-facing Patient Access Representatives or PAR Now program. It prepares un-and underemployed for positions as a clerical medical assistant in the Revenue Cycle job family. Like MA NOW graduates, PAR NOW graduates earn stackable credentials that open multiple doors for the graduates.
- ***Community Health Worker (CHW)*** is helping to build a diverse workforce to service community clinics and support health equity initiatives at the neighborhood level. In 2022, nearly 50 CHWs were trained by Delgado Community College, in partnership with Clover (previously Kingsley House in New Orleans) and funded by a grant from Blue Cross Blue Shield.
- ***Patient Care Assistant (PCA) to Certified Nursing Assistant (CNA)*** is a 8-week pathway program for those with a strong desire for bedside caregiving who lack a credential. New hires enter an ''earn as you learn'' pathway that includes didactic training at a local community college while students supplement the ancillary staff in the hospital as they build their skills. Students graduate as a Certified Nursing Assistant and enter a pathway to progress to LPN and then on to RN.
- ***In-Patient Bedside Coding*** is a 2-year program to build the knowledge and capacity for an individual to serve as an in-patient coder. This highly sought-after talent is in short supply across our Nation. The complexity of in-patient coding requires advance training. Our apprenticeship allows students the opportunity to grow their knowledge, skills, and abilities to successfully compete in this high demand occupation. Ochsner has successfully trained two cohorts, including one that progressed during the height of the COVID–19 pandemic.

Ochsner's Efforts to Strengthen and Diversify the Physician Workforce

Ochsner is proud of our long-standing commitment to train the next generation of primary care and specialty physicians. We are working diligently to create more resident and fellowship opportunities throughout the region by building new GME programs in Lafayette and the Greater New Orleans Area. We are proud to have developed Ochsner's Program to Introduce Medicine to Underrepresented Students (OPTIMUS), which provides education about career options in medicine, hands-on simulations and experiments. Ochsner also sponsors the Ochsner Academics Summer Internship for Students (OASIS) program. OASIS provides formative experiences to undergraduate students interested in pursuing a career as a physician, physician assistant, or researcher in the biomedical sciences with a focus on supporting African American and Hispanic students, as well as students of Ochsner employees.

Although Black and African American populations account for 13 percent of U.S. residents, according to the AAMC, representation of African Americans within medicine lags, as they comprise only 5 percent of all U.S. doctors. Research shows an urgent need for a Historically Black College and University (HBCU) medical school. Recognizing this significant and growing need, in January 2023, Ochsner and Xavier University announced plans to create the Xavier Ochsner College of Medicine.

Together, Xavier and Ochsner will create a new curriculum and use facilities, personnel, and administrative processes of both institutions to support the new school of medicine. Xavier's College of Pharmacy, established in 1982, is the oldest in Louisiana and has for years been among the top in the Nation in producing African American graduates with Doctor of Pharmacy degrees. The new Xavier Ochsner School of Medicine will build upon this strong legacy and result in greater diversity and representation among medical practitioners, which is critical to improving health outcomes by increasing quality of care, access, and patient trust in their health care providers.

Other Investments to Build A Diverse and Inclusive Workforce

Ochsner recognizes that an essential component to advancing equity and reducing health disparities is ensuring that our own workforce and that of the Nation reflect our diverse communities and society. To that end, in November 2020, Ochsner announced the creation of the Ochsner-Xavier Institute for Health Equity and Research (OXIHER) to focus on five key strategies to address health inequity in Louisiana, including recruiting, educating, and training a diverse health care workforce.

OXIHER trains health care workers to lead and innovate in health equity. Ochsner is pursuing this strategy through several initiative including the following:

- In addition to the new medical school and OXIHER, Xavier and Ochsner also have worked to improve diversity within the health sciences by establishing a new Physician Assistant (PA) Program. In May 2022, Ochsner and Xavier celebrated the first graduating class of 37 students in the full-time graduate PA Program with a 93 percent completion rate. The program leads to a master's degree in health sciences and trains the next generation of providers to make a meaningful impact on health care. In 2021, Ochsner and Xavier also established a Bachelor of Arts in Medical Laboratory Science Program. Genetic counseling and health informatics programs will be available in the near future and will be offered to students through classroom instruction at Xavier and clinical rotations at Ochsner facilities. Xavier will be the first university in Louisiana to offer a genetic counseling training program. It will be the only such program based at an HBCU.
- NextOp and Ochsner have been awarded a $1.1 million grant to help transition military and veteran talent in the Mississippi River Delta area. The Workforce Opportunity for Rural Communities Initiative Grant from the U.S. Department of Labor and the Delta Regional Authority will be used to help qualified applicants find careers in the health care industry. Over the course of 3 years, the goal is to hire 300 veterans into clinical and non-clinical careers with Ochsner.

Innovations to Reduce Workforce Strain, Boost Care Delivery, Increase Teaching Capacity, and Enhance Workplace Safety

Nurses have experienced unprecedented strain, stress, exhaustion, and anxiety since the start of the PHE and the resulting, understandable burnout has contributed to the numbers leaving bed-side nursing. To help reduce the strain on our workforce and address burnout, we have undertaken a number of steps and launched new efforts, including the following initiatives:

- We are leveraging certified nursing assistants who can perform functions like taking vital signs, freeing nurses to engage in the provision of other care and services aligned with their training and allowing them to practice at the top of their licenses. Similarly, we are bringing more LPNs to general medical surgical areas in the inpatient setting so they can provide care and assistance in a manner consistent with their state scope of practice and training.
- Through innovationOchsner, we have a long history of successfully leveraging technology to solve access to care challenges, as seen through our successful digital hypertension and diabetes health offerings, Connected MOM, telehealth platform, eICU, and the virtual care program Ochsner Connected Anywhere. Utilizing our experience with these initiatives, we currently are piloting a Virtual Nursing Program at our Ochsner Medical Center Kenner location. There, we have a bunker with a cadre of nurses who work a 12-hour shift but are not directly located on an inpatient unit. The Virtual Nurse Program, which provides 24-hour virtual nursing support to the patient care team, is an innovative staffing model focused on patient-centered care and safe distribution of workload across an integrated team of virtual and bedside nursing personnel. The bunker contains a bank of computers and a high-tech early warning system through EPIC, which together allow for the monitoring of up to 20 patients at a time.

  The pilot has already improved risk adjustment mortality index and turnover rates and we are in the process of expanding the program to other Ochsner campuses. Further, the bunker technology allows the remote nurses to virtually enter certain patient rooms to assist with clinical and administrative matters, such as discharge paperwork, which often can be burdensome to the bedside nurse and can cause delays in getting patients home or to the next care setting. This approach allows bedside nurses to focus on direct care and leverages the bunker nurses—via technology hook-ups—to manage non-direct care matters—resulting in more efficient care delivery, a better patient discharge experience, and less strain on the bedside nurse.

Roles and Responsibilities in Virtual Nurse Care Model		
Virtual Nurse	**Mutual/Shared**	**Beside Care Team**
• Admission Documentation • Care Plan • Discharge Education • Transfer Documentation • Proactive rounds • Conduct real-time quality surveillance (nightshift) • Document emergent/urgent Code Blue/Rapid Response • 24-hour chart checks • Review trends (early intervention for deterioration: AI alerts	• Educate patients • Monitor patients • Document Care • Respond to patient/family questions • Collaborate with interprofessional care team	• Conduct physical assessments • Conduct Bedside Handoff • Hourly Purposeful and Safety Rounds • Provide Direct Patient Care (med administration, treatments, care plan) • Manage discharge process • All ''hands-on'' care

- We are also leveraging technology by providing patients with MyChart Bedside on personal tablets to help connect them with their care and their care team. MyChart Beside puts Ochsner's integrated, electronic health record in patients' hands, giving them real-time access to lab results, medications, and treatment plans. Patients also can order meals, call housekeeping, and have other non-clinical needs addressed. This reduces the burden and demand on nurses to handle non-clinical concerns for patients, allowing them to focus their time, efforts, and expertise on clinical matters.
- Recognizing that our nursing schools have limited capacity due to insufficient numbers of teaching faculty, we are supporting several of our full-time employed Ochsner nurses in stepping out of their clinical roles 2 days a week to serve as clinical adjunct faculty at colleges of nursing. Ochsner continues to pay their salaries in full, which provides schools of nursing with faculty at no cost.
- There is nothing more important to Ochsner than the safety and security of our employees and our patients and their family members. Tragically, workplace violence against health care workers has been escalating and disruptive or violent incidents in hospitals—many involving hostile visitors—are on the rise, including in our own system. As part of our commitment to the mitigation of workplace violence we have deployed a multifaceted approach. A key component of this effort is our multidisciplinary Workplace Violence Committee, which is focusing on patients, employees, and visitors. Within our internal communication daily safety escalation huddles workplace safety is discussed for each campus and as a system, in addition to patient safety. We are providing education for our employees on workplace violence and offer support programs for employees who have been victims. Further, we are implementing enhanced security solutions and improving our tracking of incidents and analysis of related data. During the previous session of Congress, we were proud to lend our support to Congressman Troy Carter's resolution condemning violence against health care workers and the bipartisan *Safety from Violence for Healthcare Employees (SAVE) Act,* which would establish legal penalties for assaulting or intimidating hospital employees.

Recommendations for Federal Policy, Programs, and Funding

We sincerely appreciate you prioritizing the health care workforce and thank you for your interest in working with Ochsner to advance solutions for Louisiana and the Nation. We offer the following ideas for the Committee's consideration. We note that some of these policies fall squarely within the jurisdiction of this Committee, while other initiatives will require programmatic changes to Medicare, Medicaid, and other programs, which may be in the purview of other Senate Committees:

Health Care Workforce Shortages

- Provide funding to non-profit health systems and academic partners working together to increase the pipeline of physicians, nurses, and allied health professionals. Prioritize efforts that demonstrate a commitment to addressing economic and health disparities in the health care workforce.
- Address nursing shortages by investing in nurse faculty salaries and hospital training time, including reimbursement for hospitals and health systems that make their nurses available as faculty to colleges of nursing.
- Authorize and fund new programs to support and scale innovative solutions that reduce the burden on bedside nurses and other clinicians, like our Virtual Nurse Program.
- Boost the Nation's ability to leverage availability of international physicians and nurses. Increase the visas available through proposals like the bipartisan *Health Care Workforce Resilience Act* which allows for recapture from previous fiscal years unused immigrant visas for physicians (15,000) and nurses (25,000), exempts these visas from country caps, and directs State Department and Department of Homeland Security to expedite these processing of these recaptured visas.

Access to Care

- Increase the number of physician residency slots and safeguard GME funding from reductions.
- Establish new scholarships for minority health professional students in return for work in rural or safety net hospitals, or those in federally designated health professional shortage areas.
- Provide additional Medicare funding to hospitals experiencing extraordinary inflationary pressures caused by the pandemic, including a fix to the hospital market basket update to correct for lag times.
- Prevent further reductions to Medicare and Medicaid physician payments, which may have a negative impact on patient access to certain services, and support adjustments for inflation and rising input costs.
- Make permanent Medicare coverage of certain telehealth services made possible during the pandemic, including lifting geographic and originating site restrictions, expanding practitioners who can provide telehealth, and allowing hospital outpatient billing for virtual services.
- Redesign current Medicare coverage and payment policies for remote patient monitoring to remove barriers—such as cost-sharing—that thwart patient access to innovative care delivery models shown to improve patient health outcomes and reduce the overall cost of care for patients.

Conclusion

On behalf of the nurses, physicians, and other professionals who serve the more than one million individuals we care for each year, thank you again for this opportunity to present testimony regarding the current health care workforce challenges we face and for allowing us to discuss ways in which the shortages can be addressed. We are confident that through public-private partnerships we can together recruit, train, educate, and retain a diverse and robust health care workforce to ensure access to quality primary and specialty care for patients across the Nation. We are eager to work with you on this national imperative and welcome the opportunity to discuss our experience further and answer any questions.

[SUMMARY STATEMENT OF LEONARDO SEOANE]

About Ochsner Health

- Ochsner, headquartered in New Orleans, is a clinically integrated not-for-profit academic health system with a network of 4,600 affiliated and employed physicians and a combination 47 of owned, managed, and affiliated hospitals throughout Louisiana, Mississippi, and Alabama.
- Ochsner serves as the top health care educator in Louisiana, maintaining the state's largest group of GME programs with 31 accredited residency and fellowship programs, through which more than 330 residents and fellows are trained each year.

Focus of Testimony

- Louisiana and Mississippi face unique challenges in health care delivery, as historically the lowest-performing states in terms of health outcomes in the U.S.
- Staffing shortages have had a tremendous impact on the Ochsner health care workforce and overall patient care. Despite multiple efforts to address these shortages, Ochsner currently has nearly 1,200 open registered nurse positions. By 2030, Louisiana will rank third in the Nation for shortage of physicians and Mississippi is projected to have the worst physician shortage in the Nation. Rural and underserved communities throughout Louisiana and Mississippi are expected to be the hardest hit.
- Main causes of nursing shortages in the states Ochsner serves include lack of training capacity, impact of shortages on burnout and premature retirement, and skyrocketing system costs.
- Ochsner has led multiple efforts to train and expand a diverse health care workforce through the Ochsner-Xavier partnership, specifically the Xavier Ochsner School of Medicine and Institute for Health Equity and Research (OXIHER), and other workforce development programs aimed at increasing the participation of persons from historically underrepresented and underserved backgrounds.
- Ochsner has led initiatives to reduce health care workforce strain, improve patient care, and enhance workplace safety, including leveraging CNAs and LPNs, making its clinical nurses available as faculty to colleges of nursing, deploying technology in innovative ways to enhance delivery of inpatient care, and providing employee education and support programs related to workplace violence.

Recommendations to Senate Help Committee

- Support efforts to address health care workforce shortages, including investing in nurse faculty salaries, hospital training time, and non-profit health systems and academic partners working to increase the health care workforce pipeline, among other suggested initiatives.
- Advance initiatives to expand access to care, including increasing the number of physician residency slots, safeguarding GME funding from reductions, establishing new scholarships for minority health professional students, providing additional Medicare funding to hospitals experiencing extraordinary COVID–19 related-inflationary pressures, preventing further reductions in physician payments, and making permanent Medicare coverage of certain telehealth flexibilities granted under the PHE, among other suggested policy and programmatic changes.

The CHAIR. Dr. Seoane, thank you very much for your testimony. Our final witness will be Dr. Douglas Staiger, Professor at Dartmouth College. Dr. Staiger received this Ph.D. in economics from MIT and has served as faculty at Stanford and Harvard before joining Dartmouth in 1998. Dr. Staiger, thanks for being with us.

STATEMENT OF DOUGLAS STAIGER PH.D., PROFESSOR, DARTMOUTH COLLEGE, HANOVER, NH

Dr. STAIGER. Thanks, Chairman Sanders, Ranking Member Cassidy, Members of the Committee. It is an honor to be here this morning. No group of workers has been touched more directly and deeply by the COVID–19 pandemic than frontline health care providers, particularly nurses.

I am going to focus my comments on nurses this morning, and I am an economist, so I am going to focus on data about employment and earnings in nurses. The U.S. has enjoyed steady growth in the registered nurse workforce, doubling the number of RNs per capita over the last four decades.

However, since the start of the COVID–19 pandemic, RN workforce has been in flux. So, developing effective policies to strength-

en the current and future RN workforce requires timely data. Over the last 20 years, I have worked with the research team to identify emerging trends in the health care workforce and forecast the future supply of RNs. And based on our recent and ongoing research, we see three key issues going forward.

First, after a sharp decline in 2021, our unemployment recovered in 2022 and now is nearly 5 percent above where it was in 2019 before the pandemic, so there has been strong growth. RN earnings have grown slightly faster than inflation during the pandemic, whereas earnings in other occupations have grown more slowly than inflation.

Encouragingly, as of 2022, both RN employment and earnings are at or above their pre-pandemic trends. But the big change that we have seen during the pandemic has been a shift of RN employment away from hospitals and into other settings, such as outpatient clinics, physician offices, schools, etcetera.

All of the growth in RN employment since 2019 occurred outside of hospitals, and that is very unusual. We haven't seen that in years before. This helps to explain why hospitals are reporting shortages of RNs, right. If this trend continues, actions will be needed to improve the work environment and attract RNs back to working in hospitals.

Otherwise, hospitals will need to develop strategies and be supported to better utilize a smaller RN workforce. Second key issue for the future supply of RN s is the educational pipeline. Application to nursing schools dipped in 2020 but rebounded strongly in 2021 and have continued their upward trend.

Today are as high as they have ever been. However, the pandemic decreased academic preparedness of high school students entering nursing programs, which threatens to slow their educational progression and entry into the workforce.

Similar patterns are seen in nurses taking the licensure exam, continued steady growth in numbers taking the exam, but a notable decline in pass rates, from 88 percent pre-pandemic to about 81, 82 percent in the last couple of years.

These trends paralleled the decline in academic achievement during the pandemic for students in K–12 education, particularly those attending high poverty schools who lag roughly half a grade level behind pre-pandemic achievement levels.

Nursing schools and employers realize they have to provide their nursing students and new nursing employees with additional training, and this may need Federal support. Third question key issue is the adequacy of the rural RN workforce, which I know is a concern of Members of the Committee.

The number of RNs per capita in rural areas is actually comparable to urban areas and projected to steadily grow amidst declining rural physicians and limited rural nurse practitioners. So, it is actually quite different from physicians, where physicians in rural areas are definitely underrepresented.

However, rural RNs are markedly less diverse than the population they serve, and only half of rural RNs have a bachelor's degree or higher, compared to over 70 percent for urban RNs, a rec-

ommendation 10 years ago from the National Academy of Medicine that 80 percent of RNs have bachelor's degrees by 2020.

The Department of Health and Human Services has recently announced large investments in the rural health workforce, which could be used for programs such as the scholarship and loan forgiveness, that increase bachelor's degrees among rural RNs and help achieve greater diversity among RNs in rural communities.

Putting all this evidence together, we have updated our forecasts and actually continue to forecast strong growth in the RN workforce. Forecast that there will be an additional million RNs over the next decade in the workforce, on top of the current workforce, employed workforce of about 3.5 million.

The main concerns that need to be addressed in the near term are the shift of our own workforce away from the hospital, decreased preparedness of students entering and exiting nursing schools, and the need to diversify the rural workforce and increase bachelor's degrees among rural RNs.

Finally, as I stated at the beginning, effective workforce planning and policymaking requires timely data and analysis. It would be valuable if there was a Federal effort to coordinate collection of better data on health care workforce that could be used to monitor the lingering effects of COVID–19 pandemic. This was something also that was recommended in the earlier National Academy of Medicine report. Thank you.

[The prepared statement of Dr. Staiger follows:]

PREPARED STATEMENT OF DOUGLAS STAIGER

Introduction

The U.S. has enjoyed steady growth of the registered nurse (RN) workforce since the 1970's, providing the backbone of the Nation's growing and evolving health care delivery systems. Now, 3 years into the COVID–19 pandemic the RN workforce is very much in flux. The acute needs of the first 2 years of the pandemic placed extraordinary demands on health care workers and health care institutions, with registered nurses often at the center of the crises. Reported shortages of key nursing personnel have been widespread, leading to cancellation of elective care, bed closures, and severe strain on the provision of both essential acute and long-term care services. These strains on the nursing workforce have led to reports of burnout, early retirement, and workplace dissatisfaction.

Developing effective strategies to strengthen the current and future RN workforce requires timely data on challenges facing the current workforce and forecasts of where the workforce is heading over the next decade. In the next three sections of this testimony, I summarize recent and ongoing research on the nursing workforce by me and others that is particularly relevant to understanding the state of the current RN workforce. In the final section, based on this evidence, I provide some recommendations on where we go from here.

The analyses that I discuss here focus on economic impacts using data collected in Federal surveys of the Nation's workforce that include RNs, including many analyses that are currently under way and not yet publicly available. This research describes the current nurse workforce, compares nurse workforce trends before and during the pandemic, identifies changes in where RNs were working during the pandemic, and builds on our 20-year record of forecasting the future growth of the RN workforce. However, these federally collected surveys do not gather information about the non-economic impacts of the pandemic on RNs. The COVID–19 pandemic has exerted an enormous toll on nurses, physicians, and other health care workers, particularly in hospitals that were impacted initially by the pandemic and by ensuing strains and waves of the Corona virus. For that broader context, I defer to others to offer insights on the non-economic impact of the pandemic on the RN workforce in the U.S.

Employment and Earnings of RNs [1]

Over the last four decades the RN workforce grew steadily from just over one million RNs in 1982 to 3.2 million in 2020. Today, the number of per capita RNs in the U.S. is either on par with or higher than most other OECD countries, in contrast with the number of physicians, which is among the lowest of these nations. In 2000 there were projections of looming RN shortages as large numbers of RNs were nearing retirement age and few younger people were entering the profession. [2] In response to these projections numerous initiatives and public awareness campaigns generated increased interest in nursing as a career among younger people, resulting in continued steady growth of the workforce.

Since the start of the COVID–19 pandemic the RN workforce has been in flux. Recently published data found that the total employment of RNs declined by more than 100,000 between 2020 and 2021, the largest such decline since at least 1980. However, RN employment recovered dramatically in 2022 and is now nearly 5 percent above where it was in 2019. Hourly earnings of RNs (adjusted for inflation) were relatively unchanged in the decade before the pandemic, but have grown slightly faster than inflation since 2019, while earnings across all occupations have grown more slowly than inflation. [3] Thus, as of 2022, both RN employment and erning have grown at or above their pre-pandemic trends.

The most notable development during the pandemic has been a shift of RN employment away from hospitals and into other settings such as outpatient clinics, MD offices, schools, etc.: All of the growth in RN employment between 2019 and 2022 occurred outside of hospitals. This helps to explain why hospitals continue reporting shortages of RNs despite robust growth of the overall RN workforce. Why this has occurred, and whether this trend will continue, is less clear. The shift away from hospital employment was particularly dramatic for older RNs, consistent with reports of increased stress and difficult working conditions exacerbated by the pandemic: A recent Medscape survey found that 40 percent of RNs said that COVID–19 had negatively impacted their career satisfaction. Actions will be needed to improve the workplace environment and attract RNs back to working in hospitals. Otherwise, hospitals will need to develop strategies to better utilize a smaller RN workforce.

The Nursing Pipeline [4]

A key factor in understanding the future supply of RNs is the educational pipeline. The number of applications to baccalaureate nursing programs has risen rapidly over the past 20 years (more than doubling). While application growth slowed in 2020, it accelerated again in 2021, allaying concerns of declining interest in a nursing career. However, the pandemic decreased the academic preparedness of high school students entering nursing programs, which threatens to slow their educational progression and entry into the workforce. [5]

Similar patterns have occurred in annual graduations from nursing education programs and the number of NCLEX test-takers (the RN licensure exam), which have grown steadily through the pandemic and have never been higher. However, pass rates on the NCLEX declined sharply during the pandemic, from 88 percent in 2018 and 2019 to 81–82 percent in 2021 and 2022, again suggesting decreased preparedness of graduates to enter the workforce. Pass rates are likely to fall further with

---

[1] This section draws largely from: Auerbach, Buerhaus, Donalan, and Staiger, "A worrisome Drop in the Number of Young Nurses," Health Affairs Forefront, April 13, 2022; Buerhaus, Staiger, Auerbach, Yates, and Donalan, "Nurse Employment During the First Fifteen Months of the COVID–19 Pandemic," Health Affairs, January 2022; and Auerbach, Buerhaus, and Staiger, "Implications of the COVID–19 pandemic for the future supply of registered nurses," unpublished manuscript, 2023.

[2] Buerhaus, Staiger, and Auerbach, "Implications of an Aging Registered Nurse Workforce," JAMA, June 14, 2000.

[3] The number of nurses working for employment agencies—including travel nurses—has nearly doubled during the pandemic. While these nurses are paid more than other nurses, they remain a small fraction of the workforce, accounting for less than 3 percent of the RN workforce in 2022.

[4] Data on applications to BSN programs and NCLEX discussed in this section come from the National Council of State Boards of Nursing and the American Association of Colleges of Nursing.

[5] *https://www.prnewswire.com/news-releases/amid-a-national-nursing-shortage-prospective-nursing-students-say-lack-of-academic-preparedness-is-the-driving-decision-to-delay-or-forego-nursing-school—301621715.html*

the introduction of the more difficult NextGen NCLEX coming later this year. Developing strategies to reverse these trends is essential.

Rural Nurses[6]

Rural RNs play an integral role in providing care for an underserved population with worse health outcomes than urban counterparts. In contrast to physicians, the number of RNs per capita in rural areas is comparable to urban areas. While the number of physicians serving rural populations has decreased in recent years, and rural nurse practitioners (NPs) remain in short supply, rural RNs have steadily grown in numbers at a rate comparable to urban RNs. Moreover, young rural nurses appear on pace with urban nurses to adequately replace older nurses and continue to grow the workforce.

While the numbers of rural RNs appear to be sufficient, the characteristics of the workforce do not align with the needs of the rural population. Rural RNs in 2019 were markedly more likely to be white, non-Hispanic (89.1 percent) than either urban RNs (68.4 percent) or the rural population they serve (77.3 percent). In 2011, the Institute of Medicine recommended that 80 percent of RNs have a bachelor's degree by 2020, yet only half of rural RNs had a bachelor's degree or higher in 2019 compared to over 70 percent of urban RNs. The Department of Health and Human Services has recently announced "record-setting investments" to bolster the rural health workforce, including RNs, and to advance equity and ensure access to care. These burgeoning investments in the rural health workforce present opportunities to help diversify, increase educational access, and further rural readiness for RNs moving forward.

Where Do We Go from Here?

While 100,000 RNs left the workforce in 2021, the RN workforce rebounded in 2022 and is back on track with pre-pandemic projections. In ongoing work with David Auerbach and Peter Buerhaus building on our 20-year record of forecasting the future growth of the RN workforce, we have estimated updated forecasts of growth in the RN workforce that incorporate these trends through 2022. Over the next decade we project the national RN workforce to not only replace the expected retirement of an estimated 500,000 RNs but further expand by nearly 1 million RNs, with growth in RNs serving both rural and urban populations.

Nevertheless, there are three main concerns looking ahead:

1. *Addressing the shift of the RN workforce away from the hospital.* While the exact reasons for this shift are not yet clear, the trend is consistent with reports of increased stress and difficult working conditions in hospitals exacerbated by the pandemic. Improving the workplace environment will require constructive engagement with nurses to identify supportive characteristics of an organization's culture and reset trusting relationships with administrative and executive leaders. Much work has been done that hospitals and other organizations can draw from to frame and guide these conversations, particularly the National Academy of Medicine's National Plan for Health Workforce Well-Being (2022). Maximizing the services provided by the remaining RNs in the hospital will require redesigning of care delivery models and removal of unnecessary restrictions on nurses' scope of practice.

2. *Addressing the decreased academic preparedness of students entering and exiting nursing schools.* The decline in academic preparedness of students exiting nursing school may be short-lived if it is driven by remote instruction during the pandemic. However, it may continue for many years as students graduating from high school suffer the lingering effects of the pandemic. Recent estimates suggest that students in all grades, particularly those attending high poverty schools, lag roughly half a grade level behind pre-pandemic achievement levels.[7] In either case, at least in the short term, nursing schools and employers will need to develop ″booster″ programs to provide their nursing students and new nurse employees with needed training. Otherwise, the pipeline of incoming nurses will be both fewer in number and less well prepared. It would be appropriate for the

[6] This section draws from Yates, Auerbach, Staiger & Buerhaus, "Characteristics of rural registered nurses and the implications for workforce policy," The Journal of Rural Health, 2023.
[7] *https://projects.iq.harvard.edu/cepr/education-recovery-scorecard*

federal government to provide some support for this training through pandemic relief funds.

3. *Addressing the need to diversify the rural workforce and increase bachelor's degrees among rural RNs.* The American Rescue Plan and CARES acts directed a new Health Workforce Strategic Plan from the Department of Health and Human Services, in which increased rural access to care and workforce diversity are critical goals. Because RNs represent a large and growing proportion of health care providers serving rural communities, policymakers should consider directing some of these resources toward the RN workforce to increase bachelor's degrees among rural RNs and help achieve greater diversity among the RN providers in rural communities. For example, scholarships that require subsequent service in rural hospitals (like loan forgiveness but without the negative connotations associated with debt) could be used to encourage under-represented groups to become rural RNs or to encourage rural RNs with an associates degree to obtain a baccalaureate degree.

Finally, as I stated at the beginning, developing effective strategies to strengthen the current and future RN workforce requires timely data. One of the 4 key messages in the Institute of Medicine's 2011 report The Future of Nursing: Leading Change, Advancing Health was that "Effective workforce planning and policymaking requires better data collection and an improved information infrastructure." The ACA created the National Health Care Workforce Commission and the National Center for Workforce Analysis to, among other things, coordinate the collection of data and analysis of the health care workforce. This would be an opportune time to use those existing structures to support better data collection and continued analysis for monitoring the lingering effects of the COVID–19 pandemic on the health care workforce.

[SUMMARY STATEMENT OF DOUGLAS STAIGER]

In my written testimony, I summarize recent and ongoing research on the nursing workforce by me and others that is particularly relevant to understanding the state of the current RN workforce, and then provide some recommendations on where we go from here. Recent evidence suggests the following:

1. After a worrisome decline in 2021, registered nurse (RN) employment has recovered in 2022 and is nearly 5 percent above where it was in 2019. RN earnings have grown slightly faster than inflation, whereas earnings across all occupations have grown more slowly than inflation. But the big change during the pandemic has been a shift of RN employment away from hospitals and into other settings such as outpatient clinics, MD offices, schools, etc.: All of the growth in RN employment between 2019 and 2022 occurred outside of hospitals. This helps to explain why hospitals are reporting shortages of RNs.

2. Applications to nursing schools dipped in 2020 but rebounded strongly in 2021 and continue their steady upward trend. However, there are concerns about decreased academic preparedness of entering students. Similar patterns are seen in nurses taking the licensure exam—continued steady growth, but a notable decline in the pass rates in 2021.

3. The number of RNs per capita in rural areas is comparable to urban areas and is projected to steadily grow amidst declining rural physicians and limited rural Nurse Practitioners (NPs). However, rural RNs are markedly less diverse than the populations they serve and only half of rural RNs have a bachelor's degree or higher compared to over 70 percent for urban RNs.

Putting this evidence together, we continue to forecast strong growth in the RN workforce over the next decade. The main concerns looking ahead are (1) a shift of the RN workforce away from the hospital, (2) decreased preparedness of students entering & exiting nursing schools, and (3) a need to diversify the rural workforce and increase bachelor's degrees among rural RNs.

The CHAIR. Thank you very much. Let me begin the questioning, and I will give the mic over to Senator Cassidy, and we will go around the table.

As I mentioned earlier, in my state, in our largest hospital, we have seen a huge expenditure of $125 million for traveling nurses at a time when we have more young people who want to become nurses but can't accommodate them in our nursing schools.

Dr. Herbert, is that in fact just a Vermont problem or is that a main problem? Is that a national problem?

Dr. HERBERT. Senator Sanders, it is very much a national problem. The traveling nurse situation that you described, you are exactly right. We are seeing the exact same thing in Maine. There's a number of reasons for it.

But I think what you are hearing from the panel today, there is consistency in terms of the nurse educator problem. But there's also hospitals are really strapped with the workload issues that I that I described earlier in terms of reimbursements.

It is complicated, but the clinical training sites like hospitals need support to be able to accommodate more trainees, which will help with the problem.

The CHAIR. Okay. Dr. Szanton, how are we going to—give me some specific ideas as to how we get more nurse educators out there so we can accommodate the number of young people who want to become nurses?

Dr. SZANTON. If we can increase all the programs through HRSA, like the nurse corps, that would be a really concrete suggestion. Currently, almost none of our students are able to get the nurse corps because we are a master's program.

I think solving all the problems that we talked about and having more simulation passing the FAAN Act would be ways of quickly trying to increase the nurse faculty abilities of this country.

The CHAIR. Okay. Dr. Hildreth, it is widely recognized, not debated, that African Americans, Latinos, and Native Americans are underrepresented in the health care profession and debates that what is the impact of that. You know, people say, so what is the difference? You know, so you have a white doctor, a black doctor who cares? Is there a difference? What is the difference?

Dr. SEOANE. Thank you, Senator Sanders. The data is very clear, as my colleague referenced earlier, that when the health care workforce reflects the population, they care for, outcomes are better. That is not to say that a white doctor can't provide great care to a black patient.

That happens every single day in our Country and vice versa. But when the provider team looks like the population they are caring for, the outcomes are better. That has been demonstrated over and over again. That is what we lose by not having a diverse workforce, the best outcomes for communities.

The CHAIR. Thanks very much. Dr. Seoane, you talked about large areas of Louisiana, in fact, all over this country, not having enough physicians, nurses, etcetera.

It is a little bit outside of the scope of this hearing, although I am going to get back to it because we have jurisdiction over the community health center program. Do you think that expanding community health centers in rural areas in America would make a lot of sense?

Dr. SEOANE. Thank you for that question, Senator Sanders. I do. I think they are important. Ochsner is starting 13 community health centers throughout Louisiana. They serve an important need.

The CHAIR. Are these federally qualified community health centers?

Dr. SEOANE. These are our own. We have gone outside the federally qualified centers. So, we partnered with federally qualified health centers, and we are starting our own community health centers, too. We are meeting all the Federal health qualified center guidelines, but it was quicker to get there into our communities to serve.

The CHAIR. Would it be advantageous if they were FQHCs? Would it work well for you or not?

Dr. SEOANE. It would be advantageous if we could work with the Government to make health centers like Ochsner be able to start these federally health qualified centers and spread them more quickly.

The CHAIR. Good. Let me ask, go back to Dr. Herbert. One of the areas that we do have jurisdiction over, and I am very strongly in support of, teaching health centers, GME. And that is an opportunity to get residents out of teaching hospitals and into primary health care facilities. Perhaps you and Dr. Hildreth can say a word about that. Is that a good idea to expand those programs?

Dr. HERBERT. That is a very good idea. And because of the caps on GME funding from the Federal Government, states have actually stepped in and done some creative things. I mean, for example, the State of Georgia has done that.

We are now working with colleagues in Maine to establish, trying to get some legislation through the State of Maine to actually directly fund GME through partnerships based in community hospitals, but in partnerships with the teaching hospitals.

There are some creative things that can be done. Could be done much more fast, much more quickly if the CMS rules were changed in the way they fund GME. But there is innovative, other innovative ways of doing it.

But we absolutely need more GME. This is critical not only for primary care but for some specialty care as well. Senator Sanders and I worked—Senator Collins, and I apologize. We are talking this morning about obstetrics and the closure of obstetric units in rural hospitals and community hospitals.

Again, GME is really the key to addressing these various issues.

The CHAIR. Dr. Hildreth, do you agree or—?

Dr. HILDRETH. I definitely agree. And as you referenced earlier, Senator Sanders, we want to make health care happen in the lowest cost setting possible, and that is certainly outpatient setting for primary care. I definitely agree that more GME in those settings would be great.

The CHAIR. Great, good.

Dr. HILDRETH. Thank you.

The CHAIR. Thank you very much.

Senator Cassidy.

Senator CASSIDY. I am going to defer to Senator Paul.

The CHAIR. Senator Paul.

Senator PAUL. Thank you. Dr. Szanton, are you pro-choice with regard to patients making individualized medical choices?

Dr. SZANTON. Broadly, thank you, yes.

Senator PAUL. Are you aware that your university doesn't allow choice with regard to vaccination, that you require all of your students to have three vaccines in order to be students?

Dr. SZANTON. Yes.

Senator PAUL. It is sort of choice, but not so much when regarding vaccination. Are you aware of the increased risk of myocarditis with the COVID vaccine, particularly with successive COVID vaccinations in males between the ages of 16 and 24?

Dr. SZANTON. Senator, thank you for the question. I am prepared to talk about the nursing crisis, and that we have vaccine requirements across the board for——

Senator PAUL. Here is the problem, if you exclude everybody from being a nurse who believes in basic immunology, you are going to include a lot of smart people, people who believe that you can get immunity from both vaccination as well as infection.

If you say, well, we are just not going to take the people who believe in that old fashioned infection thing, providing immunity, we are only going to take the people who will do as they are told. I mean, do you think individuals should be treated the same when they come to the emergency room?

If you have got an 18-year-old with chest pain and a 68-year-old obese diabetic with chest pain, you think they get treated the same in the emergency room? There are differences based on age. We used to always make differences even on the flu vaccine. We advise it for people at risk. We have done this forever.

This is the first time we have done it. We are now doing it with an experimental vaccine, one that has not been approved. Do you think that prior infection affects your immunity?

Dr. SZANTON. Senator, I am not—I don't make the choices about the vaccinations. That is a Johns Hopkins University——

Senator PAUL. Right, but you are a leader at Johns Hopkins University and you could well have your opinion stated. Dr. Marty Makary is there, and Dr. Marty Makary has been very active in this. He has looked at the incidence of myocarditis and he says it is 28 times more likely to get myocarditis from the vaccine than from COVID for a particular cohort of young men. Women, this also applies to, but more men and women.

I assume you have men and women in your nursing program. This is a big deal and it might affect them. It affects the Marines. It affects everybody else. We finally fixed it with the Marines. We are not making them do it anymore. But the thing is, is you are at an institution of higher learning. We should have questions.

I know sometimes we have to do as we are told, but you are also dean of the school. You have a voice. And we should be curious about things. In Britain, France, Germany, Norway, Sweden, Den-

mark, they don't have university mandates on this. Some countries don't recommend it for children at all.

There really is a debate and discussion. You can have an opposite debate, but if you believe in choice, when something has a debate and there are arguments on both sides, you would give people the choice. So, the CDC did a study of a million patients. That is a pretty big study. It is an observational study, but it is a large study. And they asked, what are the chances that you will go to the hospital? And they divided into different groups.

One group was vaccination, and it showed a 20 times, and this has been repeated a lot, 20 times lowering of your rate of going to the hospital if you have been vaccinated. I think most people accept that.

Now, it doesn't stop transmission. So, when you mandate this, you can't make any arguments about protecting other people. It is only about you at this point. But what they also found in this study of a million people was that people who had not been vaccinated but had been infected on a prior occasion by COVID were 57 times less likely to go to the hospital. So really it isn't an argument against vaccination.

I mean, if you haven't been infected, you ought to be vaccinated, but you got to have a choice. You are not giving people any choice. And actually, this applies to all your universities. None of your universities—I think we all mandate three vaccines. And frankly, I think the literature actually shows it to be malpractice.

That is why you should all have a voice in this. A large study in Israel shows that the rate of myocarditis among vaccinated is about 1 in 3,000 to 1 in 6,000. There is another study that shows it is 40 times greater. So, between 28 and 40 times. And this isn't an argument against vaccination, it is an argument for thinking and understanding the people of different ages could respond differently.

My hope, and what I would offer to all of you is that people should speak up. We are living in a world where everybody sticks your head in the sand and says, do as you are told, take three vaccines. And there are people with myocarditis that are seriously ill currently. I mean, think about this.

Here is a question, your 15-year-old kid has had COVID, takes the vaccine, and has myocarditis enough to be hospitalized. What would you do? Would you give him another vaccine?

Dr. SZANTON. Thank you. I am not—I will take into consideration what you have said and I will bring it back——

Senator PAUL. Well, it is an individual decision, and you ought to be able to answer. At least be honest and look backward. The thing is, the CDC says if your kids had myocarditis, got sick and went to the hospital, as soon as he gets better, give him another one. I think most parents in the country would say that is a stupid idea and defies all common sense and they would resist this.

But when the Government tells you to do it and it is a really stupid idea that defies common sense, guess what, people lose trust in Government. People—we want to have trust in the people run-

ning our medical schools and our nursing schools. But somebody needs to ask these questions.

Dr. Marty Makary is doing it. Dr. Vinod Prasad is doing it out at UC San Francisco. And it is a growing movement, but I would hope that you all will open your minds to at least thinking about the choice of the individual in medicine.

The CHAIR. Okay. Thank you, Senator Paul.

Senator Hassan.

Senator HASSAN. Well, thank you very much, Mr. Chair and Ranking Member Cassidy, for this hearing. And thank you to all of our witnesses. I greatly appreciate what all of you do. Dr. Staiger, I wanted to start with a question to you.

Thank you again for being here and for sharing your expertise on the workforce shortages facing health systems in New Hampshire and all around the country. As we work to address this shortage, we don't want nurses or other health care workers to have to leave their jobs to get a degree or credential that they need to advance their career.

Last Congress, I worked with Senator Young to introduce the Upskilling and Retraining Assistance Act, which would double the amount of tax-free educational assistance that workers can receive as a benefit from their employers.

Dr. Staiger, would offering tax free education benefits help keep health care workers in the field and ease the labor shortages facing hospitals and other providers?

Dr. STAIGER. I actually think that is quite a good idea. It is—I think of it as scholarships from your employer, right. These are often offered with the agreement that you have a commitment to the employer afterwards, which is a good way, rather than doing a loan, to support this.

You keep them in, they tend to take a day off here or there, and they stay connected. I especially think these are if you had to target this, it should be targeted in places that are—where we have particular need, sure.

Senator HASSAN. That makes sense. Let me turn to Dr. Herbert. When I visited with health care leaders at Memorial Hospital in North Conway last month, they told me about the challenges that they face every day as a result of the nursing shortage.

While it is essential that we train more registered nurses, we also need these nurses to continue to practice in rural areas of states like New Hampshire and Maine and Vermont after they get their license. So how can we encourage nurses trained in rural states to stay and practice there after graduating?

Dr. HERBERT. Thank you very much for the question. We use a three-pronged approach that we found helpful. The first is we try to attract students from rural areas. And what we found is students from rural areas are more likely to go and practice in a rural area, even if it is not their same hometown.

That is the first key. Second, and this is very important, regardless of where they come from, during training, placing them in clinical sites in rural areas, very, very important. They get a taste of

rural life and many of them actually really like small town and rural life and prefer to work in those settings.

Third and most importantly is something I mentioned before, which is either scholarship or loan repayment programs with strings attached, with a commitment to practice in those areas.

You can do it on the front end of scholarships, on the back end as loan repayment, but there needs to be an incentive because, as Chairman Sanders said, if you are looking at a big debt that you need to pay off and there is a major hospital in Boston that will give you x additional salary, we need to at least—even if we don't even if we don't make up the entire amount, we need to offset that enough to incentivize people to practice in rural areas. That three-pronged approaches, we found it helpful for not only nurses but dentists and other professionals.

Senator HASSAN. Well, I thank you for that response. I will add that the other piece of the conversation that came up in North Conway and has come up all around my state, is just the need for housing for employees, especially in rural New England right now, Northern New England.

Dr. HERBERT. Couldn't agree more.

Senator HASSAN. Dr. Szanton, I wanted to ask you a question. In response to the growing shortage of licensed nursing assistants, New England College has created a joint nursing education program with Eliot Hospital in Manchester.

The college's students earned 25 percent of their college credits working as licensed nursing assistants at Eliot Hospital. They graduate with a Bachelor of Science in Nursing. How can we encourage these kinds of innovative partnerships and other efforts to train and develop more licensed nursing assistants?

Because what we are finding is these nursing assistants are doing the work they need at the bedside, but they are also getting critical clinical experience with oversight from nurses in a clinical setting.

Dr. SZANTON. Absolutely. I think that is a wonderful idea. And we have such a shortage, especially in the hospitals, that it is going to take it all of the above kind of strategy, and some training in the clinical places, and some in the universities. And that sounds like a wonderful idea.

Senator HASSAN. Thank you. Dr. Seoane, in December, Congress funded the training of 200 new physicians, including at least 100 psychiatrists or addiction medicine specialists, building off a bill that Senator Collins and I did, called the Opioid Workforce Act.

Dr. Seoane, how will additional psychiatrists help meet the existing behavioral health crisis, and what more can we do to continue developing the behavioral health workforce?

Dr. SEOANE. Thank you for that question. There is a critical shortage of psychiatrists in the U.S., and in particular in my state. That is why at Ochsner we have our scholarships around primary care and psychiatrists. And psychiatrists are part of a team.

They are psychologists, nurse practitioners, and others that can participate in that. But that program is essential to growing the workforce. And psychiatrists are they are the spearhead to help be

part of the solution for this mental health crisis that we are facing in the United States.

Senator HASSAN. Thank you very much, thank you, Mr. Chair.

The CHAIR. Thank you, Senator Hassan.

Senator Cassidy.

Senator CASSIDY. I will once again defer this time to Senator Collins.

Senator COLLINS. Thank you very much, Senator Cassidy. Dr. Herbert, I do want to follow-up with you on the issue of the shortage of nursing faculty. It just is astonishing to me that at last, I guess it was in 2021, almost 92,000 applications for baccalaureate and graduate nursing programs were turned away, with faculty shortages cited as the top reason. And the University of Maine this year had 1,239 applications for only 80 slots.

I think there is this misperception that people don't want to become nurses when in fact we have a ton of applicants from people who do want to enter the field of nursing, but we don't have the professors to teach them. And that is why the Chairman and I and the Ranking Member have been working hard to come up with a solution.

I want to—more with you on how we bridge the faculty gap. You mentioned in your testimony, Dr. Herbert, that in some cases, practicing clinicians can be recruited to serve as faculty instructors in their existing workplaces. Could you give the Committee an example of how UNE is working with an academic institution or a hospital to expand training capacity?

Dr. HERBERT. Thank you very much, Senator Collins. We are doing exactly that. First of all, I agree with everything you said. It is a real problem. And you are also right that there is a lot of demand out there for people who want to become nurses and other health care professionals, and, but with limitations on what we can do. At UNE, we have increased the number of nurses.

We trained 300 percent in the past 10 years, so we are continuously looking how we can expand that. A program along the lines that you are describing is something we are doing in partnership with MaineHealth. MaineHealth is Maine's largest health care network of providers, and also has branches in New Hampshire as well, Southern New Hampshire.

We, what we are doing is we are actually using the faculty onsite, using nurses onsite. We provide professional development and support from the university to have them train people onsite, in the MaineHealth hospitals, hospitals system. So, using clinicians, this is part of that laddering approach.

We are also training the nurses, upskilling the nurses, going from LPNs to RNs, RNs to BSNs, BSNs to nurse practitioners onsite, in partnership with MaineHealth. And we are looking to expand that program with other health care programs as well. So, trying to find creative ways of addressing the faculty shortage.

Senator COLLINS. Thank you. Dr. Staiger, I saw you nodding. Did you have something to add?

Dr. STAIGER. I was just going to say I—there has been such strong growth in the number of people going through nursing schools. Applicants have outpaced that, so that is why there—the thing and so we shouldn't be surprised there are faculty shortages.

It has been chronic because we have tripled the number of students going through nursing programs in the last 25 years. That, nobody thought that could happen 25 years ago. It has been heroic what the nursing schools have done.

It is, it is a chronic problem. I also think it is a problem that the nursing schools have been able to solve with help, and I am optimistic going ahead.

Senator COLLINS. But we have still got this huge gap. Dr. Hildreth, I was very moved by your testimony, and I was reminded of the fact that one reason UNE has been so successful in getting its graduates to practice in rural areas is they do that third-year program in rural areas. So, do you do something similar to that in order to encourage people to return to underserved areas?

Dr. HILDRETH. Thank you, Senator Collins. I mentioned earlier that we are really happy that the Governor of Tennessee, Governor Lee, and his leadership helped us create a program where we recruit students from rural areas to come to university there, and they are admitted into medical school at the same time.

It is an accelerated program in which their tuition is paid, both undergraduate and medical school, and they have committed to go back and work in the communities they come from. I think that is a model that should be repeated all over the country. Thank you.

Senator COLLINS. Thank you.

The CHAIR. Thank you very much, Senator Collins.

Senator Hickenlooper.

Senator HICKENLOOPER. Thank you, Mr. Chair. And thank all of you for your work and your commitment to this at a time when, as both the Chair and the Ranking Member made so clear in their opening statements, this is an emergency and you all share that sense of urgency. Dr. Seoane, while I was Governor in Colorado, we worked hard to expand youth apprenticeship opportunities.

I was moved to read the testimony about the different ways Ochsner is using apprenticeships to foster interest in medicine and as a workforce solution. Especially enthusiastic to learn about the Ochsner Nursing Pre-Apprenticeship Program, which is open to high school sophomores hoping to serve more than 600 students over the next 2 years.

That really is incredible. Have any of your pre-apprenticeship program graduates remained with Ochsner or stayed in the field, and has opened these programs to high school students helped—you know, do you see an impact in terms of addressing your challenges?

Dr. SEOANE. Thank you very much for that question, Senator. It is early in the program. We started in 2021. We have currently about 350 apprenticeships in the program. By this fall, we will have 600 students in the program.

It is early in the program. But we—but this grew out of another program, the MA Now Program, which is a program where we went into our communities, underserved communities, where they had high unemployment rates, partnered with our local community partners there to identify applicants for MA Now Program. And then we certified those programs.

There is 6 months training. We trained them, they got a certificate program to be an MA. Now we have over 600 of those MA we hired through that program. The apprenticeship program for us is very important as we launched our Healthy State Initiative, which is Ochsner's initiative to do a collective impact in Louisiana to improve our health rankings from 50th, which unfortunately is where we have been, 50th or 49th for the last 30 years, to 40th over the next 10 years.

High school graduation rate is one of the key factors for our poor health rankings. So, this apprenticeship program really gets at two components. One, can we get to our sophomores in high school, keep them in high school by allowing them to work as apprentices to nurses, and therefore pay them some during high school, and then they get a free year of community college when they finish high school, and then they are an LPN.

We are early on in the program, Senator, but we are very enthusiastic about it.

Senator HICKENLOOPER. Great. I am very excited about it as well. I have talked to both Cassidy and Senator Sanders about the value of apprenticeships, looking at that on a broader scale in health care. The pandemic showed us how important it is to address the shortage of public health workers.

Colorado offers a first of its kind state program called Colorado Public Health Works that connects AmeriCorps volunteers with a registered apprenticeship program run by the Trailhead Institute.

This allows AmeriCorps members to gain valuable, on the job apprenticeship experience while helping meet our public health needs at the same time. Dr. Staiger, how can we build out programs like this to help address our larger public health workforce needs?

Dr. STAIGER. Not sure I have great concrete advice on that. I think these kind of programs are critical. Everyone has talked about the step step programs and people going there wasn't—didn't used to be a career ladder here for people to get trained and gradually move up from medical assistant to RN to NP, etcetera.

I think the more we can encourage that, the better. I still think this is best done by providers, right. They are the most close to the ground. They can figure this out. So, providing them with the resources and incentives to develop these programs.

Senator HICKENLOOPER. All right. But facilitating also, I think using resources like AmeriCorps and making sure that you can facilitate that connection.

Dr. STAIGER. Yes, that is exactly——

Senator HICKENLOOPER. Dr. Hildreth, as I do—well, I will leave that. I will go on to the next one. I can get carried away. Dr. Herbert, I was going to ask you about the IPE and that effort. Well, let's just—I will give that a written question. Just know that I am

very attracted to and, appreciate the IPE model, and I think the collaboration and what it allows providers is a big thing.

I will go to Dr. Hildreth, and you have spoken about the critical needs in terms of how important it is to increase diversity. I have been on a number of roundtables where the small numbers of not just doctors but midwives, in terms of how expectant mothers are taken care of, really, the women of color don't get offered the same choices, right.

The only way we are going to change that is really to change the makeup of who are tending to them. How can we foster programs that encourage early exposure, this kind of early exposure at the Federal level that make sure that younger kids see a role for them in health care?

Thank you, Senator, for the question. What we have done at Meharry is we have adopted two middle schools. And what we do is we make sure that our student in medical school, dental school, and our graduate programs are present with those kids to show them that it is possible for them because they see students in professional programs that look like them, and we think this is a very powerful way to get students engaged early on and keep them engaged by having our students interact with them. Thank you for the question.

Senator HICKENLOOPER. Thank you. I yield back.

The CHAIR. Senator Cassidy.

Senator CASSIDY. I will defer to Senator Romney.

Senator ROMNEY. Thank you, Senator Cassidy. I was struck by the Chairman's opening comments that we spend so much per person in this country and health results are not that much different. We spend almost double as much as the people in the average developed nation in health care.

Sometimes we in Washington think, well, the answer is to spend more. But I would suggest that there must be a different approach. If we are already spending almost twice as much as everybody else, then there has got to be some other reason that we are not able to provide the quality at a reasonable cost that we would like to do.

I note that my prior experience in the private sector showed that almost everything that we buy gets better and better, better quality and lower cost in real terms over time, and that productivity increases over time.

The exception to that are really three major areas, health care, education, and the military. Those happen to be three areas that are dominated by Government. I think I have an idea as to where the problem lies and would suggest the right answer is, is not more Government.

In this case, I think we can look at health care and say, we have—what is the old Pogo cartoon? I have met the enemy and the enemy is us. And one aspect of that enemy relates to immigration. My understanding is that typically almost 20 percent of the nurses and medical professionals this country come from foreign countries. But the backlog of medical professionals that want to come into this country has become enormous.

We required them to be interviewed, and given our security needs, it is appropriate that they be interviewed about the State Department. But apparently, the State Department is still so concerned about COVID that they are not interviewing these people.

Places like the Philippines, where there are some 30,000 people who want to come here and serve as nurses, we can't get those nurses in. Are you aware of this feature, given by the President of college at the University of New England, are you aware of the fact that our Government is just not doing the interviews necessary to bring people in that would help dramatically reduce our nursing shortage?

Dr. HERBERT. Senator Romney, I'm going to be honest with you, I am not aware of that. I am not up on that particular issue with the interviews. But if I—I am going to be happy to speak to because I agree with you about the importance of immigrants in our health care workforce.

More broadly, if I can just very quickly say, one of the things we need is programs like we are doing at UNE in our pharmacy school and our dental school, which are programs that are accelerated programs that take foreign trained dentists or pharmacist or doctors for that matter, and then help them become eligible for American licensure.

To meet the requirements so they can sit for their exams and become eligible. So, these accelerated programs are very valuable. And because we have professionals who are legal, they have green cards, they are in some cases citizens, and who could work but can't work in their field that they were trained.

They may have been a surgeon for 20 years in a foreign country, but and these are often people of color from the developing world. So, we have developed programs in that regard. But then you also have, and just in the case of Maine, to give you an example, we have a lot of asylum seekers from Africa and they are sitting in hotel rooms and can't work and they want to work.

Senator ROMNEY. Yes. Let's interview these people. Let's stop allowing our Government workers to work from home saying, because they have COVID, we can't allow you to come back to the workplace. You can't do the interviews of these people who want to come to our Country and fill the desperate needs we have in health care.

If we have a nursing shortage and a doctor shortage, let's let those who are in line that are qualified come here. I agree with you with regards to the education programs. I note with regards to educating our own citizens here, the work that you are doing in your respective institutions is critical.

There is one in the Western part of our Country called Western Governors University. You are probably familiar with it. It graduates more nurses than any other institution of higher learning in the country. Its tuition, Mr. Chairman, is $6,700 every 6 months, very reasonable tuition compared to the cost in most places. 126,000 students at Western Governors University.

It is a not for profit. It was established by former Governor Mike Leavitt and the Governors of five other western states. We have a

capacity to educate. They can take on more students at reasonable cost. So, the approach is that we can learn from one another and expand the best practices that we are seeing in some places.

But legal immigrants, following the legal process, where the State Department does the job, they need to do and doesn't stay home because of COVID, will allow us to dramatically reduce the shortage that we are seeing in this country. Thank you, Mr. Chairman.

The CHAIR. Senator Kaine.

Senator KAINE. Thank you, Mr. Chairman. Chair Sanders and Ranking Member Cassidy, thank you for making this the first hearing of this Committee in the 118th Congress. I think this issue is huge and challenging, but one that is very amenable to some bipartisan work that can be done.

Senator Romney beat me to the punch, not the first time, because I wanted to talk about immigration. I was interested in none of the opening testimony was this put on the table as a potential solution, although I think in some of your written testimony, a couple of you mentioned it. Just to give you a numbers on this.

According to the Migration Policy Institute, as of 2018, the foreign born comprise almost 18 percent of the 14.7 million people in the U.S. who work in health care, nearly 1 in 5. The foreign born make up a disproportionate share of certain both high and low skilled health care workforces.

28 percent of our physicians and surgeons are foreign born, and 38 percent of our home health aides were born outside the United States. And this isn't just about employment-based immigration, it is also focused on family and humanitarian immigration systems.

Another statistic, more than 310,000 health care workers, 12 percent of the immigrants who are employed in health care occupations are not here on work related visas, they are here for humanitarian reasons, resettled refugees, asylees, special immigrant visa holders, TPS recipients, and Cuban and Haitian entrants.

President Herbert, you have already addressed this with Senator Romney, but what could we do with an immigration reform that is focused on health care or other critical workforce areas that would make all of your jobs easier in educating a diverse and sufficiently sized health care workforce?

Dr. HERBERT. Senator Kaine, thank you very much. First of all, I should say I am not an immigration expert. I make no pretends to be, but I echo your concerns. I think that there is no question that immigrants disproportionately go into health care at various levels. They are very hard workers. They want to work.

I can tell you from personal experience, at least locally, what I see is a lot of folks who want to work, they are here legally, but they are not able to work because of arcane regulations that really should be changed. And so, yes, we need—and we think we need to encourage immigration.

In a state like Maine, where we are losing native population and the only way our population is staying stable and even growing is through immigration. And there are many new Mainers who want to work and are not able to.

Senator KAINE. My perception, and I don't have the data on this, but my perception in Virginia is that the foreign-born health care workforce is also more likely to work in rural Virginia.

If I talk to the physicians in Appalachia, they are more likely to be foreign born than if I am doing it where I live in Richmond or metropolitan—other metropolitan areas of the state. I have other topics I want to get to, but is anyone else want to weigh in on immigration? Yes, Dr. Hildreth.

Dr. HILDRETH. Senator Kaine, thank you for the question. I have nothing against bringing in foreign born folks to work in our health care enterprise. We have lots of talent we have not tapped into in our own country here.

For example, it used to be that 26 percent of all the black students who went to medical school came from HBCUs. It is now less than 10 percent. Why is that? Because we have underinvested, under-resourced those schools.

I would submit to you, but that by properly resourcing the schools we have, we can fill a lot of that gap with native born talent right here in the United States.

Senator KAINE. I have a piece of legislation that is called the Expanding Medical Education Act, which I am going to reintroduce this Congress, I introduced that in the last, that is very focused on HBCUs and other minority serving institutions. In your testimony and in doctor—is at Seoane.

Dr. Seoane's testimony, you both laid out some innovative programs you are doing and the need for additional investment. I completely agree with that. Let me ask a question about the direct care workforce shortage or just bring it to the attention of the Committee. Our direct care workforce shortage is often left out of the conversation about health care workforce shortages.

Direct care professionals make an average of $11.75 an hour. They are some of the lowest paid workers in the economy, but they provide difficult hands-on care to seniors and people with disabilities. And this workforce shortage kind of compounds other shortages.

I go to hospital emergency rooms and they say we have to keep people in hospitals longer because the direct care workforce shortage means that there are no placements where we can discharge someone from a hospital to a long-term care setting or to appropriate home health care.

I hope as we look at this problem, we will focus on the direct care workforce. Finally, Mr. Chairman, I would like to introduce a letter for the record. Johnson and Johnson wrote a letter to thank Senator Cassidy and the whole Committee for a bill we passed, the Lorna Breen Health Care Provider Protection Act, which is to provide mental health resources to frontline health care workers.

One of the ways we will keep a robust health care workforce is making sure that they have the resources they need to be resilient. I would like to introduce that letter for the record, if I could.

The CHAIR. Without objection.

[The following information can be found on page 81 in Additional Material:]

Senator KAINE. Thank you. I yield back.

The CHAIR. Thank you very much, Senator Kaine.

Senator Cassidy.

Senator CASSIDY. I will defer to Dr. Marshall, who for the first time in 2 weeks, is not wearing Kansas City Chiefs colors.

[Laughter.]

Senator MARSHALL. Well, thank you, Ranking Member and Chairman. I want to just remind folks that Kansas has two nationally ranked basketball teams in the top 10 and it is time to move on to basketball season. But I am honored to be here today to talk about an issue near and dear to my heart.

This is the dream, the nightmare that I have lived the last 40 years of my life. There has been a physician shortage in rural America for at least 40 years. There has been a nursing shortage in rural America for at least 20 years. So, the challenge before me as a person operating a private practice in rural America has been to recruit doctors, and then as running a hospital, is recruiting nurses.

Myself, I went back to rural America. One of the reasons is, was I had a scholarship, a state sponsored tuition scholarship if I would go back to an underserved area. My partner was a recipient of a National Health Service Corps loan as well and was able to repay it. So those are certainly some of the things that are working.

I want to talk about nursing shortage for just a second. 80 percent of the nurses could come from community colleges. Let me say that a different way. 80 percent of the jobs in health care can be done with community college nurses.

Community colleges are the answer to the nursing shortage. Those folks are typically from a small town. They are going to go to that small town community college, are more likely to stay in that small town.

Of all the students from my hometown that went off to the university medical school, I could maybe count on my hand the ones that came back. There was a 4-year program in Fort Hays, more of a rural community program. Those folks were more likely to stay back. But once those young nurses tasted life in the big city, they like it and they stay there.

As we think about going forward, I hope we can come back and talk to the community colleges nursing programs a little bit more. What can we do to accentuate them and the small colleges as well? There are quite a few small colleges with good 4-year programs as well.

By the way, their student debt is maybe a fourth or a fifth of what a person who went to a university would be. Talk about physician shortages for a second. We will go on the other end of the spectrum. A lot of our physicians are leaving the market right now because of burnout. Issues like prior authorization, surprise billing.

Our ER doctors have just been overworked and underpaid, if you will, but mostly they are burned out. They are getting burned out on that with the surprise billing issues and just frankly, just the COVID epidemic just overwhelmed the system.

Those folks are leaving, leaving like we have never seen them before. Nurses again we forced them to take a vaccine. Some of them didn't like that. And certainly, they were burned out as well. Anyone want to speak to burnout in the profession? Just one of you go ahead.

Dr. SEOANE. I will speak to it. Thank you for that question, Senator Marshall. Look, I think what sometimes we forget when we are not on the front lines of health care every day is that the pandemic for us, for many of us, we can go and turn off our TV and go back home or work from home or work from our offices, and we can get away from the pandemic.

We can get away from those stressors. For those frontline nurses and those frontline physicians, they can never get away from the pandemic. It is day in, day out, and it takes a toll. It is an impact on ill people, death and dying, and it has been a marathon for them, not a sprint.

That marathon continues. I think we have got to work on ways that we can improve the working environment. And it has been a more violent working environment as there has been more verbal and physical assaults on health care providers.

To that end, I think at Ochsner, we have really taken the approach of we have a wellness office. We have provided a lot of wellness programs for our nurses and physicians. We also worked with our State Legislators and State of Louisiana to make violence in the health care workplace a felony.

Also training our workforce on de-escalation techniques. But we have to be proactive in this area. And then I think the other thing, and speaking with the nursing programs, is we got to develop innovative new ways to think of respite for our frontline nurses. So, one of the things——

Senator MARSHALL. I am sorry, I am running out of time. I am. Sorry. So those are—I mean would you quickly talk, though about residency programs. Where Kansas loses our doctors and our medical students is residency programs. We don't have, specifically our primary care doctor slots.

One of the challenges I see is that the orthopedic residencies are a moneymaker for hospitals, so the hospitals are willing to fund them, but primary care is not a moneymaker for hospitals, and consequently they don't want to fund them. They want more Government funding.

Just—I am sorry, I am over time, quickly address just how big medical center hospitals look at primary care residencies as opposed to, say, a specialty residency that makes money?

Dr. SEOANE. Well, primary care doctors are essential for any large health system. And especially a group practice integrated health system like ours, primary care doctors are key. So, we value them as much as we value our orthopedists.

As Senator Sanders already mentioned, I think being able to fund community-based clinic, primary care to expand our funding for primary care residencies, we would be very excited about that.

Senator MARSHALL. Thank you. I yield back.

The CHAIR. Thank you, Senator Marshall.

Senator Markey.

Senator MARKEY. Thank you, Mr. Chairman, very much. And thanks to our witnesses, and thanks for focusing upon the critical health care issues that are facing our Country today. Massachusetts is renowned for its top research institutions and its second to none health care system.

It creates an ecosystem for innovation and for care. But at the same time, even in Massachusetts, there are 19,000 positions sitting empty in acute care at hospitals. Half of all licensed practical nurse positions at acute care hospitals sit empty.

But home care aides, mental health workers, social workers, paramedics, 1 in 3 of those jobs is empty in Massachusetts. I appreciate the concerns I am hearing from more rural states, but we have the exact same set of issues.

It is an urgent crisis. Patients are facing long wait times for an annual well visit. Kids are sitting in adult emergency rooms for hours, days, weeks, waiting for mental health treatment in Massachusetts.

People trying to get help meet deadly delays in access to opioid use disorder treatment like methadone medication, and the health care system strained under the weight of surges like the COVID pandemic and natural disasters.

Meanwhile, our health care heroes who get into their careers to help people, in their greatest hour of need are facing their own hour of need. The current system is forcing them to make impossible choices when faced with huge caseloads, immense pressure, intense burnout.

Advocates in health care unions across the country are fighting to make sure we can keep our workers on the job through better pay and safer working conditions. But without enough of these critical workers, health care centers are closing their doors, turning people away, happening in Massachusetts, are forcing patients to wait in line for care.

We have to make sure that we care for our health care workers. So let me ask you, Dr. Herbert. I am hearing over and over again that children are waiting for behavioral health services or people are having trouble getting treatment for a substance use disorder.

For people in rural communities, in Western Massachusetts or in Northern New England, obviously these problems are very real. Can you talk about that and what you would recommend as a solution?

Dr. HERBERT. Absolutely. And let me begin by saying that I completely agree with you. My comments are largely focusing on rural, the underserved areas and rural areas. They are absolutely, and as the Chairman entered it in his introductory comments mentioned, there are underserved areas in urban areas as well that are just as acute and problematic.

In terms of behavioral health, we need—there is a number of things that we need. The first thing I would say is there is a critical shortage of psychiatrists, but we are not—we are never going to train enough psychiatrists to meet the psychiatric needs of underserved areas. It is just, I just don't see it happening in the next

decade. There are answers, though, for example, nurse practitioners.

We can train more nurse practitioners in psychiatric—to be psychiatric nurse practitioners, and we are developing precisely one of those programs right now. So, there is—we need the full range of behavioral, investments in the full range of behavioral health services, all the way from psychiatry, nurse practitioners, down to in some states like Maine, there are opportunities for a credential for undergraduates with an undergraduate degree to work in behavioral health.

Most states don't have that. We do. I think more states should so that you can actually at entry level mental health position, behavioral health in nursing homes, and in various kinds of community settings, schools with just a bachelor's degree, and so we need investments across the board.

Senator MARKEY. Yes, no question. My wife is a psychiatrist, so I appreciate this mental health crisis that we have in our Country right now. We have a climate crisis as well. And climate can impact upon a community's health care resources. Dr. Seoane, could you talk about that in Louisiana.

Dr. SEOANE. You know, unfortunately, because of our geographic location, we are no strangers to hurricanes. And we have dealt them—I grew up in New Orleans, so I have dealt with them for a long time, and we continue to deal with them. It is unfortunately part of our way of life down on the Gulf Coast, and we just look at ways to be resilient and adaptive.

Senator MARKEY. How difficult is it, given the sometimes catastrophic events that you have to deal with?

Dr. SEOANE. I think it is quite obvious that we deal with this. I will say it brings the community together, and of course, it is difficult, yes.

Senator MARKEY. Okay. Thank you, thank you, Mr. Chairman.

The CHAIR. Thank you, Senator Markey.

Senator Cassidy.

Senator CASSIDY. I will defer to Senator Budd.

Senator BUDD. I thank the Chair. Thank the Ranking Member. I have heard firsthand from patients, doctors, nurses, and hospitals all around North Carolina about ongoing workforce challenges.

I think we need to focus on preparing future health care workforce. For example, Wake Forest, Early College of Health and Sciences, partners with Wake Tech, Community College, and WakeMed to provide students with hands on experience, certifications, and even college credit. So, in the House of Representatives, I led the Critical Health Care Careers Act.

The bill would help community colleges prepare the next generation of health care workers. Students should have the opportunity to gain on the job experience to prepare them for careers in health care.

Dr. Seoane, what steps is your health system in Louisiana taking to offer new credentials and educational opportunities for workers to join the health care workforce?

Dr. SEOANE. Thank you for that question. I mentioned the MA Now Program, which is one where we partner with our communities, where there is high unemployment or underemployment to introduce workers into the health system through the medical assistant job.

Then it is about upskilling, as Senator Cassidy has mentioned. We like to call it earn as you learn or the ladders, and then taking those MAs and then working with our community colleges to be able to, as their work, support them, give them free tuition, to be able then to become LPNs, associate degrees.

Then now we are working with our university partners for them to be able to have bachelor's degree. That story that Senator Cassidy shared with us is exactly what we are trying to do by getting more entry level into health care and then being able to meet our health care needs. And it is a win, win across the board, right.

We are leveraging the human capital of the State of Louisiana and Mississippi, but we are also giving people a living wage for them to raise their family.

Senator BUDD. Thank you. So earlier in your testimony, I understand that you mentioned using non-physician providers like CNAs, licensed practical nurses. Do you agree that maintaining access to services delivered by non-physician, such as testing, treatment, vaccinations at local pharmacies, do you think that is an important part of addressing the health care workforce shortage?

Dr. SEOANE. You know, medicine is a team. It is a team effort. Physicians are a very important part of that team, but many other providers are also extremely important part of that team, so I agree.

Senator BUDD. Yes. So, what steps do you think institutions should take? I know you are from the Louisiana perspective, but as you think about all the way to North Carolina, what can institutions do to better prepare health care workers to serve patients outside of a traditional hospital setting? I am thinking in-home telehealth, community health centers, or anything else.

Dr. SEOANE. You know, health care is shifting to outpatient. And one of the things we need to do is to be able to be innovative about how we care for more patients. And it has already been mentioned at this Committee at lower cost settings.

As we can transition an inpatient stay to a home stay, as we can leverage a medical home model where we can have digital tools, telehealth tools to—for patient who may have stayed in the hospital 3 days now could stay 2 days.

That obviously opens up more hospital beds to care for more acute patients, but it is also a more family, patient friendly model as we transition toward this medical home model. So, we would agree with that, and we currently are pursuing innovative models that we can do that.

Senator BUDD. Thank you very much. I would like to yield back to the Ranking Member.

The CHAIR. Thank you very much.

Senator Baldwin.

Senator BALDWIN. Thank you, Mr. Chairman. Thank you to our panel of witnesses. Really appreciate the conversation that we are having today. I wanted to start and raise once again an issue that came up in previous questioning relating to violence and harassment faced by health care providers, and how that impacts the question that we are tackling today.

A recent study found that more than two-thirds of nurses reported experiencing verbal abuse, and 44 percent reported being subject to physical violence. Last year, I was proud to reintroduce the Workplace Violence Prevention for Health Care and Social Service Workers Act.

This Act would require health care and social service employers to write and implement workplace violence prevention plans to prevent and protect their employees from violent incidents Violence against health care workers is totally unacceptable, and we need, I think, to do more to provide protection.

Dr. Szanton, I would like to ask you to reflect on how violence against health care workers contributes to reduction of staffing levels, burnout, and the consequences of reduced staffing for patient safety. But since Dr. Seoane also raised this, I would like to call on you additionally to comment.

Dr. SZANTON. Thank you for the question, Senator. Absolutely, it is an issue. I think we are in the middle of the mental health crisis and a substance use crisis, and the way that the country feels more and more fractured.

I think all of those together add to—you know, I talk to nurses who say I used to be the hero walking into their room and I used to have this respect based on being a nurse, and now I don't always get that.

Suffer verbal abuse and sometimes physical abuse. I do think that it has been mentioned that hospitals are going to shrink and become more and more operating rooms and intensive care units and that almost everything else will happen out in the community.

I do think that when people are at home and in their community, and in lower cost settings, and more family centered settings, that some of that will dissipate.

Senator BALDWIN. Thank you.

Dr. Seoane.

Dr. SEOANE. Yes. I will say it is 28 years of practicing medicine, including my training, and I have never seen such a charged environment as every day throughout our health system, at our safety huddle, our daily safety huddle, there is an issue around either verbal and physical abuse to our health care provider. So, it is a true crisis.

We have like I said, we have been working with our State Legislators to make sure that it is a felony. We have put up signage. And also, it is not just the, as you have pointed out, the physical abuse, but the verbal abuse.

Part of that state bill was that if you interrupt the ability to deliver health care by being verbally abusive, that that also is now a crime, so.

Senator BALDWIN. Well, and it also sounds like you said your health care system is taking proactive steps. We want to see that more uniform around the country. I also, turning to a different topic, I have been proud to lead the bipartisan Palliative Care and Hospice Education and Training Act with my colleague, Senator Capito.

The bill would grow, improve, and sustain the palliative and hospice care workforce. It addresses each aspect of the health care workforce pipeline. Importantly, the bill provides grants to schools of medicine and teaching hospitals to train physicians who plan to teach and establishes fellowship programs to give providers the opportunity to learn more about providing palliative and hospice care.

Dr. Seoane, could you briefly describe why it is important for academic health systems to provide physicians with both training, to teach, and opportunities to build their skills, upskill. And as a follow-up, how does additional training support or alleviate burnout?

Dr. SEOANE. Senator Baldwin, thank you very much for that question, because 15 years ago, I created a course to train residents in the intensive care unit around death and dying and palliative care.

In that course, we taught residents with real cases, cases that they experienced during their month in the intensive care unit. And we had a debrief at the end where we went through what they learned, but really kind of an emotional reset for them.

There were some real critical learnings from that. One of them was, while we were teaching them skills about having—how to have difficult conversations and how to manage patients that are critically ill, we quickly learned that one of the most important parts of the course was actually the benefit to the residents would be able to debrief, the mental health and wellness for the residents to be able to be able to speak about what they had experienced in that month.

Because remember, for many of these young medical students are residents. That is their first experience with death and dying. So, it has an incredible benefit to the wellness of our health care workers. I have experienced that firsthand through that course.

I want to thank you for putting that legislation forward. We are trying to start our own fellowship in palliative care. That is the next program that we actually are going to start. And it is critically important for the way we practice medicine.

As our population ages, it is critically important, not just for health care providers, that we be able to provide the appropriate care for patients in their time of need.

The CHAIR. Thank you, Senator Baldwin.

Senator Murkowski.

Senator MURKOWSKI. Thank you, Mr. Chairman. Thank you for this hearing today. As you and I have discussed, workforce within health care is something that is critically important.

We both come from rural states, and when I think about the challenges that we face in providing health care in a big state geographically with a small population and the many challenges that

we face, we can overcome a lot of that, but if we don't have the trained workforce, it just doesn't come together.

Don't take my lack of Chair time here as an indicator that I am not interested in addressing the challenges that we face in this. We have got competing hearings this morning, and so I have been jumping in between.

But one of the ways that we have been trying to facilitate better access to care in a remote place like Alaska, where 80 percent of our communities are not connected by a road, is telehealth. We are working on the broadband to connect everybody so that that telehealth actually is more than just the device, but it actually works.

I know that this subject has been raised, but I would ask you, Dr. Seoane, apparently you had mentioned a pilot program for virtual nursing education. So, in other words, this is a big challenge for us in Alaska.

We got a nursing program, but how you get the teachers to teach it. Can more be done with the nursing education programs for telehealth as opposed to just how we are thinking about telehealth generally?

Dr. SEOANE. Yes. Thank you for that question, Senator Murkowski. Look, telehealth is a critical component for how we reach our rural communities and address some of this, including on mental health, where there are many good models.

With the pandemic, we saw about a 400, 500 percent increase in telehealth used in a pandemic. And we are able to demonstrate effective care for many patients using telehealth. I think we have learned a lot from the pandemic.

On the nursing side, our virtual nursing program really is a, not an education program, although there are some learnings for the bedside nurse, as it is a patient facing program. And so, there is a bunker where we 24 hour monitor the patients and that allows the nurse then to be at the clinics—at the bedside, caring for the patient, and all of that electronic health, medical records, and all of that administrative work can be done by the nurses in the bunker.

For instance, a good example would be upon discharge, which could be an arduous process of all the paperwork to discharge, the bunker can do a lot of the administrative and all the discharge work while the bedside nurse can just do the clinical work and we can quickly facilitate transitions from a patient from the hospital to their home.

We haven't done a lot of on the telehealth education on the nursing side other than that program. And like I said, the good—the education component is that bunker also can work with the bedside nurse as an education part.

Senator MURKOWSKI. Let me ask a little bit different question. And again, it speaks to some of the ways that we are addressing health care challenges in Alaska. We rely a lot on EMS, EMTs. I was just visiting with a woman from Chicken, Alaska. Chicken has probably never been a population of more than a 100 people.

Probably—but her son is an EMT there, and basically what they do is they work to make sure that anybody, anybody out there can

be trained in emergency services. But I understand that right now we have a significant shortage of EMS professionals.

Studies have found that less than 20 percent of EMS organizations, at least in Alaska, have an adequate level of staff across the Nation. Turnover of EMS professionals hovers near 30 percent.

Very few stay in their role long enough to establish the stability that they need. What more do we need to do in this area? We have been talking about everything else, but what about emergency medical services? Dr. Herbert, you are nodding. I don't know who to direct this to, so I will just throw it out there.

Dr. HERBERT. Thank you. I was just agreeing with you. I tend to nod. I am not a good poker player, so.

Senator MURKOWSKI. I am a nodder too. That is okay.

Dr. HERBERT. But I will—first of all, I completely agree with you about EMS. And so, there are many of us, I am sure my colleagues on the panel are responding by strengthening our programs in that regard. And we have a robust program at my university. But if I could speak briefly about the telehealth piece, because I completely agree with you. We face the same challenges in Maine.

The last time you and I talked was in Reykjavik, and there are people in Iceland and in Scandinavia that are really leading the world in terms of telehealth developments. And so, we have a lot to learn from those folks.

Telehealth is exploding in terms of beyond just telehealth, digital medicine, being able to monitor chronic conditions remotely and feed that information back in real time to providers. And then in terms of rural settings, people think of telehealth being from the provider to the patient, but it is also the provider back to the tertiary care medical center to get the consultation that they need.

Tremendous work going on in this. What I would simply add is that we need to make sure that our regulations, the state level regulations, licensing boards, accrediting bodies, Government reimbursement, that it keeps up.

We saw some positive changes during the pandemic. We need to make sure that those are sustained. But there is—my concern is that with the incredible innovation that is going on, and this really is going to be transformative over the next 10 years, that these entities are going to fall behind, and this creates tension and delays the full utilization of telehealth and digital medicine.

Senator MURKOWSKI. Thank you. I am well over my time, so thank you all. And we will probably be following up on some of the telehealth conversations. Thank you so much.

Senator LUJÀN. Thank you, Senator.

Senator Smith, you are recognized for questions.

Senator SMITH. Thank you, Chair Lujàn. And thank you to all of you for being here. I want to just note my good friend, Senator Murkowski, and I have worked a lot on rural health care issues together, so I appreciate your questions about that.

Both of us have large areas of rural communities in our state. Though I think Alaska trumps Minnesota in some ways on that. I just want to thank you for your questions there. I am grateful for

this hearing and the bipartisan spirit of this hearing. I would like to start by focusing on the mental health care workforce.

You know, even before the pandemic, we knew that there was a growing need for mental health services. And the pandemic has, I think, shone a light on the deep need and made the need bigger.

HRSA estimates that by 2025, we will need an additional 250,000 mental health professionals, from psychiatrist and mental health and substance abuse, substance use disorder specialists, school psychologists, school counselors.

Of course, as Senator Murkowski is pointing out, rural communities are much more likely to have a shortage of mental health professionals, and people of color are much, much more likely to live in places where there is a shortage of mental health care. So today we are talking about the barriers that are facing people who want to get into this field, and one of them is money.

This morning, I reintroduced my bipartisan bill, the Mental Health Professionals Workforce Shortage Loan Repayment Act. You do not need to remember the name, just remember the idea. With Senators Murkowski and Hassan.

What our bill would do is to provide student loan repayment for mental health professionals who want to practice in places where there are shortages. Dr. Herbert, if I could start with you.

Could you talk about the importance of loan repayment programs? You said how important it was that they were strategic in your opening remarks. I would like you—I would like to hear more about that and tell us what you think we should have in our minds as we design and move these student loan repayment programs.

Dr. HERBERT. Well, thank you, Senator, for the question. I completely agree with you about the mental health crisis. And it is important that—there is a number of things to say about this.

First of all, we need to make sure that we train people in primary care who are not mental health specialists to do mental health first aid, to be able to—people in our schools, for example, teachers, to be able to recognize and be able to make appropriate referrals. So that is one piece that is there.

In terms of loan repayment programs, these can work very, very well if they are done strategically. So just to give you one example, the Chairman mentioned dentistry before, and we haven't talked a lot about that today.

We have an incredible partnership with Delta Dental, Northeast Delta Dental for loan repayment programs for dental graduates who decide to set up shop in underserved rural areas. And we have been able to place in the 5-years, five graduating classes of our new dental school, we have been able to place about 20 dentists in very, very remote rural communities that didn't have dentists before.

With regard to mental health, it is the exact same thing. We just need to make sure that we are targeting—that there is a strong contingency where they need to practice in underserved areas, either rural or urban areas, and it is not just—I mean, I am great about loan repayment programs in general, but to be maximally effective, they have to target underserved areas.

Senator SMITH. Yes, exactly. I appreciate your comment about training in primary care, because our brains and our bodies are connected. It is one person, one body, and we too often segment out our mental health care from our physical health care in ways that are not good for our overall health care.

Thank you for that. Dr. Hildreth, I so appreciated your testimony, which I was able to hear before I went off to other committees, about the crucial role that historically black medical schools play, and the assets that you have when it comes to relationships, and expertise, and trust.

I wonder if you could just—and also, I mean, you very well pointed out the disparities that you experienced in terms of the resources that you have available to build on your mission. I wonder if you could talk a bit more about that.

Maybe I care a lot and have focused a lot on the great disparities in maternal health care, maternal morbidity, the disparities between black women and white women, and how that kind of pans out as you think about the practices and the people that you work with.

Dr. HILDRETH. Senator Smith, thank you for the question. And clearly, as we have alluded to earlier, when the provider can relate to the patient in terms of culture, race, and all of that, the outcomes are better.

There are studies to show that black women who are cared for by black OBs have better outcomes, and our babies do as well. But it all comes back to what I said earlier. We are—have been training health care professionals who are really competent and skilled, connected to their communities for decades, but our challenge is the infrastructure we have to do that. What we teach and how we teach it has changed dramatically.

Majority institutions have been able to keep up with that change, but we don't have the resources, for example, to do small group teaching as opposed to on a stage. Standing in front of 100 students in a lecture hall is a great way to teach, but it is a terrible way to learn.

We need to change how we teach this. We like to do that at our institutions, but we don't have the resources to do it. I would just submit again that if you gave us those resources, the payoff would be tremendous for the country. But thank you for the question.

Senator SMITH. Thank you very much, thank you.

Senator CASSIDY. I will defer to Senator Braun.

Senator BRAUN. Thank you, Mr. Chair. I come from the world of fixing issues. I ran a company for 37 years that was so little, many of the issues didn't even come to the forefront because you were worried about turning the lights on in the morning, off in the evening, and all the stuff that happened in between.

Lucky enough to take a little hard scrabble company and turn it into a national distribution logistics company. Biggest thing I wrestled with once we got larger was the high cost of health care. And now, we have not only got that to contend with, we have got the issue of how are you going to get people into the business of it

when it is the largest sector of our economy. Travel, 92 counties in Indiana, workforce, workforce, workforce.

It was a bigger issue now than it was pre-COVID, and that is what I heard mostly pre-COVID. I can say one thing, if you give good benefits, you pay your people well, folks come to your door to work there. I weigh in on those issues a lot, and every company is going to find its own way to do that. But let's look at this issue.

I don't think that we would want to look to the Federal Government to take on something so granular when currently we borrow 30 percent of every dollar we spend here. I don't know if you know that. It was about 20 percent when I got here just 4 years ago. Terrible long term business plan.

We are not going to be able to solve anything by borrowing money from our kids and grandkids, and that is what this place does. Let me turn my attention to what I think would work. I think companies, I think the health care industry, let's focus in on what we are talking about, has now become so top heavy where doctors, the practitioners are wondering if it was even worth it to get their degree.

Nurses as well, analogous to farmers in big Ag. Had a startup recently in Indiana where a bunch of anesthesiologists and surgeons wanted to start their own practice. It was almost impossible to do. Most of them got fired from their hospital they were working for. Let me tell you what they were able to do. They were able to take a gallbladder removal that cost $21,000 in Indiana if you were covered with insurance, $32,000, that is bizarre, if you didn't have insurance but could afford to pay for it. They are doing it for $8,000.

They are going to pay themselves twice as much in terms of fees. That is what is got to change, basically, or else you are not going to have anybody wanting to get into the industry. And until you fix the industry itself with competition, transparency, removing the barriers to entry, making it entrepreneurial, the whole idea of getting people to work within it is almost going to be a secondary consideration.

Now let's get to the matter of what we are talking about here, workforce in a broken industry, how do you improve upon it? Well, No. 1, I wouldn't look to this place. That ought to be something that would be easy among the people in the business.

If you are occupying 18 to 20 percent of our GDP, you ought to be making some effort to do workforce through your own businesses, which now is mostly hospitals, over 40 percent, pharma is 15 percent, practitioners are shrinking because they are going on the payroll of hospitals, and then you have got insurance, which is kind of the Darth Vader of the whole industry in terms of getting to any of this getting fixed.

I would say, because I wrestled and I was on our school board locally for 10 years, this ought to be something we are doing better in K-12. Look at the parents that regret that they didn't have some guidance somewhere along the way in high school or back in middle school that, don't pursue a 4-year degree when only 35 percent of the jobs need it.

I get 10 people show up for that one. I got one open. I am lucky on a Friday if three people come in for a job that would pay as much as most 4-year degrees. But they show up on Monday, and we got to get that figured out.

Better guidance in high school. Starting to take high demand, high wage jobs, which nurses would be one of them. Doctors, if you can put up with how long it takes to be educated and not to be frustrated once you become one, we need to do that back there, where you live within your means and you get results.

Dr. Seoane, I would like you to comment and anybody else fairly briefly, should we be doing more here, or is a solution getting better value when they are in K-12, essentially middle school through high school, for the problems we are dealing with and talking about here?

Dr. SEOANE. I think partnerships are important. I think we need to work together. And we have done some of the programs you have described. That is exactly what we have kind of done with.

We have got the high school apprenticeship, going to our high schools, partnering with our high schools, creating that nurse apprenticeship program to keep them to graduate high school and then become LPNs, and then move up.

Those programs that I describe in my statement have all been supported through the Ochsner health system. But to scale them, we need support from our universities, we need support from our community colleges, we need support from our Government. I do think it is a partnership.

Senator BRAUN. Good news. I see that happening back in my own home state. And anybody else want to weigh in on that? Yes, sir.

Dr. HILDRETH. Thank you. I want to make a point that is often missed, which is our health care is actually sick care. And if we focused on keeping people without the need to see a doctor, to be hospitalized, that is the solution. And some of that $4.3 trillion we spend on sick care, if we reduce that by 10 percent, we would have $400 billion to invest in public health, and that is exactly what we should be doing, in my humble opinion.

Senator BRAUN. Amen to that, because I will part with this, back 15 years ago, when I was sick and tired of hearing how lucky I was that it is only going up 5 to 10 percent each year, I was large enough to self-insure, I found out they were making 25 percent profit margins on the plan I had in place, and the insurance companies told me just what you said.

An ounce of prevention worth a pound of cure, avoid the business we are in. I took it to heart. Paid for 100 percent of wellness. Skin in the game from dollar one. We have not had a premium increase in 15 years and I got a healthier profile of employees. Thank you.

The CHAIR. Okay. Thank you very much, Senator Braun. If you see people running in and out, it is not lack of interest, it is a vote on the floor.

Senator Lujàn.

Senator LUJÀN. Thank you, Mr. Chairman. I want to thank everyone for being here today as well. In rural areas like New Mex-

ico, primary care providers serve as vital lifelines for all health care needs.

That is why the Project Echo Model, which was developed at the University of New Mexico by Dr. Sanjeev Arora, is so critical. Dr. Herbert, Project Echo, as you know from the University of New England, Maine's own effort is a telementoring model that gives health care providers access to the tools and mentoring they need to treat complex medical cases.

Project Echo was found to be effective at equipping primary rural providers to screen for skin cancer when patients don't have access to dermatologists, as just one example. Dr. Herbert, as we work to address the shortage of health care providers in rural areas, how can we better utilize and innovate models like Project Echo to expand access to lifesaving medical care?

Dr. HERBERT. Excellent question. Thank you very much. And we do have a Project Echo project at our university as well, so I appreciate the question. I think it touches on a number of issues.

First of all, the importance of prevention that we were just talking about. Early assessment and intervention of problems. Training primary care professionals to stretch their scope of practice. So earlier today we were talking about scope of practice laws that are overly limiting in terms of what primary care can do.

Universities have a role in making sure not just in training new students, but in providing continuing education and professional development for existing providers using tools like Project Echo.

But also, other kinds of continuing education tools to make sure that our primary care workers, physicians and others, are equipped to address a broader range of concerns. Because there is no way in a rural state, we are going to be able to place highly trained specialists of every kind in every community.

Senator LUJÀN. I appreciate that very much. Mr. Chairman, we have already seen and witnessed the benefits of Echo models for health delivery. We are starting to see more and more benefit for educational opportunities as well with the Echo model, so I am hoping that we will see expansion.

Dr. Hildreth, this will be for you, sir. Despite the growing need for behavioral health services, the behavioral health workforce has unfortunately been hemorrhaging workers.

More than 122 million Americans and 65 percent of New Mexicans live in areas with mental health professional shortages. While training and education are critical to build on behavioral health workforce, I want to focus on keeping the providers we have. Dr. Hildreth, how would dedicated retention efforts for behavioral health workers impact this vital workforce?

Dr. HILDRETH. I think the retention is a really important part of our strategy. But I would also say that getting more training in behavioral health to primary care physicians who are at the front lines of this.

We are not going to be able to train enough psychiatrists to solve this problem, but by bolstering the training of primary care doctors in behavioral health, that is going to be a big part of the solution.

Again, one of the things I worry about is, they play such an important role in our health care system, but they are, to me, underpaid for what they do because they are the frontline in bringing down the costs.

Because if you can catch someone early with a chronic disease and get them into care, that is going to reduce the long-term cost for the country. I would just suggest that training primary care doctors in behavioral health has to be a part of the solution. Thank you.

Senator LUJÀN. I very much appreciate that. Doctor, thank you. Dr. Szanton, how can we explore promoting utilization of services to include midwife expansion and benefits?

I have been a big proponent and having to explain to so many that the services that midwives provide is not just delivering babies to many communities.

This is the only care that they have and they are the primary care providers in the area. So, in that respect, how can we explore promoting utilization of these services to not only support these families, but strengthen the health care workforce as well?

Dr. SZANTON. Thank you. Yes. Nurse midwives provide vital care throughout the postpartum period, pre-partum, and during. And they work often with doulas. And I think there has been a lot of emphasis today about rural areas.

I think that focusing also on the infrastructure we do have in rural areas like postal workers like daycare centers, like Meals on Wheels, that we have got a lot of infrastructure we can take advantage of for the health of the Nation.

But back to the midwives, they are just really essential components, often under looked, and can provide really comprehensive tailored care.

Senator LUJÀN. I appreciate that response. Mr. Chairman, in my closing time, Senator Murkowski was asking some questions around EMS providers as well, which I very much appreciate the attention there.

As some of you may know, I survived a stroke a year ago. My sister, who took me to the hospital from a rural community 30 minutes or so away from Santa Fe to where I live, had the foresight to stop at a local fire department because they were washing vehicles as she was passing by.

That was 5 minutes from my home. Those EMS providers provided incredible care to me, immediately being able to provide stabilization, and I know communicating with that emergency room before I arrived. Had it not been for them, I don't know that I would be here today.

I hope that we will see more support and attention with this kind of service, and especially acknowledging some local governments and communities across the country, their budgets don't allow for that kind of investment. I thank you for that as well.

The CHAIR. Well, thank you, Senator. I did mention that in my opening remarks, and we are going to get back to that. Senator Cassidy has been a true gentleman, scholar, gentleman allowing his colleagues to go before him. Senator Cassidy.

Senator CASSIDY. Yes. I have lots of questions, but even though I am last, limited time, so I will go a little rapid fire.

It has been a fantastic panel, by the way. I don't know if we have ever seen this much kind of participation from Members, and congrats to the Chair. I think it has just gone very well and you have all been really good.

Dr. Seoane, happy Mardi Gras to all of those who are not as blessed as you and I to live in New Orleans and for this upcoming weekend. We have got to do something relatively quickly. Facilities for HBCUs, nursing, the pipeline, it is actually kind of okay.

It finally gets there. One of the things that I have been thinking about how we could initially, boom have an impact, aside from immigration change, which would be huge, Dr. Seoane, you mentioned the press of people coming to ERs and even the violence associated with.

I have read that we have an absence of medication assisted therapy clinics. I am assuming there are a fair number of people come to ERs. Dr. Hildreth, you are in an urban area as well. Oh, my gosh.

Dr. Szanton, oh my gosh, that if we had effective MAT, in which we were keeping people from coming to the ER because they were less likely to be an overdose or withdrawal, that that could be something that could be relatively quickly implemented to have a relatively rapid response. Dr. Seoane.

Dr. SEOANE. Senator Cassidy, thank you for that question. Look, I couldn't agree more. I think those are critical and important. I think it goes beyond just the medication assistance therapies programs.

There is other interventions like it was mentioned digital medicine, digital monitoring, but there is actually digital management programs, digital hypertension, digital diabetes.

We did a pilot in 3,000 Medicaid patients in rural areas where we manage their diabetes or their hypertension through the digital program.

We showed in 1 year, in a Medicaid population, decreased hospitalizations and decreased ER visits. So I think you are right, Senator Cassidy, we need to move care into the community to prevent the ER visits.

Senator CASSIDY. That has been a theme from all of you. Dr. Staiger, I have been just chomping at the bit to ask you this question. Are you ready? The sophistication of your research, you say that the pass rate of licensing exam is down. Now, you have done some sort of multivariate analysis.

Is it—who is less likely to pass? Is it the online school? Is it the for profit school? Is it the person who graduated during the pandemic? Is it poor preparation prior to coming to school? What are the variables that can be affected?

Dr. STAIGER. We are working on that. I don't have—Oh, come on.

[Laughter.]

Dr. STAIGER. But I can—I have some answers. The people who are not passing the licensure exam are people who were in nursing

school during the pandemic. And all belief is that it was the, you know——

Senator CASSIDY. So that cuts across the institution. Johns Hopkins, all the way to your community college?

Dr. STAIGER. Well, I can't say Johns Hopkins specifically, but they are seeing it across the board in terms of the declining pattern.

Senator CASSIDY. Let me ask you then, online nursing instruction, which I will come back to you, ma'am. Online nursing instruction, I am out by the bedside person and your quote, I will steal it, Dr. Hildreth.

In fact, I will attribute it the first time, but then after that, I will just forget you. Speaking to 100 people is a great way to teach, but a bad way to learn. So online seems like a great way to teach, but a bad way to learn for nursing skills. Am I right or am I wrong?

Dr. STAIGER. Well, I think the challenge has been particularly for clinical skills, right, that bedside skills. And the exam, and it is changing in April is—focuses increasingly on clinical skills and clinical experience for the nurse licensure exam.

That is becoming—you know, the belief is that the pass rates are going to get much worse this year this next year because of that.

Senator CASSIDY. Because there has been a lack of preparation for clinical.

Dr. STAIGER. Lack of the clinical experience——

Senator CASSIDY. So let me move on. Dr. Szanton, I suspect you are chomping at the bit. Now, I endorse what Marshall said, the woman or the man that goes to the community college, I think is probably more likely to stay in her community.

I will just say from my personal experience as a physician, certificate nurses, the one that I worked with for 30 years, she was just fantastic. There is a clear bias toward BSNs, but it seems more expensive, it seems a longer pipeline to get them out, and again, as he says, there may be a predisposition for those folks to stay where they were trained at the university town as opposed to their community.

We got a couple of things to throw before you. One, what about that, the Marshall issue? Dr. Staiger, what about this kind of clinical skills gap? And what should we be thinking about in terms of online training and what I would intuitively think would make them less prepared?

Dr. SZANTON. Thank you very much for those questions. About the online training, so at Johns Hopkins, I can't speak for all nursing schools, but at Johns Hopkins, when we talk about an online program, what they mean is that the some of the didactic portion when you are learning about pathophysiology and you are learning about how the heart works, and that that can be online modules.

But they come to campus multiple times a year and they have clinical experiences wherever they are. There is—at least at Johns Hopkins, there is no such thing as online only nursing program. To your point, that wouldn't make sense.

Senator CASSIDY. I know that there is some online only classes? Do I know that? Some universities all do 100 percent online. Dr. Staiger, did you know that.

Dr. SZANTON. Classes——

Dr. STAIGER. During the pandemic, and there was—typically, no, right. They all——

Dr. SZANTON. For example, at Johns Hopkins March 2020, everything shut down briefly, but we pivoted quickly and people were back doing clinical hours. Sometimes they were more out in the community than in the hospital, for example. But people got really hands on clinical experiences during the pandemic. I want to just mention about RN, I wouldn't call it a bias respectfully, toward BSN education.

There are decades of evidence, and I am sure you can back me up, showing that health systems that have a higher proportion of BSNs have better health outcomes for the patients.

Of course, you need a team of all different kinds of people, but there is a lot and a lot of evidence that we would be happy to share over time about the need for the BSNs.

Senator CASSIDY. Now, the choice is between the marginal increase in outcome, which again, you want a multivariate analysis to look at that, as opposed to having a shortage of nurses. Which would be more impactful, more nurses or more of them being BSNs?

Dr. STAIGER. You know, nurses first, right, then skills, then upskilling. And you know the evidence—the National Academy of Medicine came out and this was their recommendation, so I won't argue with that. It is not perfect evidence, but it is good evidence. I think the key to the associate degree nurses is the entry in the career steps.

You know, it is a way for people to get in with 2 years, but then have a career ahead of them where they can get trained up to be a bachelor's nurse. And the key is facilitating that. That is how you get people to enter at these lower wage jobs, is they see the career ahead.

Senator CASSIDY. With upskill, can I have one more question? Dr. Hildreth, you alluded to, Dr. Szanton spoke specifically, that if we address the burden of chronic disease, we can decrease our utilization.

Dr. Seoane mentioned an innovative program in terms of digital health. We are going to have some hearings on pharmaceuticals, but whatever we say about pharmaceuticals, they have been incredibly innovative.

We know the burden of metabolic disease disproportionately falls upon the poor, and that if we do something about the metabolic syndrome, then we are going to decrease renal failure, hypertension, diabetes, heart disease, stroke.

I say that, I am not sure there is a question there, but just an observation, that there has been a consistent refrain that if we do something about the burden of chronic disease, that we can decrease the demand upon our health care facilities, if you will, a more fundamental way to address the shortfall as opposed to just

more nursing schools, which we also need. Any comment on that, sir?

Dr. HILDRETH. Thank you, Senator Cassidy. I will just repeat what I said earlier. Our health care system is actually a sick care system.

We need to be focused on the social determinants of health, where you live, where you work, how much money you make, your educational attainment, all of those things contribute much more to your health than going to see a doctor.

Now, in my job, I am in the business of training doctors, dentists, researchers, but the reality is that what we need more of this investment in public health.

I would argue that re-integrating public health in primary care is the best way forward, so we can actually get better outcomes for communities, not one person at a time. Thank you.

The CHAIR. Thank you, Senator Cassidy. Look, I agree with Senator Cassidy. I thought this, Senator Cassidy, was an extraordinary hearing.

I think we had the attendance of virtually every Member here on both sides, which tells—should tell us and tell all of us, rural, urban, no matter where you are from, we have got a major crisis in health care workforce.

This has been a great panel and I want to thank each and every one of you for being here. We are going to get back to you. We are going to produce legislation. I don't do hearings for the sake of hearings.

All of you have been invaluable in your contributions. So, let's work together. Let's do something for the American people and thank you very much.

For any Senators who wish to ask additional questions, questions for the record will be due in 10 business days, March 3rd at 5.00 p.m.

Finally, I ask unanimous consent to enter at the record a statement from Senator Casey and 19 statements from stakeholder groups sharing their health care workforce priorities. So, ordered.

[The following information can be found on page 79 and 83 in Additional Material:]

The CHAIR. The Committee stands adjourned.

ADDITIONAL MATERIAL

SENATOR ROBERT P. CASEY, JR., STATEMENT FOR THE RECORD

I regret that I was unable to attend the Committee on Health, Education, Labor, and Pensions (HELP) hearing on Thursday, February 16, 2023 due to medical leave. This hearing covered a critical and timely matter: health professional shortages and their impact on the health care system.

The COVID–19 pandemic placed an immense strain on the health care workforce across the field, from outpatient to intensive care. While the world went into lockdown, health care facilities and the personnel that staff them remained open, fielding the swell of patients exhibiting the symptoms of a virus the medical community was only beginning to understand. The data suggest that one in five health care workers quit their jobs during the pandemic. Working long hours, often without adequate personal protective equipment, health care providers were steadfast in their commitment to serving their communities.

We must apply lessons learned during the acute phases of the COVID–19 pandemic to future policy. I look forward to working with my colleagues on both sides of the aisle this Congress to reauthorize the Pandemics and All Hazards Preparedness Act to fortify our health care system against future public health threats. It will be vitally important to prioritize building supports for our frontline health care personnel, so they are able to provide the best care possible when it is needed most.

There are a number of Federal programs aimed at building the health workforce pipeline, including the National Health Service Corps (NHSC) and Medicare Graduate Medical Education (GME) payments to support residency slots to train new doctors. In Pennsylvania, loan repayment programs like the NHSC are especially important for our rural health care facilities who may otherwise struggle to attract new providers without incentives like loan repayment. I was pleased to see that the Consolidated Appropriations Act, 2023 included an expansion of GME slots, but systemic underinvestment in these—and similar—programs can limit their impact.

There are further considerations for specialty providers, who receive extra training. I have led efforts to reauthorize the Children's Hospital Graduate Medical Education program for many years. This program supports the pediatric health care workforce and addresses shortages in pediatric specialty care by supporting residency slots at freestanding children's hospitals. I look forward to working on the reauthorization of this important program this Congress.

As it stands, our health care workforce does not reflect the diversity of the communities they serve. My bill, the Allied Health Workforce Diversity Act, recently passed with the Consolidated Appropriations Act, 2023. This legislation authorizes $8 million per year over the next 5 years for a new grant program aimed at recruiting a diverse body of professionals in the allied health fields, including occupational therapists, physical therapists, speech-language pathologists, and audiologists.

Our work is not done once a health care worker is hired, though. Health care workers consistently face elevated rates of workplace violence, and I am proud to support Senator Baldwin's work in addressing this serious issue. There was an outpouring of support for our health care professionals during the acute phases of the COVID–19 pandemic, in recognition of their truly heroic work. We must continue to show up for our providers, and I look forward to working with my colleagues on the HELP Committee this Congress to develop new, innovative ways to build this critical workforce.

Pennsylvania's world-class medical community will be part of these developments, and I will continue to work on behalf of our health care providers to make sure we have the proper resources to keep up with the changing health care landscape without sacrificing care quality.

Johnson & Johnson

February 16, 2023

The Honorable Bernie Sanders
332 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Bill Cassidy
455 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Chairman Sanders and Ranking Member Cassidy:

On behalf of Johnson & Johnson, we would like to thank you for holding the hearing, "**Examining Health Care Workforce Shortages: Where Do We Go From Here?"** For healthcare to work, it takes a strong, thriving workforce of doctors and nurses, and when we work together to support those on the front lines of care, we are advancing better health for us all. Guided by Our Credo and our commitment to patients, doctors and nurses, J&J has supported the healthcare workforce for more than 100 years, and we are dedicated to building a world where health care professionals can thrive.

According to a 2021 U.S. Surgeon General Advisory[1], burnout among health professionals is a driver of health workforce shortages and retention challenges. While healthcare providers have long dealt with a critically high degree of burnout and stress, recently 60% of health workers reported that stress from the pandemic has harmed their mental health and 75% of nurses report exhaustion. According to a Medscape report[2], 43% of physicians surveyed reported "not wanting to risk disclosure to medical board" as a reason for not seeking help for burnout or depression.

The Committee's work to pass the Dr. Lorna Breen Health Care Provider Protection Act represented a landmark effort in addressing this issue, yet additional action is necessary to take better care of those who care for all of us. We are committed to partnering to cultivate workplaces where doctors, nurses and all on the front lines of care will want to stay and grow because they are supported and valued.

A nursing shortage has loomed in healthcare for many years. Johnson & Johnson has taken a leadership role in addressing this issue through our *Campaign for Nursing's Future*, originally launched in 2002, the 2019 establishment of the Center for Health Worker Innovation, and ongoing advocacy, scholarships, clinical and leadership education, mental health resources and more.

We encourage the Committee to consider legislation that includes:

- **Talent Pipeline Initiatives**: Support funding for pathway and clinical training programs, loan repayment and incentives to drive increases in faculty and preceptors, access to education and graduates serving underserved areas.

- **Mental Health Resources**: Support adoption and robust funding for wellness programs and initiatives to ensure clinicians can freely seek mental health treatment and services without fear of professional repercussions and career setbacks.

- **Fostering Culture Change**: Support efforts to advance workplace violence prevention programs that address the needs of healthcare professionals and encourage opportunities to reduce administrative burden and allow clinicians to focus on high-value work.

[1] https://www.hhs.gov/surgeongeneral/priorities/downloads/health-worker-burnout-consequences.jpg
[2] https://www.medscape.com/slideshow/2022-lifestyle-burnout-6014664?uac=85323SN&faf=1&sso=true&implD=3962382&src=wnl_physrep_220122_Burnout2022#24

Johnson & Johnson

It is imperative that we continue to prioritize the critical needs of our frontline health workers and create a healthcare system and working environment in which nurses, doctors and all healthcare workers flourish, their well-being is a top priority, and their innovation is championed.

Thank you for your leadership on this most critical issue. Johnson & Johnson stands ready to partner to address this crisis. Nurses, doctors and the entire health ecosystem need engagement at every organizational level, and from grassroots communities to Capitol Hill and beyond. Now is the time for collaboration and innovation.

Please contact Kelly Waters at kwaters5@its.jnj.com should you have any questions.

Sincerely,

Jane M. Adams
Vice President, Federal Government Affairs

Lauren Moore
Vice President, Global Community Impact

February 15, 2023

The Honorable Bernie Sanders
United States Senate
Washington, DC 20510

The Honorable Bill Cassidy, M.D.
United States Senate
Washington, DC 20510

Dear Chair Sanders and Ranking Member Cassidy,

The HR Policy Association (Association) and the American Health Policy Institute (Institute) appreciate the Committee holding this important hearing on "Examining Health Care Workforce Shortages." This issue is critically important for patients seeking timely and affordable treatment from mental health and substance use disorder (MHSUD) providers, particularly in rural areas.

The Association is the leading organization representing chief human resource officers of 400 of the largest employers in the United States. Collectively, their companies provide health care coverage to over 20 million employees and dependents in the United States. The Institute, a part of the Association, examines the challenges employers face in providing health care to their employees and recommends policy solutions to promote affordable, high-quality, employer-based health care. The Institute serves to provide thought leadership grounded in the practical experience of America's largest employers.

Over the past three years, large employers have taken a number of steps to improve access to MHSUD providers. Many employers are providing enhanced employee assistance programs in addition their health plan mental health benefits, expanding mental health navigation programs, tele-behavioral health benefits, center-of-excellence providers, and contracting with third-parties to supplement existing vendors and broaden access. Although these efforts have substantially increased access to and the utilization of employer provided MHSUD benefits, the fundamental problem remains – a severe shortage of MHSUD providers that is projected to increase.

According to the Health Resources and Services Administration, 158.4 million Americans live in 6,599 Mental Health Professional Shortage Areas and 7,957 additional behavioral health (BH) practitioners[1] are needed to fill these provider gaps.[2] Moreover, given the elevated need for MHSUD services post-Covid and the current homeless/fentanyl crisis, by 2035, the U.S. is projected to have a significant shortage of adult psychiatrists, child and adolescent psychiatrists, psychologists, addiction counselors, mental health counselors, and marriage and family therapists.[3]

---

[1] Behavioral health providers are health care practitioners or social and human services providers who offer services for the purpose of treating mental disorders including: psychiatrists, clinical social workers, psychologists, counselors, credentialed substance use specialists, peer support providers, and psychiatric nurse providers.

[2] Bureau of Health Workforce, Health Resources and Services Administration (HRSA), U.S. Department of Health & Human Services, Designated Health Professional Shortage Areas Statistics: Designated HPSA Quarterly Summary, as of December 31, 2022, available at: https://data.hrsa.gov/Default/GenerateHPSAQuarterlyReport.

[3] Bureau of Health Workforce, Health Resources and Services Administration (HRSA), U.S. Department of Health & Human Services, Behavioral Health Workforce Projections, 2020-2035, November 2022, available at: https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/Behavioral-Health-Workforce-Projections-Factsheet.pdf.

165 Probst J et al. Oct 2019. "Rural Registered Nurses: Educational Preparation, Workplace, and Salary." Rural and Minority Health Research Center. **https://www.sc.edu/study/colleges_schools/public_health/research/research_centers/sc_rural_health_research_center/documents/ruralregisterednurses.pdf**.

166 U.S. House of Representatives. Committee on Appropriations. Jul 19, 2021. "Report Together with Minority Views to Accompany HR. 4502." 117th Cong. **https://www.congress.gov/117/crpt/hrpt96/CRPT-117hrpt96.pdf**.

167 Health Resources and Services Administration. 2021. "Justification of Estimates for Appropriations Committees, Fiscal Year 2022." U.S. Department of Health and Human Services. **https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2022.pdf**.

Health Resources and Services Administration. 2019. "Justification of Estimates for Appropriations Committees, Fiscal Year 2020." U.S. Department of Health and Human Services. **https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2020.pdf**.

Health Resources and Services Administration. 2017. "Justification of Estimates for Appropriations Committees, Fiscal Year 2018." U.S. Department of Health and Human Services. **https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-2018.pdf**.

168 Health Resources and Services Administration. 2021. "Nurse Corps Scholarship Program, School Year 2021-2022, Application & Program Guidance." U.S. Department of Health and Human Services. **https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/funding/nursecorps-sp-guidance.pdf**.

169 Health Resources and Services Administration. 2021. "Nurse Corps Loan Repayment Program, Fiscal Year 2021, Application & Program Guidance." U.S. Department of Health and Human Services. **https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/funding/nursecorps-lrp-guidance.pdf**.

170 42 U.S.C. § 296m(a).

171 Health Resources and Services Administration. "Nurse Corps Scholarship Program…" (2021).

172 Health Resources and Services Administration. 2020. "Nurse Corps Loan Repayment and Scholarship Programs Report to Congress for Fiscal Year (FY) 2019." U.S. Department of Health and Human Services. **https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/about-us/reports-to-congress/nurse-corps-report-congress-fy19.pdf**.

173 Yoo B et al. 2016. "The Effect of Prior Healthcare Employment on the Wages of Registered Nurses." *BMC Health Services Research*. 16(1):1-12. doi:10.1186/s12913-016-1667-0.

174 American Association of Colleges of Nursing. Sep 2020. "Nurse Faculty Shortage." Fact Sheet. **https://www.aacnnursing.org/Portals/42/News/Factsheets/Faculty-Shortage-Factsheet.pdf**.

175 National Nurses United. "Deadly Shame…" (2020).

176 See NNU's sixth survey of RNs on Covid-19 which included the effects on nurses of stressors and mental health impacts of the pandemic. National Nurses United. Sep 27, 2021. "National Nurse Survey Reveals That Health Care Employers Need to Do More to Comply with OSHA Emergency Temporary Standard." National Nurses United. **https://www.nationalnursesunited.org/press/national-nurse-survey-reveals-health-care-employers-need-to-do-more-to-protect-workers**.

American Hospital Association™
Advancing Health in America

Washington, D.C. Office
800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100

Statement

of the

American Hospital Association

for the

Committee on Health, Education, Labor and Pensions

of the

U.S. Senate

"Examining Health Care Workforce Shortages: Where Do We Go From Here?"

February 16, 2023

Chairman Sanders, Ranking Member Cassidy, M.D., and members of the committee, 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 provide information regarding health care workforce shortages.

SUSTAINING THE HEALTH CARE WORKFORCE

Health care careers are often a calling, and a qualified, engaged and diverse workforce is at the heart of America's health care system. However, long building structural changes within the health care workforce, combined with the profound toll of the COVID-19 pandemic, have left hospitals and health systems facing a national staffing emergency that could jeopardize access to high-quality, equitable care for patients and the communities they serve.

Prior to the COVID-19 pandemic, hospitals were already facing significant challenges that were making it difficult to sustain, build and retain the health care workforce. In 2017, the majority of our nursing workforce was close to retirement, with more than half age 50 and older, and almost 30% age 60 and older. Yet, nursing schools had to turn

away over 90,000 qualified applicants in 2021 due to lack of faculty and training sites.[1] Hospitals faced similar demographic trends for physicians, with data from the Association of American Medical Colleges indicating that one-third of practicing physicians will reach retirement age over the next decade. Hospitals also were reporting significant shortages of allied health and behavioral health professionals. On top of this, clinicians reported feelings of extreme stress and anxiety on the job. A National Academy of Medicine report indicated that between 35% and 54% of U.S. nurses and physicians had symptoms of burnout, which it characterizes as high emotional exhaustion, cynicism and a low sense of personal accomplishment from work.

Unfortunately, the COVID-19 pandemic only served to deepen and accelerate health care's workforce challenges. A 2021 survey from the Kaiser Family Foundation-Washington Post found that nearly 60% of health care workers had experienced a decline in their mental health as a result of their work during the pandemic, and nearly 30% had considered leaving their profession altogether. In addition, a survey by AHA's American Organization for Nursing Leadership found that one of the top challenges and reasons for health care staffing shortages reported by nurses was "emotional health and well-being of staff."

The result of these mounting pressures on the health care workforce has created a historic workforce crisis complete with real-time short-term staffing shortages and a daunting long-range picture of an unfulfilled talent pipeline. Just within the week of February 9, Department of Health and Human Services (HHS) data showed that 623 hospitals (or 16.7% of reporting hospitals) anticipated a critical staffing shortage. In addition, projections from the Bureau of Labor Statistics estimate U.S. health care organizations will have to fill more than 203,000 open nursing positions every year until 2031. There also are significant projected shortages of physicians and allied health and behavioral health care providers, which will likely be felt even more strongly in areas serving structurally marginalized urban and rural communities. This also has resulted in a 20.8% increase in total labor expenses from 2019 to 2022, according to Syntellis Performance Solutions 2023 CFO Outlook for Healthcare.[2]

TRAVEL NURSE, TEMPORARY LABOR ISSUES

To help offset the critical shortage of workers and maintain appropriate levels of care for patients, nearly every hospital in the country was forced to hire temporary staff at some point during the pandemic, including contract or travel nurses.[3] Hospitals' reliance on travel nurses and the inflated associated costs to employ them has grown significantly since the start of the pandemic. This notably peaked in 2022 during the omicron surge. The hours worked by travel nurses as a percentage of total hours worked by nurses in

---

[1] https://www.aacnnursing.org/News-Information/Press-Releases/View/ArticleId/25183/Nursing-Schools-See-Enrollment-Increases-in-Entry-Level-Programs
[2] https://www.syntellis.com/resources/report/cfo-outlook-healthcare
[3] https://www.amnhealthcare.com/siteassets/amn-insights/surveys/amn-survey-of-temporary-allied-healthcare-professional-staff-trends-2021.pdf

hospitals grew from less than 4% in January 2019 to over 23% in January 2022, according to data from Syntellis Performance Solutions.

The use of contract labor continues to remain much higher than pre-pandemic levels, which has led to increased labor expenses overall for hospitals and health systems. Data from a forthcoming Syntellis Performance Solutions/AHA report will show that travel nurse full time equivalents (FTEs) per patient day rose over 183.4% from 2019 to 2022. Though travel nurses are often the bulk of contract labor, similar trends have affected specialties and departments across hospitals. For example, emergency service contract FTEs per ED visit rose 187.2% over the same time period. As a result, contract labor as a share of total labor expenses rose 178.6% from 2019 to 2022.

This is largely due to health care staffing agencies that took advantage of this desperate moment in history by drastically increasing the hourly rates they charged to hospitals. From January 2019 to January 2022, those rates rose by 213%. However, these agencies are not passing along a comparable increase in wages to travel nurses and other clinicians. According to an analysis conducted by the AHA of data from Syntellis Performance Solutions and Emsi Burning Glass Market Analytics, during pre-pandemic levels in 2019, the average margin retained by staffing agencies for travel nurses was about 15%. In January 2022, the average margin had grown to an astounding 62%.[4] These high margins have fueled massive growth in the revenue and profits of health care staffing agencies. Several staffing firms reported significant growth in their revenues to as high as $1.1 billion in just the fourth quarter of 2021,[5] tripling their revenues and net income compared to 2020 levels.[6]

The AHA remains concerned that the conduct of some of these travel nurse staffing agencies bears all the hallmarks of collusion and perhaps other abuses. The AHA sent letters urging both the Federal Trade Commission and the White House to use their authority to investigate these reports of anticompetitive behavior.

Additionally, last year nearly 200 bipartisan members of Congress sent a letter highlighting their concerns and calling on the White House to enlist one or more federal agencies with competition and consumer protection authority to investigate the exorbitant price increases by these agencies. However, no action has been taken, and many hospitals and health systems continue to face significant financial and operational concerns in part due to the unsustainable rates charged by health care staffing agencies.

---

[4] https://www.aha.org/costsofcaring
[5] https://www.axios.com/amn-healthcare-pandemic-travel-nurses-profit-revenue-ebb5bcfd-4ca9-4263-a091- fb87bbb8d105.html
[6] https://www.healthcaredive.com/news/hospital-lobbies-congress-ftc-travel-nurse-rate-caps-covid/618194/

SUPPORTING THE WORKFORCE

Hospitals and health systems exist and function because of the doctors, nurses, technologists, facilities management specialists and many other professionals who work in them. We cannot take care of patients without these caregivers and team members who are always there ready to care. Hospitals and health systems are committed to supporting them.

That's why we're collaborating to expand training options, recruiting internationally, launching nurse education programs, reimagining workforce models, investing in upskilling and providing nontraditional support for health care workers.

Collaborating

- Mary Washington Healthcare in Virginia partners with Germanna Community College on an Earn While You Learn program, onboarding two cohorts of as many as 60 nursing students each year, who work 12-20 hours a week using a clinical rotation model. The program now includes an additional nursing school as well as mentor models for nursing assistants and is considering an apprenticeship model for other clinical roles such as surgical technologists.
- Participants in the Jump Start program at MercyOne in Iowa receive a monthly stipend while they finish nursing school, and MercyOne covers the cost of board exams and licensing fees. After RN licensure, the nurses begin work at MercyOne.
- Freeman Health System in Missouri partners with Crowder College to provide an opportunity for education and employment through a 16-week paid certified medical assistant apprentice program.

Recruiting Internationally

- While the U.S. must do more to invest in training the next generation of health care workers at home, we believe recruiting qualified immigrants, and expediting their entry into the country, is an effective short-term approach that deserves support from Congress.
- Over the next three years, Sanford Health in Sioux Falls, S.D., plans to hire more than 700 internationally trained nurses to work in its health system. Sanford covers housing during the initial transition period and has instituted a program to help the nurses get acculturated to their new communities.
- Louisiana-based Ochsner Health is offering employment to eight Ukrainian nurses and will assist their families in settling in the U.S. in the pilot phase of CGFNS International's "Passport2Liberty" initiative.

Launching Nursing Programs

- Nearly 60 schools and hospitals across the country have partnered to start or expand nursing programs in 2022. Programs range from accelerated BSN programs and virtual nursing programs to brand-new nursing schools and licensed practical nursing programs.

- Corewell Health System in Michigan is providing $20 million to Oakland University — $10 million in grants for nursing students and $10 million to support infrastructure expansion and faculty hiring. Students who receive a grant must commit to work for Corewell Health for two years following graduation.

Reimagining Workforce Models

- As part of its ongoing efforts to better recruit and retain talented health professionals amid the significant labor shortages, Pittsburgh-based Allegheny Health Network launched “Work Your Way,” a mobile internal staffing model to provide flexible work life solutions for nurses, surgical technologists and other team members. This unique program allows health professions with the freedom and flexibility to choose how and when they want to work.

Upskilling

- UCHealth in Colorado plans to invest $50 million in its new Ascend leadership program to help current and prospective employees earn clinical certification, participate in foundational learning programs such as English language and college prep, and earn degrees in areas such as social work and behavioral health. Newly hired employees also will be able to earn a high school diploma or GED.
- Along with three educational partners, the University Medical Center of El Paso (Texas) will pay up to $5,000 annually for two years for employees to earn a degree in nursing, respiratory, imaging or other hard-to-fill fields. Employees maintain full-time employment status and compensation while working part-time. Under another new program, the hospital is offering eligible employees pursuing a health care degree up to $5,250 a year in student loan-repayment assistance.
- To fill the scores of medical assistant openings, in Nashville, Tenn., Vanderbilt University Medical Center partnered with Nashville State Community College to train current employees, including truck drivers and environmental services staff. During the training, workers continue to receive their full salary plus tuition reimbursement. They also are training high school students to receive medical assistant certification.
- In Pennsylvania, Geisinger’s Nursing Scholars Program awards $40,000 in financial support to each employee who is pursuing a nursing career and makes a five-year commitment to work as an inpatient nurse. The program is open to any employee who has worked with Geisinger for at least a year and is not already a registered nurse or provider.

Nontraditional Support

- St. Luke’s Wood River Medical Center, located in a popular Idaho tourist area, is building 12 single-family homes that will be long-term rentals for employees.
- Bozeman Health in Montana has invested in 100 units in a future workforce housing complex to provide employees with affordable rentals.
- Northwell Health, Johns Hopkins, Cleveland Clinic and BJC Healthcare are among employers offering grants or forgivable loans that can be used for associated housing costs.

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 the following.

- Addressing physician shortages, including shortages of behavioral health providers, by increasing the number of residency slots eligible for Medicare funding while rejecting cuts to Medicare graduate medical education (GME).
- Addressing nursing shortages by reauthorizing nursing workforce development programs to support recruitment, retention and advanced education for nurses and other allied health professionals and investing in nursing schools, nurse faculty salaries and hospital training time.
- Reducing administrative burdens that take clinicians away from the bedside and contribute to burnout, such as excessive and unnecessary use of prior authorization, as well as inappropriate coverage denials that require substantive clerical rework by staff.
- Supporting apprenticeship programs for nursing assistants and other critical support staff positions.
- Supporting the National Health Service Corps and the National Nurse Corps, which award scholarships and assist graduates of health professions programs with loan repayment in return for an obligation to provide health care services in underserved rural and urban areas.
- Supporting expedition of visas for foreign-trained nurses and continuation of visa waivers for physicians in medically underserved areas.
- Supporting the health care field in eliminating racism and fostering inclusive approaches to care delivery for all patients by incentivizing cultural humility training in medical training programs and in-service training for health care professionals.
- Supporting efforts to increase the diversity of the health care workforce, including through funding for GME and federal scholarship programs.
- Adopting policies to substantially expand loan repayment and other incentive-based programs to retain existing talent and attract new talent.
- Enhancing workplace safety for all team members, including by enacting federal protections for health care workers against violence and intimidation, and providing hospital grant funding for violence prevention training programs, coordination with state and local law enforcement, and physical plant improvements.
- Directing the Government Accountability Office to study the business practices of travel nurse staffing agencies during the pandemic, including potential price gouging and excessive profits, increased margins that agencies retain for themselves, impact of increased reliance on travel nurses in rural areas, and how these practices contribute to workforce shortages across the country.

CONCLUSION

The AHA appreciates your recognition of the challenges ahead and the need to examine America's health care workforce issues. 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.

Statement by the Association of American Medical Colleges before the Senate Committee on Health, Education, Labor and Pensions hearing, titled "Examining Health Care Workforce Shortages: Where Do We Go From Here?" February 16, 2023

Thank you for the opportunity to submit testimony on health workforce challenges facing our country and for prioritizing this issue as the first Senate Health, Education, Labor and Pensions (HELP) Committee hearing of the 118th Congress.

The AAMC (Association of American Medical Colleges) is a nonprofit association dedicated to improving the health of people everywhere through medical education, health care, medical research, and community collaborations. Its members are all 157 U.S. medical schools accredited by the Liaison Committee on Medical Education; 13 accredited Canadian medical schools; approximately 400 teaching hospitals and health systems, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools and teaching hospitals and the millions of individuals across academic medicine, including more than 193,000 full-time faculty members, 96,000 medical students, 153,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Following a 2022 merger, the Alliance of Academic Health Centers and the Alliance of Academic Health Centers International broadened the AAMC's U.S. membership and expanded its reach to international academic health centers.

The AAMC lists our key priorities as follows:

- expanding the health care workforce, in particular through additional Medicare-supported graduate medical education (GME) positions and increased investment in the Health Resources and Services Administration (HRSA) health workforce programs;
- medical research supported by the National Institutes of Health (NIH);
- health equity; and
- fiscal solvency for hospitals and health systems to ensure ongoing access to high-quality, cutting-edge care for people everywhere.

There are numerous issues under the Senate HELP Committee's jurisdiction that impact academic medicine and our nation's health in addition to workforce[1], but with respect to our recent discussion and the subject of this hearing, we are pleased to offer the following recommendations for bipartisan action on the health workforce in the 118th Congress.

[1] Specific issues under the Senate HELP Committee's jurisdiction that impact academic medicine and the nation's health that align with our priorities include federal support for research and the NIH; public health emergency preparedness; drug pricing and the 340B program; hospital nursing shortages and other key workforce challenges; student loan and repayment reform; and social determinants of health.

Expanding the Workforce and Graduate Medical Education

The AAMC continues to project that physician demand will grow faster than supply (primarily driven by a growing, aging U.S. population) leading to a projected total physician shortage of up to 124,000 physicians by 2034. Within this total, we project a shortage of primary care physicians of up to 48,000 and a shortage of non-primary care specialty physicians (e.g., psychiatry, infectious disease, and general surgery) of up to 77,100 by 2034. Make no mistake – these shortages in the physician supply will have real impact on patients, particularly those living in rural, frontier, island or non-contiguous settings, and other already underserved communities. The AAMC's "Health Care Utilization Equity" scenario finds that if underserved populations were to experience the same health care use patterns as populations with fewer barriers to access, the U.S. would need up to an additional 180,400 physicians just to meet *current* demand.[2]

Addressing the nation's physician workforce shortages in both primary care and among needed specialists requires a multipronged, innovative, public-private approach beyond just increasing the overall number of physicians, such as implementing team-based care and better use of technology. We are open to and in fact, ask for, innovative solutions to address health workforce shortages. Since academic year 2002-2003, total medical school enrollment has grown by more than 38% as medical schools have expanded class sizes and more than 32 new medical schools have opened. While this increase is encouraging, additional action is needed to address the physician shortage.

Growth in graduate medical education (GME or residency training) is also needed to address projected physician shortages. Dating back to 1997, Medicare caps the number of GME positions it supports at each teaching hospital.[3] According to an analysis of FY 2020 Medicare Cost Report data, there are approximately 122,699 medical trainees in GME positions. Medicare reimburses only 90,522 of those medical trainees at or below the direct GME (DGME) cap established in 1997. According to the same cost report analysis, the average actual cost per medical trainee for a facility was $183,889, while the average actual Medicare DGME payment per resident was only $50,406.[4] The majority of the difference in the cost to train and the Medicare DGME payment must be shouldered by the clinical revenue at a teaching hospital and given the financial solvency issues facing many of these facilities, funding to train residents is another challenge.

To help grow a sustainable physician workforce to meet patient needs, the AAMC strongly supports the expansion of Medicare support for GME and urges the inclusion of additional GME positions in any health care legislation.
One key element of addressing the physician shortage is increasing Medicare support for GME, which will help boost access to high-quality care, particularly for rural and other underserved populations. In the 117th Congress, Senators Robert Menendez (D-NJ), John Boozman (R-AR), and Majority Leader Charles Schumer (D-NY) introduced the AAMC-endorsed bipartisan Resident Physician Shortage Reduction Act of 2021 (S. 834), which would gradually raise the

[2] The Complexities of Physician Supply and Demand: Projections From 2019 to 2034, Prepared for the AAMC by IHS Markit Ltd., June 2021.
[3] P.L. 105-33.
[4] AAMC Analysis of FY2020 Medicare Cost Report data, July 2022 Hospital Cost Reporting Information System (HCRIS) release. If FY2020 data is not available, FY2019 data is used.

number of Medicare-supported GME positions by 2,000 per year for seven years, for a total of 14,000 new positions. These new GME positions would target teaching hospitals with varied needs, including hospitals in rural areas, hospitals serving patients from federally-designated HPSAs, hospitals in states with new medical schools or branch campuses, and hospitals already training residents in excess of their Medicare caps. The legislation has broad stakeholder support and has been endorsed by over seventy members of the GME Advocacy Coalition, which represents a broad range of disciplines.

GME programs administered by HRSA, including Children's Hospitals GME and Teaching Health Centers, are important complements to Medicare GME that help to increase the number of residents training in children's hospitals and community health centers, respectively. To facilitate new rural residency programs, the HRSA Office of Rural Health Policy provides technical assistance and start-up funding to rural hospitals under the Rural Residency Planning and Development programs. Funding for these programs at HRSA specifically targeting GME at children's hospitals and teaching health centers, and rural areas will have impact on the physician workforce shortage in those settings.

Unique Financial Challenges of Teaching Hospitals and Health Systems

While running a health system, particularly an academic one, has always been challenging, recent years have significantly increased financial pressure. The AAMC has heard concerns from across its membership about shrinking and negative margins, a reality that is reflective of a broader trend in the U.S., with about half of U.S. hospitals ending 2022 with a negative margin. Though some challenges can be attributed to recovery from COVID-19 and general economic conditions, certain systemic issues persist, including workforce and staffing challenges, a shrinking financial base, low reimbursement rates, and ever-increasing mission-related costs. We know these challenges are realized across many health care facilities, but the problem at academic medical centers and teaching hospitals warrants special attention.

Teaching hospitals and health systems are social and economic anchors of their communities with their commitment to their missions of patient care, education, research, and community collaboration.[5] These missions, which are critical now more than ever, are in jeopardy as AAMC-member institutions are forced to make difficult decisions that stand to dramatically impact their communities. At the AAMC, we are gathering information about the specific financial challenges our teaching hospitals are facing so that we can clearly articulate them, and their drivers, to Congress and relevant agencies. As we compile this information, we will share it with members of the Senate HELP Committee to inform future legislative and policy proposals. The ability to accurately articulate the unprecedented challenges facing teaching hospitals and health systems through feedback from those institutions most impacted is key for a pathway forward. Teaching hospitals could be forced to consider potentially painful choices to maintain hospital operations, placing at risk specialized services that cannot be found elsewhere, such as burn units and trauma centers, or whether to eliminate key workforce training programs as the nation continues to grapple with a worsening physician shortage as well as shortages of all types of health care providers. Our member institutions and their missions have been pushed to the

[5] Economic Impact of AAMC Medical Schools and Teaching Hospitals

brink, and without action to ensure their financial stability and invest in key workforce programs, patients across the country may lose access to the care they need.

Enhancing the Rural Workforce, Primary Care, and Diversity

We recognize the value of diversity in healthcare and the health workforce, and we realize that diversity may be in many different forms. The HRSA Title VII health professions and Title VIII nursing programs play an important role in connecting students to health careers by enhancing recruitment, education, training, and mentorship opportunities. Inclusive education and training experiences expose students and providers to backgrounds and perspectives other than their own and heighten cultural awareness in health care, resulting in benefits for all patients and providers. Studies also show that underrepresented students are more likely to serve patients from those communities.[6] Despite their success and widespread interest, currently only 21 schools have HRSA Health Careers Opportunity Program (HCOP) grants and only 18 have HRSA Center of Excellence (COE) grants — down from 80 HCOP programs and 34 COE programs in 2005 before the programs' federal funding was cut substantially.

There is broad agreement that there is a shortage of health providers in rural, frontier, and island or non-contiguous communities. Important to addressing shortages across the spectrum of health providers in these areas is conducting education and training in these communities and drawing on members of these areas to enter health professions. Medical students who grow up in rural communities are much more likely to return to these areas to practice medicine, including primary care. Many medical schools aim to identify potential candidates from rural communities and encourage them to pursue a career in medicine.[7] The HRSA Title VII Area Health Education Centers (AHECs) specifically focus on recruiting and training future physicians in rural areas, as well as providing interdisciplinary health care delivery sites. Additionally, the HRSA Title VII Primary Care Training and Enhancement (PCTE) and Medical Student Education programs support education and training programs for future primary care physicians. Though we have seen progress towards diversifying the future physician workforce across the spectrum of our AAMC-member institutions, there is more work to be done.

The AAMC encourages increasing federal investment in minority serving institutions (MSIs), including Historically Black Colleges and Universities (HBCUs), Predominantly Black Institutions (PBIs), Hispanic Serving Institutions, and Tribal Colleges and Universities. AAMC also supports the Expanding Medical Education Act (S. 3422), which would authorize HRSA grants to establish or expand medical schools, including regional branch campuses, and would prioritize HBCUs and MSIs or those that propose to establish or expand schools in medically underserved communities or areas with shortages of health professionals where no such schools exist.

---

[6] Stewart, K., Brown, S. L., Wrensford, G., & Hurley, M. M. (2020). Creating a Comprehensive Approach to Exposing Underrepresented Pre-health Professions Students to Clinical Medicine and Health Research. Journal of the National Medical Association, 112(1), 36-43. doi:10.1016/j.jnma.2019.12.003.
Goodfellow A, Ulloa JG, Dowling PT, Talamantes E, Chheda S, Bone C, Moreno G. Predictors of Primary Care Physician Practice Location in Underserved Urban or Rural Areas in the United States: A Systematic Literature Review. Acad Med. 2016 Sep;91(9):1313-21. doi: 10.1097/ACM.0000000000001203. PMID: 27119328; PMCID: PMC5007145.

[7] Attracting the next generation of physicians to rural medicine, Peter Jaret, Special to AAMCNews, Feb. 2020.

Part of fortifying the physician workforce is taking care of existing, practicing physicians. We know that physicians and other health professionals dedicate their careers to keeping people healthy, but too often they do not receive the care they need to address their own well-being. The HRSA Title VII Preventing Burnout in the Health Workforce program authorized by the Dr. Lorna Breen Health Care Provider Protection Act (P.L. 117-105), which received no funding in the FY 23 omnibus, should receive funding to support existing physicians.

To help shape the physician workforce, the AAMC recommends significantly increasing funding for the HRSA workforce development programs under Title VII and Title VIII of the Public Health Service Act.
For FY 2024, the AAMC joins an alliance of national organizations, the Health Professions and Nursing Education Coalition (HPNEC), in recommending at least $1.51 billion for Title VII and Title VIII combined.

Addressing Medical Education Debt and Promoting Public Service

Medical education costs can also be a significant deterrent and burden for individuals interested in medicine, and the AAMC is deeply concerned about the impact these costs may have on the physician pathway.[8] Medical school leaders across the country are committed to serving the interests of medical students and reducing this burden. Some institutions have increased institutional aid, while a few have committed to eliminating debt or tuition altogether in the hopes of attracting diverse candidates and increasing interest in primary care.[9] In the 117th Congress, the AAMC endorsed the Ways and Means "Pathway to Practice" and National Medical Corps Act (H.R. 9105) scholarship programs to help address the financial debt burden for students who are underrepresented in medicine. Importantly, the Pathway to Practice program would prioritize applicants who attended HBCUs or MSIs, as well as those who participated in certain HRSA pathway programs.

Public service loan repayment programs offered by HRSA, NIH, VA, the Department of Defense, and the Indian Health Service are effective, targeted incentives for recruiting physicians and other health professionals to serve specific vulnerable populations. Increasing federal investment in these programs is a proven way to increase the supply of health professionals serving HPSAs, nonprofit facilities, and other underserved communities. For example, the Public Service Loan Forgiveness (PSLF) program administered by the Department of Education encourages physicians to pursue careers that benefit communities in need. The AAMC supports preserving physician eligibility for PSLF to help vulnerable patients and nonprofit medical facilities that use the program as a provider recruitment incentive.

The NHSC in particular has played a significant role in recruiting primary care physicians to federally-designated HPSAs through scholarships and loan repayment options. Despite the NHSC's success, it still falls far short of fulfilling the wide-ranging health care needs of all HPSAs due to growing demand for health professionals across the country. Congress provided a historic $800 million supplemental NHSC funding under the American Rescue Plan, and we

[8] Physician Education Debt and the Cost to Attend Medical School: 2020 Update.
[9] Will free medical school lead to more primary care physicians? Ken Budd, Special to AAMCNews, Dec. 2019.

believe this will have a positive impact. Nevertheless, additional funding for the NHSC is needed.

Immigration must be mentioned as we consider health workforce shortages, as the US health workforce has been bolstered by individuals who have come from other countries to our nation. Over the last 15 years, the State Conrad 30 J-1 visa waiver program has brought more than 15,000 physicians to underserved areas — comparable to (if not more than) the NHSC, at no cost to the federal government. As the 118th Congress considers immigration reform, the AAMC reiterates that the bipartisan Conrad State 30 and Physician Access Reauthorization Act would allow Conrad 30 to expand beyond 30 waivers per state if certain nationwide thresholds are met. We applaud this bipartisan reauthorization proposal for recognizing immigrating physicians as a critical element of our nation's health care infrastructure, and we support the expansion of Conrad 30 to help overcome hurdles that have stymied growth of the physician workforce.

In a collaborative manner with public and private cooperation, academic medicine is committed to working to address the challenges of physician and other health professions workforce shortages, and without a doubt, we have collectively made significant investments in these areas. At the same time, the AAMC believes there must be an increase in the federal government investments for federal programs that have demonstrated results and impact. The cost of inaction today will lead to higher costs, reduced access, and ultimately an underserved, less healthy population tomorrow – this cannot be our fate. We at the AAMC are committed to working with the entire Senate HELP Committee to avoid a dismal situation and to achieve better outcomes for our nation. If you have any further questions please contact AAMC Chief Public Policy Officer Danielle Turnipseed, at dturnipseed@aamc.org, or Matthew Shick, Senior Director, AAMC Government Relations, at mshick@aamc.org.

AAFP
AMERICAN ACADEMY OF FAMILY PHYSICIANS

February 16, 2023

The Honorable Bernie Sanders
Chairman
Committee on Health, Education, Labor and Pensions
United States Senate
Washington, D.C. 20510

The Honorable Bill Cassidy, MD
Ranking Member
Committee on Health, Education Labor and Pensions
United States Senate
Washington, D.C. 20510

Dear Chairman Sanders and Ranking Member Cassidy:

On behalf of the American Academy of Family Physicians (AAFP) and the 127,600 family physicians and medical students we represent, I applaud the committee for its focus on the health care workforce. I write in response to the hearing "Examining Health Care Workforce Shortages: Where Do We Go From Here?" to share the family physician perspective and the AAFP's policy recommendations for ensuring that we have a robust primary care workforce to address our nation's current and future health care needs.

The AAFP has long been concerned about the shortage of primary care physicians in the U.S., particularly the supply of family physicians, who provide comprehensive, longitudinal primary care services for patients across the lifespan, including chronic disease management, treatment of acute illnesses, and preventive care. It is projected that we will face a shortage of up to 48,000 primary care physicians by 2034.[i]

Primary care is the only health care component where an increased supply is associated with better population health and more equitable outcomes. In 2016, Americans made nearly 900 million visits to office-based physicians with almost half of those visits made to primary care physicians.[ii] Despite the significant role that primary care plays in our health system, primary care accounts for a mere 5-7 percent of total health care spending.[iii] The COVID-19 pandemic has also highlighted the urgency of building and financing a robust, well-trained, and accessible primary care system in our country.

The AAFP urges the committee to consider these recommendations:

- ***Strengthen and target federal graduation medical education (GME) programs*** **by permanently authorizing and expanding the Teaching Health Center Graduate Medical Education Program, ensuring transparency and accountability of the Medicare GME program, and creating additional federally funded GME slots targeted at primary care and underserved areas.**

- ***Diversify the physician workforce*** **by providing federal support and incentives for future and current clinicians from underrepresented and low-income backgrounds and extending the Conrad 30 Program for international medical graduates.**

1133 CONNECTICUT AVE., N.W., STE. 1100 | WASHINGTON, DC 20036-4305 | (800) 794-7481 | (202) 232-9033

- ***Address the burden of medical student debt*** **by expanding the National Health Service Corps program and other programs to provide student debt relief for physicians serving in high-need roles.**

- ***Invest in primary care*** **by ensuring Medicare and Medicaid physician payment is adequate and sustainable.**

- ***Support physician-led team-based care and integration of behavioral health and primary care*** **by funding the Primary Care Training Enhancement Program (PCTE) and other federal grant programs, and by enacting policies that incentivize comprehensive care provided by a physician-led care team.**

- ***Enact telehealth policies that extend the capacity of our health care workforce*** **by ensuring patients and clinicians have the flexibility to choose the most appropriate modality of care while protecting patient safety and the patient-physician relationship.**

- ***Stop anti-competitive contracting practices that harm clinicians and patients*** **by banning noncompete clauses in employment contracts.**

- ***Increase investment in primary care research*** **to identify trends and best practices.**

- ***Strengthen and sustain our health care safety net*** **by funding community health centers.**

Strengthen and Target Federal Graduation Medical Education Programs
We know most physicians are trained at large academic medical centers in urban areas, and evidence indicates physicians typically practice within 100 miles of their residency program.[iv] As a result, the current distribution of trainees leads to physician shortages in medically underserved and rural areas.

Today's Teaching Health Centers (THCs) play a vital role in training the next generation of primary care physicians and addressing the physician shortage. To date, the Teaching Health Center GME (THCGME) program has trained more than 1,730 primary care physicians and dentists, 63 percent of whom are family physicians. Data shows that, when compared to traditional postgraduate trainees, residents who train at THCs are more likely to practice primary care (82 percent vs. 23 percent) and remain in underserved (55 percent vs. 26 percent) or rural (20 percent vs. 5 percent) communities. This demonstrates that the program is successful in tackling the issue of physician maldistribution and helps address the need to attract and retain physicians in rural areas and medically underserved communities.

The THCGME program's authorization expires in FY 2024, and we strongly caution against a short-term extension since it does not provide the needed stability for current and future residents. In fact, flat funding of the program would mean a 40-50 percent reduction in per resident allocation for THC programs, putting them at risk of closure. **Congress should permanently authorize and expand the THCGME program by reintroducing and passing the Doctors of Community Act**.

While the new Medicare GME residency slots approved in the previous Congress were very much appreciated, additional action is needed to address disparate access to care in rural and other medically underserved areas. Merely expanding the existing Medicare GME system will not fix the shortage and maldistribution of physicians. **Any expansion of Medicare GME slots should be**

targeted specifically toward hospitals and programs in areas and specialties of need, including by considering which ones have a proven track record of training physicians who ultimately practice in physician shortage areas.

One barrier to creating a more equitable and effective Medicare GME program is the lack of transparency in how funds are used. Medicare as the largest single payer – spends about $16 billion annually on GME – but it does not assess how those funds are ultimately used or whether they actually address physician shortages.[v] CMS has indicated their authority is limited to making payment to hospitals for the costs of running approved GME residency programs. **Congress should pass legislation granting the Secretary of HHS and the CMS Administrator the authority to collect, analyze data on how Medicare GME positions are aligned with national workforce needs, and publish an annual report.**

Unlike Medicare and Medicaid, the Department of Veterans' Affairs (VA) does control the type of residents it trains and where these residents are located. A recent VA report projected that by 2033, there will be an estimated nationwide shortage of between 21,400 and 55,200 primary care physicians.[vi] Additionally, it was identified that 57 VA facilities had severe primary care shortages.[vii] **We urge Congress to designate additional VA GME slots for primary care specialties to address the current and projected shortages at VA facilities.**

Diversify the Physician Workforce

The lack of a diverse physician workforce has significant implications for public health. Physicians who understand their patients' languages and understand the larger context of culture, gender, religious beliefs, sexual orientation and socioeconomic conditions are better equipped to address the needs of specific populations and the health disparities among them. Several studies show that racial, ethnic and gender diversity among physicians promotes better access to health care, improves health care quality for underserved populations, and better meets the health care needs of our increasingly diverse population.[viii,ix] Improving quality of care for the most vulnerable groups can improve a patient's health outcome, which in turn can reduce health care costs over the long run. Studies also show that students from backgrounds currently underrepresented in medicine are more likely to care for underserved populations in their careers, and more likely to choose primary care careers.[x]

While primary care specialties fare better than other specialties in representation of racial and ethnic minorities in the workforce, the entire physician workforce lags significantly behind the racial and ethnic diversity of the U.S. population. Today, Black and Hispanic Americans account for nearly one-third of the U.S. population, but just 11 percent of physicians.[xi,xii]

We urge the reintroduction and passage of the Strengthening America's Health Care Readiness Act, which increases investment in the National Health Service Corps and, notably, allocates 40 percent of the funding for racial and ethnic minorities and students from low-income urban and rural areas. The **AAFP also supports federal programs, such as Title VII workforce training programs that are crucial in increasing underrepresented minority participation in the health professions.** Unfortunately, sustainable federal funding for pathway programs has not been consistent over the years. **Congress should invest in efforts to diversify the health care workforce to improve access to health care, reduce spending, and better meet the needs of our increasingly diverse population.**

Family physicians are acutely aware of the current shortage of primary care physicians across the country and the important role International Medical Graduates (IMGs) play in not only addressing

this shortage but in increasing the racial and ethnic diversity of the physician workforce. The Conrad 30 Waiver Program has brought more than 15,000 foreign physicians to underserved and rural communities. With communities across the country facing physician shortages, the Conrad 30 Waiver Program ensures that physicians who are often educated and trained in the U.S. can continue to provide care for patients during the COVID-19 crisis and beyond. **We urge Congress to reintroduce and pass the Conrad State 30 & Physician Access Act to provide immigration certainty to the thousands of international medical graduates caring for patients in underserved communities.**

Address the Burden of Medical Student Debt

The average student loan debt for four years of medical school, undergraduate studies and higher education is on average between $200,000 and $250,000.[xiii] Research has shown that loan forgiveness or repayment programs directly influence physician practice choice. The rising level of educational debt disproportionately affects underrepresented and low-income students and limits their representation in the health workforce but reducing student debt will diversify the physician pipeline and help reduce physician shortages. **Congress should expand funding for federal programs, including the National Health Service Corps Program, that incentivize physicians to go into primary care practice by providing loan forgiveness. We also urge the reintroduction and passage of the Resident Education Deferred Interest (REDI) Act to allow medical residents to defer their student loans interest free during residency, and we recommend that the interest on medical student loans be deductible on federal tax returns.**

Invest in Primary Care

Despite evidence indicating that additional investments in primary care would improve population health and advance health equity, primary care has been historically underfunded in the U.S. Medicare and Medicaid have historically undervalued primary care. In the short-term, inadequate payment rates mean that primary care physicians lack the resources needed to provide comprehensive, continuous care for their patients and may be forced to accept fewer Medicare or Medicaid patients. In the long-run, payment distortions between primary and specialty care will continue to drive more physicians to go into higher paid specialties, worsening the maldistribution of the physician workforce. A recent Medicare Payment Advisory Commission (MedPAC) analysis highlighted that the median compensation remains much lower for primary care physicians than for physicians in certain other specialties, such as radiology and surgical specialties – underscoring concerns about the mispricing of fee schedule services and its impact on the primary care pipeline.[xiv]

Medicare's current physician payment system is undermining physicians' ability to provide high-quality, comprehensive care – particularly in primary care. Statutory budget-neutrality requirements and the lack of annual payment updates to account for inflation will, without intervention from Congress, continue to hurt physician practices and undermine patient care. **We urge Congress to pass legislation to provide for an annual update to the Medicare Physician Fee Schedule based on the Medicare Economic Index (MEI) to ensure that payment rates keep pace with rising practice costs, enabling practices to keep their doors open.** The AAFP also strongly supports the Centers for Medicare and Medicaid Services (CMS) proposal to implement a new add-on code for complex evaluation and management (E/M) visits: G2211. The G2211 code recognizes the inherent complexity of primary care office visits and provides commensurate Medicare reimbursement. We were dismayed when Congress elected to delay implementation of that code, and **we urge Congress to support full implementation of G2211 in the CY 2024 Medicare physician fee schedule.**

Congress must also act to bolster the primary care physician pipeline by enacting Medicaid payment parity. On average Medicaid, pays just 66 percent of the Medicare rate for primary care services and

can be as low as 33 percent in some states.[xv] This severely reduces the number of physicians who participate in Medicaid and limits access to health care for children and families. Increasing Medicaid payment rates will improve access to care for Medicaid patients, lead to better health outcomes, and reduce longstanding health disparities. **The AAFP urges Congress to pass the Kids' Access to Primary Care Act of 2021 (H.R. 952) to permanently raise Medicaid payment rates for primary care services to at least Medicare levels.**

Support Physician-Led Team Based Care

The ability to deliver high-quality primary care depends on the availability, accessibility, and competence of a primary care workforce working as a team to effectively meet the health care needs of all patients. **We urge Congress to increase investment in primary care training programs, such as HRSA's Primary Care Training and Enhancement (PCTE) Program, that strengthen the physician-led care team and increase patient access to comprehensive care.**

The PCTE program strengthens the primary care workforce by funding enhanced training for future primary care clinicians, teachers, and researchers through five-year grants. Currently PCTE grants are supporting programs to integrate dental care into primary care, integrate behavioral health in primary care, provide enhanced training in prevention and maternal health, and enhanced primary care training for non-physician primary care providers. The PCTE program improves the capacity of the existing primary care workforce by equipping primary care clinicians and educators with additional skills. Lessons learned from the evaluation of PCTE grants can be used as the foundation for larger scale federal workforce training programs.

It is important to highlight that the most efficient patient care is provided by physician-led team-based care. A July 2018 survey conducted on behalf of the American Medical Association found that more than four out of five patients prefer a physician-led health care team. Nine out of ten respondents said that a physician's additional years of education and training are vital to optimal patient care, especially for complex or emergency conditions. There have been efforts to expand the scope of practice for non-physicians to address workforce shortages. However, it has not solved the access problem - research shows that since 2004, the number of nurse practitioners entering primary care has dropped by 40 percent.[xvi,xvii]

The AAFP recognizes non-physician providers (NPP), such as nurse practitioners and pharmacists, as an integral part of physician-led health care teams. However, NPPs cannot substitute for physicians especially when it comes to diagnosing complex medical conditions, developing comprehensive treatment plans, ensuring that procedures are properly performed, and managing highly involved and complicated patient cases. **The AAFP opposes federal efforts to inappropriately expand NPP and pharmacist scope of practice that undermine physician-led care teams, potentially lead to fragmented care, and worse quality of care.**

Support Integration of Behavioral Health and Primary Care

The AAFP applauds the HELP Committee for its ongoing interest in improving mental health and substance use disorder care and urges Congress to pass additional legislation to our nation's behavioral health crisis.

Family physicians provide comprehensive mental health services and are a major source for mental health care in the U.S. While psychiatric and other mental health professionals play an important role in the provision of high-quality mental health care services, primary care physicians are the first point of contact for most patients. Nearly 40 percent of all visits for depression, anxiety, or cases defined as "any mental illness" were with primary care physicians, and primary care physicians are more likely to be the source of physical and mental health care for patients with lower socioeconomic status and for

those with comorbidities.[xviii] Given the dire shortage of behavioral health clinicians, especially in many rural and underserved communities, equipping primary care clinicians to provide frontline mental health and substance abuse disorder treatment is essential for ensuring patients have timely access to care.

The AAFP urges the reintroduction and passage of the bipartisan Improving Access to Behavioral Health Integration Act. The bill makes necessary changes to existing federal programs to ensure primary care practices can integrate behavioral health care services by providing grant funding that covers the steep start-up costs. This initial financial support is critical to improving access to integrated services and ensuring patients and payers can achieve the long-term cost savings that behavioral health integration often provides.

Additionally, to improve access to integrated tele-mental and behavioral health care in primary care settings, **the AAFP encourages Congress to establish a new program for adults that mirrors HRSA's Pediatric Mental Health Care Access Program (PMHCA)**. This program, recently reauthorized in 2022, promotes behavioral health integration into pediatric primary care by using telehealth, and has a proven track record of increasing mental and behavioral health needs despite ongoing workforce shortages by meeting children and adolescents where they are. Given the well-documented shortage of mental and behavioral health clinicians and the growing demand for specialized care, a HRSA-funded program that provides primary care clinicians with virtual access to specialists could increase timely access to care for adult patients.

Enact Telehealth Policies that Extend the Capacity of Our Health Care Workforce

The increased use of telehealth during the COVID-19 pandemic has shown that it may help address some acute physician shortages, but it is important to note that it is just an extender and not a substitute for more physicians. Telehealth offered by a patient's usual source of care can expand timely access to care while also improving care continuity and quality. For example, primary care physicians often connect patients to community-based services to address unmet health-related social needs and coordinate care across various physicians and other clinicians. Standalone telehealth services, such as those provided by direct-to-consumer companies, are not connected with resources in patients' communities nor are they positioned to follow-up with other clinicians involved in a patient's care. The AAFP recently raised concerns about telehealth providers engaging in unscrupulous business practices that claim to improve access to treatment but in fact jeopardize patient safety and privacy. **As Congress contemplates long-term changes to telehealth policy, it is critical to recognize that telehealth is one modality of providing care but cannot and should not fully replace in-person primary care. The AAFP also calls on Congress to make investments in broadband, digital literacy training, and digital health tools to bridge the digital divide and equitable access to telehealth.**

Stop Anti-Competitive Contracting Practices that Harm Clinicians and Patients

Noncompete agreements in health care impede patient access to physicians, deter advocacy for patient safety, limit physicians' ability to choose their employer, and stifle competition. Despite projected physician shortages, many health care employers still intentionally restrict physician mobility and workforce participation via noncompete agreements. Currently, noncompete agreements are enforced through a patchwork of state laws. Twelve states deem noncompete agreements unenforceable and against public policy; however public awareness of these laws remains low, and employers still intimidate employees with the threat of legal action. Thirty-eight states allow noncompete agreements in some form, judging enforceability on factors including job type, legitimacy of business interests, and reasonableness of duration, scope, and distance. Family physicians from across the country have expressed deep concerns about how noncompete agreements are forcing them to remain in undesirable employment situations which harm their financial and mental health or

abandon their patients and travel long-distances or uproot their families to practice in a new geographic area. **The AAFP urges Congress to pass legislation to ban noncompete clauses in physician employment contracts to ensure patients have access to their physicians and to allow physicians to freely practice medicine in their communities.**

Increase Investment in Primary Care Research

Despite primary care being the only segment of health care where an increased supply is associated with better population health and more equitable outcomes, federal support for primary care research has not increased over the years, with primary care research comprising less than 0.4 percent of NIH's budget.[xix] **We urge Congress to increase federal funding for primary care research.** Many states are working to measure primary care spending. However, the lack of national definitions and benchmarks, methodological differences across states and challenges with obtaining data across payer types create measurement challenges and make comparisons difficult. Relatedly, the NASEM report recommended the development of a national scorecard to provide accountability for the nation's progress in high-quality primary care implementation. The AAFP's Robert Graham Center (in collaboration with other partners) recently created a scorecard to meet this need. **We urge Congress to invest in federal data improvements to enable more accurate measurement of primary care spend and changes in the primary care workforce – such as the impact of COVID-19 on primary care.**

Strengthen and Sustain our Health Care Safety Net

Federally Qualified Health Centers (FQHCs), including Community Health Centers (CHCs) and Rural Health Clinics (RHCs) provide comprehensive primary care and preventive services to some of the most vulnerable and underserved Americans. Family physicians are the most common type of clinician (46%) practicing in CHCs, and thus are well-positioned to ensuring accessible and affordable primary care and reducing racial, ethnic, and income-based health disparities.[xx] FQHCs also play an important role in training family physicians, and research shows that CHC-trained family physicians are more than twice as likely to work in underserved settings than their non-CHC-trained counterparts.[xxi] **We urge Congress to increase investment in FQHCs, including a long-term authorization for CHCs, to meet the health workforce needs of the underserved and to increase access to comprehensive primary care in our most vulnerable communities.**

Thank you in advance for consideration of our recommendations. The AAFP looks forward to working with the committee to develop and implement policies to strengthen and sustain our nation's health care workforce. Should you have any questions, please contact Erica Cischke, Director of Legislative and Regulatory Affairs at ecischke@aafp.org and John Aguilar, Manager of Legislative Affairs at jaguilar@aafp.org.

Sincerely,

Sterling N. Ransone, Jr. MD FAAFP

Sterling N. Ransone, Jr., MD, FAAFP
Board Chair, American Academy of Family Physicians

---

[i] IHS Markit Ltd. *The Complexities of Physician Supply and Demand: Projections From 2019 to 2034*. Washington, DC: AAMC; 2021

[ii] Centers for Disease Control and Prevention. National Center for Health Statistics. Ambulatory Health Care Data. National Ambulatory Medical Care Survey (NAMCS). 2016. https://www.cdc.gov/nchs/ahcd/index.htm. Accessed February 9, 2023.

[iii] Jabbarpour Y, Greiner A, Jetty A, et al. Investing in Primary Care: A State-Level Analysis. Patient-Centered Primary Care Collaborative and the Robert Graham Center; July 2019. https://www.grahamcenter.org/content/dam/rgc/documents/publications-reports/reports/ Investing-Primary-Care-State-Level-PCMH-Report.pdf. Accessed February 9, 2023.
[iv] Fagan BE, Finnegan SC, Bazemore AW, Gibbons CB, Petterson SM. Migration After Family Medicine Residency: 56% of Graduates Practice Within 100 Miles of Training - Graham Center Policy One-Pagers - American Family Physician.
[vv] Congressional Research Service. Federal support for graduate medical education: an overview. https://fas.org/sgp/crs/misc/R44376.pdf. Published December 27, 2018. Accessed February 9, 2023.
[vi] Dept. of Veterans Affairs. (2022, March). VA recommendations to the asset and infrastructure review commission. Dept. of Veterans Affairs. Retrieved February 13, 2023, from https://www.va.gov/AIRCOMMISSIONREPORT/docs/VAReport-to-AIR-Commission-Volume-I.pdf
[vii] Dept. of Veterans Affairs. (2021, September). VHA - OIG Determination of Veterans Health Administration's Occupational Staffing Shortages. Dept. of Veterans Affairs. Retrieved February 13, 2023, from https://www.oversight.gov/sites/default/files/oig-reports/VA/VAOIG-21-00278-23.pdf
[viii] Cooper LA, Powe NR. Disparities in patient experiences, health care processes, and outcomes: the role of patient-provider racial, ethnic, and language concordance. The Commonwealth Fund. Accessed February 9, 2023.
[ix] Poma PA. Race/ethnicity concordance between patients and physicians. J Natl Med Assoc. 2017;109(1):6-8.
[x] Walker KO, Moreno G, Grumback K. The association among specialty, race, ethnicity, and practice location among California physicians in diverse specialties. J Natl Med Assoc. 2012;104(1-2):46-52.
[xi] U.S. Census Bureau. Quick Facts: United States. Retrieved February 9, 2023, from https://www.census.gov/quickfacts/US.
[xii] Diversity in Medicine: Facts and Figures 2019. AAMC. Retrieved February 9, 2023, from https://www.aamc.org/datareports/workforce/interactive-data/figure-18-percentage-all-active-physicians-race/ethnicity-2018.
[xiii] Hanson, M. (2021, July 25). Average medical school debt. EducationData.org. Retrieved February 10, 2023, from https://educationdata.org/average-medical-school-debt.
[xiv] Medicare Payment Advisory Commission. (2021, March). *Chapter 4 -Physician and other health professional services*. Retrieved February 10, 2023, from https://www.medpac.gov/wp-content/uploads/2021/10/mar21_medpac_report_ch4_sec.pdf.
[xv] Zuckerman, S., Skopec, L., & Aarons, J. (2021, February 01). Medicaid physician fees remained substantially Below fees paid by Medicare in 2019. Retrieved February 9, 2023, from https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2020.00611.
[xvi] Wexler R. (2010). "The Primary Care Shortage, Nurse Practitioners, and the Patient-Centered Medical Home." AMA Journal of Ethics. Web.
[xvii] Agency for Healthcare Research and Quality. (2018). "The Number of Nurse Practitioners and Physician Assistants Practicing Primary Care in the United States." Web.
[xviii] Jetty, A., Petterson, S., Westfall, J. M., & Jabbarpour, Y. (2021). Assessing Primary Care Contributions to Behavioral Health: A Cross-sectional Study Using Medical Expenditure Panel Survey: Https://Doi.Org/10.1177/21501327211023871
[xix] National Academies of Sciences, Engineering, and Medicine. 2021. Implementing high-quality PC: Rebuilding the foundation of health care. Washington, DC: The National Academies Press. https://doi.org/10.17226/25983.
[xx] https://www.nachc.org/wp-content/uploads/2022/03/Chartbook-Final-2022-Version-2.pdf
[xxi] Morris CG, Johnson B, Kim S, Chen F. Training family physicians in community health centers: a health workforce solution. *Fam Med*. 2008;40(4):271-276.

American Academy of Hospice and Palliative Medicine

Testimony for the Record
Before the Senate Committee on Health, Education, Labor & Pensions
"Examining Health Care Workforce Shortages: Where Do We Go From Here?"
Thursday, February 16, 2023

Chairman Sanders, Ranking Member Cassidy, and members of the Committee, the American Academy of Hospice and Palliative Medicine (AAHPM or Academy) welcomes your attention to the critical issue of health care workforce shortages and stands ready to help advance sound policy that ensures our nation has the workforce necessary to provide high-quality serious illness care for all Americans.

AAHPM is the professional organization for physicians practicing Hospice and Palliative Medicine. AAHPM's more than 5,500 members also include nurses and other health and spiritual care providers who are committed to improving the quality of life of seriously ill patients and their families/caregivers. For over 30 years, AAHPM has been dedicated to expanding access of patients and families to high-quality palliative care and advancing the discipline of Hospice and Palliative Medicine through professional education and training, development of a specialist workforce, support for clinical practice standards, research, and public policy.

This written testimony discusses how Congress can help improve care for the expanding population of patients with serious illness throughout the continuum of care. We encourage the Committee to consider the needs of these patients and to support the bipartisan Palliative Care and Hospice Education and Training Act (PCHETA) as part of its efforts to address health care workforce shortages.

PCHETA was reintroduced in the 117th Congress by Senators Tammy Baldwin (D-Wisc.) and Shelly Moore Capito (R-W.V.) who plan to reintroduce the bill in the 118th Congress. The legislation recognizes the importance of a well-trained, interprofessional healthcare team to ensuring high-quality, coordinated, person-centered care. This bipartisan legislation would expand opportunities for interdisciplinary education and training in palliative care, including through education centers and career incentive awards for physicians, nurses, physician assistants, social workers, and other health professionals. In helping to address the long-standing shortage of healthcare providers with the knowledge and skills to provide optimal care to the growing number of Americans experiencing serious illness or multiple chronic conditions – ever more important in the wake of the COVID-19

8735 W Higgins Rd, Ste 300, Chicago, IL 60631 • 847.375.4712 • Fax 847.375.6475
www.aahpm.org • www.palliativedoctors.org • info@aahpm.org

pandemic – **PCHETA would help build a healthcare workforce more closely aligned with the nation's evolving healthcare needs and improve care and quality of life for millions of Americans facing serious illness.**

BACKGROUND

Defining the Problem

By 2050, the population aged 65 and over is projected by the U.S. Census Bureau to be 83.7 million, almost double that in 2012. As the population ages, an increasing number of people will be living with serious, complex, and chronic illness. According to the Medicare Payment Advisory Commission, in 2010 more than two-thirds of Medicare beneficiaries had multiple chronic conditions while 14 percent had six or more. Treatment of chronic and serious illnesses, such as heart disease and cancer, now accounts for nearly 93 percent of Medicare spending.

Many of the problems of our healthcare system – high costs, overutilization, lack of coordination, preventable transitions between healthcare institutions, and poor quality – become particularly evident during extended chronic and serious illness. We believe palliative care offers the solution. **A growing body of medical research has documented the benefits of high-quality palliative and hospice care for patients and families, for hospitals and payers, and for the healthcare system as a whole.**[1] Palliative care is associated with enhanced quality of life for patients, higher rates of patient and family satisfaction with medical care, reduced hospital expenditures and lengths of stay, and other positive outcomes – including longer patient survival time. Hospice care has also been associated with lower costs of care, better outcomes (such as relief of pain), and even longer life, despite its focus on comfort rather than treatment aimed at cure.

Palliative Care is an Essential Part of the Solution

AAHPM believes that palliative care providers and organizations, including hospices, are integral to meeting the "triple aim" of better care for individuals, improved health of populations, and lower growth in health care expenditures. Indeed, the National Priorities Partnership has highlighted palliative and end-of-life care as one of six national health priorities that have the potential to create lasting change across the U.S. healthcare system.

Palliative care is an interdisciplinary model of care aimed at preventing and treating the debilitating effects of serious and chronic illness, such as cancer, cardiac disease, respiratory disease, kidney failure, Alzheimer's, AIDS, ALS, and MS. It can be provided from the time of diagnosis and involves the relief of pain and other symptoms that cause discomfort, including shortness of breath, unrelenting nausea, etc.

Palliative care is patient- and family-centered — it focuses on matching treatment to achievable patient goals and supporting patients and their families/caregivers during and after treatment to maximize quality of life. In practice, this involves detailed and skilled communication with patients and families to elicit goals and preferences; expert assessment and management of physical, psychological, and other sources of suffering; and coordination of care across the multiple settings (e.g., hospital, post-acute care, ambulatory clinics, home) that patients can traverse

throughout the course of a serious illness. Palliative care can be offered alongside life-prolonging and curative therapies for individuals living with serious, complex, and eventually terminal illness and includes hospice care.

Studies have demonstrated that high-quality palliative care and hospice care not only improve quality of life and patient and family satisfaction but can also prolong survival.[2-6] Furthermore, palliative care achieves these outcomes at a lower cost than usual care, by helping patients to better understand and address their needs, choose the most effective interventions, and avoid unnecessary/unwanted hospitalizations and interventions.

However, delivery of high-quality palliative care cannot take place without a sufficient number of healthcare professionals with appropriate skills. By advancing PCHETA, the Academy believes the Committee can help build a healthcare workforce more closely aligned with the nation's evolving healthcare needs. PCHETA will help close the large gap between the number of health care professionals with palliative care training and the number required to meet the needs of the expanding population of patients with serious illness and/or multiple chronic conditions.

Workforce Challenges

While AAHPM members care for our nation's sickest and most vulnerable patients, there just are not enough specialists to meet the needs of the increasing number of Americans with serious illness who stand to benefit from palliative care.[7] And not only will the pressure of serious illness and multiple chronic conditions mount as the U.S. population ages, but the public health emergency created by COVID-19 has exacerbated the need — highlighting the current palliative care workforce shortage as well as the importance of providing better training to all healthcare providers who will be called upon to care for the seriously ill. Simply put: **Despite the growing need for palliative care, the U.S. is unable to meet patient and health system demand because of a significant shortage of trained providers.**

Even before the emergence of the coronavirus pandemic, researchers at Duke University, the University of Alabama at Birmingham, and the Mayo Clinic projected an impending palliative care workforce crisis.[8] They estimate an absolute growth rate of no more than 1% in palliative care physicians over the next 20 years, with the number of persons eligible for palliative care growing by over 20% during that same period, resulting in a ratio of only one physician for every 26,000 patients by 2030. Similarly, the George Washington University Health Workforce Institute found that current training capacity for Hospice and Palliative Medicine is insufficient to provide hospital-based care and keep pace with growth in the population of adults over 65 years old.[9] These shortages are exacerbated when considering the current rapid expansion of community-based palliative care, such as in outpatient and home-based settings.

This need for trained providers is borne out by other major institutions working to provide evidence-based policy recommendations. A National Academies of Sciences, Engineering and Medicine workshop convened to examine workforce issues related to serious illness care found that "to provide high-quality care to people of all ages living with serious illness, it is critical that the nation develop an adequately trained and prepared workforce consisting of a range of professionals, including physicians, nurses, social workers, direct care workers, and chaplains."[10]

The reality today is healthcare providers need better education about pain management and palliative care. Students graduating from medical and nursing school have very little, if any, training in the core precepts of pain and symptom management, communication skills, and care coordination for patients with serious or life-threatening illness. The 2014 Institute of Medicine (IOM) report *Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life* noted that "major gains have been made in the knowledge base of palliative care."[11] The report documented, however, that "these knowledge gains have not necessarily been matched by the transfer of knowledge to most clinicians caring for people with advanced serious illnesses." Moreover, the IOM noted that an "overall pattern of inattention to palliative and end-of-life care … still appears to predominate in the pediatric world." This lack of healthcare provider knowledge results in too many patients with serious illness receiving painful or ineffective treatments that do nothing to prolong or enhance their lives.

Noting that "hospice and palliative medicine specialists will never be sufficient in number to provide regular face-to-face treatment of every person with an advanced serious illness," the IOM report recommends expanding training opportunities to ensure clinicians across disciplines and specialties who care for people with serious illness are competent in "basic palliative care," including communication skills, interprofessional collaboration, and symptom management.

PALLIATIVE CARE AND HOSPICE EDUCATION AND TRAINING ACT (PCHETA)

Education and Training

Modeled after the existing geriatric education programs in the Public Health Service Act, PCHETA would establish Palliative Care and Hospice Education Centers to improve the training of interdisciplinary health professionals in palliative care; support the training and retraining of faculty; support continuing education; provide students with clinical training in appropriate sites of care; and provide traineeships for advanced practice nurses.

PCHETA would also provide for training of physicians who plan to teach palliative medicine, academic career awards for junior medical faculty who commit to spend a majority of their funded time teaching and developing skills in interdisciplinary education in palliative care, and career incentive awards for other eligible health professionals who agree to teach or practice in the field of palliative care.

Finally, PCHETA would further provide supplemental training for faculty members in medical schools and other health professions schools (including pharmacy, nursing, social work, chaplaincy and other allied health disciplines in an accredited health professions school or program, such as a physician assistant education program) so healthcare providers who do not have formal training in palliative care can upgrade their knowledge and skills for the care of individuals with serious or life-threatening illness as well as enhance their interdisciplinary teaching skills.

Expanding Research to Improve Healthcare Delivery

PCHETA aims to strengthen clinical practice and improve healthcare delivery for patients living with serious or life-threatening illness, as well as their families, by directing funding toward palliative care research. Research funding for palliative care and pain and symptom management comprises a

fraction of one percent of the National Institutes of Health (NIH) annual budget. From methods for improving communication and decision making to evidence-based treatments for relieving distressing symptoms of serious illness such as fatigue, nausea, shortness of breath, pain, and confusion, PCHETA would direct an expansion and intensification of research in these important areas.

The Academy appreciates the report language based on this PCHETA provision which accompanied the *Consolidated Appropriations Act, 2023*. It stresses the "need for NIH to develop and implement a trans-Institute strategy to expand and intensify national research programs in palliative care" and "urges NIH to ensure that palliative care is integrated into all areas of research across NIH and requests an update on plans to realize this coordination in the fiscal year 2024 Congressional Justification." Such coordination efforts can strengthen federal research and ensure efficient use of federal research funding.

Raising Awareness

While building the workforce and research base for the field will address key barriers to accessing palliative care services, more must be done to ensure patients and providers are aware of the benefits of palliative care so they can be sure to receive the care they need when and where they need it. According to the IOM, there is a "need for better understanding of the role of palliative care among both the public and professionals across the continuum of care so that hospice and palliative care can achieve their full potential for patients and their families." PCHETA would direct the implementation of a national education and awareness campaign so that patients, families, and health professionals understand the essential role of palliative care in ensuring high-quality care for individuals facing serious or life-threatening illness.

AAHPM is not alone in championing PCHETA. It has enjoyed strong bipartisan support in Congress (and previously passed the House twice), as well as broad support from more than 60 national and state organizations.[12] **We urge you to consider this legislation as you develop workforce proposals and to ultimately advance PCHETA in the Senate to ensure our nation has the robust, well-trained workforce necessary to ensure access to high-quality, equitable care for the expanding and diverse population of patients with serious illness, as well as their families and caregivers.**

REFERENCES

1 "The Evidence for High-Quality Palliative Care." American Academy of Hospice and Palliative Medicine. Accessed February 15, 2023. https://aahpm.org/uploads/advocacy/The_Evidence_for_High-Quality_Palliative_Care.pdf

2 Temel JS, Greer JA, Muzikansky A, Gallaher ER, Admane S, Jackson VA, Dahlin CM, Blinderman CD, Jacobsen J, Pirl WF,Billings JA, Lynch TJ. Early palliative care for patients with metastatic non-small cell lung cancer. *NEJM 363*(8)733-742 (2010).

3 Connor SR, Pyenson B, Fitch K, Spence C, Iwasaki K. Com- paring hospice and nonhospice patient survival among patients who die within three-year window. *J Pain Symptom Manage.* 2007;33(3):238-236.

4 Hanson LC, Usher B, Spragens L, Bernard S. Clinical and economic impact of palliative care consultation. *J Pain Symptom Manage.* 2008;35:340-346.

5 Morrison RS, Penrod JD, Cassel JB, et al. Cost savings associated with US hospital palliative care consultation programs. *Arch Intern Med.* 2008;168(16):1783-1790.

6 Penrod JD, Deb P, Dellenbaugh C, et al. Hospital-based palliative care consultation: effects on hospital cost. *J Palliat Med.* 2010;13(8):973-979.

7 Kamal AH, Wolf SP, Troy J, Leff V, Dahlin C, Rotella JD, Handzo G, Rodgers PE, Myers ER. Policy changes key to promoting sustainability and growth of the specialty palliative care workforce. *Health Aff* (Millwood). 2019 Jun;38(6):910-918.

8 Kamal AH, Bull JH, Swetz KM, Wolf SP, Shanafelt TD, Myers ER. Future of the palliative care workforce: preview to an impending crisis. Am J Med. 2017 Feb;130(2):113-114.
9 Lupu D, Quigley L, Mehfoud N, Salsberg ES. The growing demand for hospice and palliative medicine physicians: will the supply keep up? *J Pain Symptom Manage*. 2018 Apr;55(4):1216-1223.
10 National Academies of Sciences, Engineering, and Medicine. 2020. *Building the Workforce We Need to Care for People with Serious Illness: Proceedings of a Workshop*. Washington, DC: The National Academies Press. https://doi.org/10.17226/25789.
11 Institute of Medicine. *Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life*. Washington, DC: The National Academies Press, 2014.
12 Letter to U.S. Sens. Tammy Baldwin and Shelley Moore Capito, May 20, 2002. "Support for S. 4260, the Palliative Care and Hospice Education and Training Act (PCHETA)." Accessed February 15, 2023. http://patientqualityoflife.org/wp-content/uploads/2022/05/PCHETA-Senate-Support-Letter-117th-Congress_05202022-S4260-Revised.pdf

Statement for the Record

to the

Senate Health, Education, Labor & Pensions Committee

Examining Health Care Workforce Shortages: Where Do We Go from Here?

Angela Mund, DNP, CRNA

President, American Association of Nurse Anesthesiology

16 February 2023

Introduction

Chairman Sanders, Ranking Member Cassidy, and Members of the Committee, thank you for the opportunity to offer this statement for the record. The American Association of Nurse Anesthesiology (AANA) is the professional association for Certified Registered Nurse Anesthetists (CNRAs) and student registered nurse anesthetists, representing more than 59,000 members across the country. CRNAs personally administer more than 50 million anesthetics to patients each year and provide acute, chronic, and interventional pain management services. In some states, CRNAs are the sole anesthesia providers in nearly 100 percent of rural hospitals, affording these medical facilities obstetrical, surgical, trauma stabilization, and pain management capabilities.

We applaud the Senate Committee on Health, Education, Labor and Pensions for its leadership in holding this critical hearing on examining the healthcare workforce and the need to address shortages, especially in the nursing field where shortages are particularly acute. This hearing has added importance given the recent announcement of the end of the Public Health Emergency (PHE) on May 11, 2023, and the end of flexibilities for providers at a time when our healthcare workforce is already strained. While there are many challenges ahead of us, there are also opportunities to improve the utilization of our current workforce and take steps to increase access to care and lower costs for patients, while working to develop the healthcare workforce necessary to meet the needs of tomorrow.

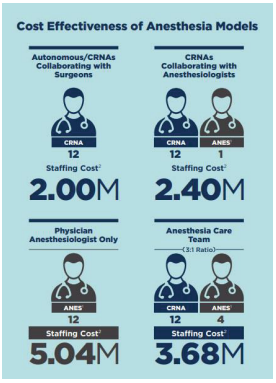
We strongly encourage Congress to take a two-step approach to addressing the current state of the healthcare workforce. First, act immediately to make PHE related waivers that increase access to care and allow for the most efficient utilization of the healthcare workforce to be made permanent. Removing unnecessary barriers to care in Medicare and Medicaid and ensuring that all patients have access to the provider of their choice is critically important to ensure we maximize the current workforce. To this end, we strongly support passage of the *Improving Care and Access to Nurses Act (ICAN)* when it is reintroduced this year. Secondly, additional investments in the future healthcare workforce, both through students and faculty are imperative to ensure that we maintain a robust pipeline of nurses to meet our future workforce needs. We encourage Congress to increase appropriations for the Title VIII Nursing Workforce Development Programs and pass the *Future Advancement of Academic Nursing (FAAN)* Act upon reintroduction.

Addressing Barries and Constraints with the Current Workforce

CRNAs are a proven, high-quality anesthesia and pain management provider, and exercise independent, professional judgement within their scope of practice. A 2021 study found that starting in 2017, there was an estimated 10.7% excess demand for anesthesia services, meaning that there was an anesthesia workforce shortage of approximately 9,000 providers before the pandemic began and current workforce issues arose, and those shortfalls were projected to

continue into the future[1]. Allowing CRNAs to work to the top of their scope has proven benefits to patients and facilities. Multiple scientific and clinical studies across a variety of practice settings have shown this to be true. A study in the Journal of Medical Care showed that increased CRNA scope led to no measurable differences in outcomes[2]. Similarly, a study published in Health Affairs found that states that had opted out of the Centers for Medicare and Medicaid Services (CMS) supervision requirement saw no change in outcomes[3]. These findings are further supported by a review of literature done by the Cochrane Library that found no identifiable differences in anesthesia delivery based on the anesthesia care model[4]. The proven ability of CRNAs to practice autonomously was also verified by data in the maternal care space[5], in a study of complications during cesarean sections[6], and in certain pain management techniques[7].

What remains unproven is the need and value of CRNA supervision requirements. Since March of 2020, Medicare has temporarily waived the physician supervision requirement of CRNA anesthesia services as a part of the Hospital and Critical Access Hospital Conditions of Participation (CoP) and ambulatory surgical center Conditions for Coverage (CfC). During the three-year period of this waiver there has been no data to show that outcomes have deteriorated. Furthermore, there has been a significant decrease in liability premiums witnessed in recent decades and these declines continued after the time CMS issued the blanket waiver on supervision. Additionally, during this same period five additional states have opted out of CMS's supervision requirements (Arizona, Oklahoma, Utah, Michigan, and Arkansas). There are now twenty-two states that have recognized that federal supervision requirements are unproven and act as an unnecessary barrier to care, and forty-three states have no supervision requirements in their nursing/medicine laws or rules. Data shows that CRNA supervision by physician anesthesiologists is one of the less cost-effective models of anesthesia delivery and that CRNAs practicing autonomously are the most cost effective for facilities and



[1] Negrusa, Sebastian; Hogan, Paul; Cintina, Inna; Quraishi, Jihan; Hoyem, Ruby; et al. *Anesthesia Services: A Workforce Model and Projections of Demand and Supply.* Nursing Economics; Pitman Vol. 39, Iss. 6,

[2] Negrusa, et al. Scope of Practice Laws and Anesthesia Complications: No Measurable Impact of Certified Registered Nurse Anesthetist Expanded Scope of Practice on Anesthesia-related Complications. Medical Care 54(10): p 913-920, October 2016. https://journals.lww.com/lww-medicalcare/Abstract/2016/10000/Scope_of_Practice_Laws_and_Anesthesia.4.aspx

[3] Dulisse, Brian; Cormwell, Jerry. No Harm Found When Nurse Anesthetists Work Without Supervision by Physicians. Health Affairs. Vol 29 #8. August 2010. https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2008.09667journalCode=hlthaff

[4] Lewis SR, Nicholson A, Smith AF, Alderson P. Physician anaesthetists versus non-physician providers of anaesthesia for surgical patients. Cochrane Database of Systematic Reviews 2014, Issue 7. Art. No.: CD010357. DOI: 10.1002/14651858.CD010357.pub2. Accessed 10 February 2023. https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD010357.pub2/full

[5] Needleman J, Minnick AF. Anesthesia provider model, hospital resources, and maternal outcomes. Health Serv Res. 2009 Apr;44(2 Pt 1):464-82.

[6] Simonson, Daniel C.; Ahern, Melissa M.; Hendryx, Michael S. Anesthesia Staffing and Anesthetic Complications During Cesarean Delivery: A Retrospective Analysis. Nursing Research 56(1):p 9-17, January 2007.

[7] Beissel DE. Complication Rates for Fluoroscopic Guided Interlaminar Lumbar Epidural Steroid Injections Performed by Certified Registered Nurse Anesthetists in Diverse Practice Settings. J Healthc Qual. 2016 Nov/Dec

patients (see infographic).[8] **As we look at how to best utilize our current healthcare workforce, we must ask at what cost to patients and facilities do we continue to force unnecessary supervision requirements on CRNAs? We strongly encourage Congress to pass legislation to end Medicare's supervision requirements and allow facilities to determine how best to maximize the anesthesia workforce.**

To address the current workforce shortages, we need to ensure that all providers are practicing to the top of their education and training. Other unnecessary barriers to care in the Medicare and Medicaid programs reduce patient access to care, add to costs, and reduce competition. In their 2021 report *The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity*, the National Academy of Medicine specifically called for the elimination of barriers to advance practice registered nurses providing care[9]:

> *Conclusion 3-2: Eliminating restrictions on the scope of practice of advanced practice registered nurses and registered nurses so they can practice to the full extent of their education and training will increase the types and amount of high-quality health care services that can be provided to those with complex health and social needs and improve both access to care and health equity.*

This echoes data from a study published in Nursing Economic$ that shows that CRNA care is correlated more with vulnerable populations such as Medicaid-eligible patients, rural populations, and lower incomes.[10] In addition, 2022 the National Plan for Health Workforce Well-being released by the National Academy of Medicine calls for preventing and reducing the unnecessary burdens that stem from laws, regulations, policies, and standards placed on health workers. Placing added barriers to CRNAs can adversely affect healthcare access for these at-risk populations. Currently, Medicare statute, regulations and policy include a number of barriers to patient care that do not serve patients, including not expressly stating CRNAs' abilities for ordering and referring medically necessary services, disincentives for physician anesthesiologists to teach students in a nurse anesthesia program, and not allowing APRN recognition in regard to the use of the Medicare locum tenens modifier. **In order to address the dual need of workforce shortages and ensuring healthcare equity, Congress needs to take action to remove barriers to CRNAs and other APRNs. We strongly urge the passage of the**

---

[8] The Lewin Group. *Update of Cost Effectiveness of Anesthesia Providers*. May 2016. https://www.lewin.com/content/dam/Lewin/Resources/AANA-CEA-May2016.pdf

[9] National Academy of Medicine; National Academies of Sciences, Engineering, and Medicine; Committee on the Future of Nursing 2020–2030; Mary K. Wakefield, David R. Williams, Suzanne Le Menestrel, and Jennifer Lalitha Flaubert, Editors https://nap.nationalacademies.org/catalog/25982/the-future-of-nursing-2020-2030-charting-a-path-to

[10] Liao, C.J., Quraishi, J.A., & Jordan, L.M. (2015). Geographical Imbalance of Anesthesia Providers and its Impact on the Uninsured and Vulnerable Populations. Nursing economic$, 33 5, 263-70. https://www.semanticscholar.org/paper/Geographical-Imbalance-of-Anesthesia-Providers-and-Liao-Quraishi/77112f1f7ca09a86142b4f5e7c065ae9a073dec2

Improving Care and Access to Nurses (ICAN) **Act upon its reintroduction in the 118th Congress.**

Improving the Healthcare Workforce Pipeline for CRNAs and Other Nurses

While the immediate need is to address constraints within the current workforce, we also need to act quickly to improve the pipeline for future nurses, to ensure that we are able to meet the growing demands of tomorrow. Across the board, nursing programs are struggling with a lack of resources, educators, and preceptors to educate a sufficient number of nurses. Title VIII Nursing Workforce Development programs are the only federal programs solely dedicated to supporting nursing education. These programs cover a wide variety of nursing education priorities, including advanced nursing education, workforce diversity, and education, practice, quality and retention, among others. These programs, which support hundreds of schools of nursing and thousands of students and faculty, received only $300.472 million in funding in fiscal year 2023. **With a significant need to increase capacity and ensure that we can build a strong and resilient nursing workforce pipeline, we urge Congress to make additional investments in Title VIII programs and pass the *Future Advancement of Academic Nursing (FAAN)* Act upon its reintroduction in the 118th Congress.**

Conclusion

The current healthcare workforce shortages, particularly among the nursing field must be addressed in a timely manner. The impending end of the PHE, with the sunsetting of critical waivers will only further exacerbate the current workforce issues. Congress should act before the May 11 deadline to extend or make permanent waivers, such as the waiver of CRNA supervision requirements that don't improve outcomes, but instead limit access to care and increase costs for patients. Patients can no longer afford unproven supervision requirements. Everyone deserves access to the highest quality healthcare that CRNAs provide without undue burdens. Congress must also act to make significant investments in nursing education to ensure we have the future nursing workforce we need to provide care to all patients. These important issues are priorities for the current Administration and federal agencies tasked with implementing these policies.

I thank the committee for its attention to this important issue and look forward to working with you as you seek to improve our healthcare workforce. The AANA hopes to be a constructive partner, to work with you as you tackle the issues facing our healthcare workforce. Should you wish to discuss these issues further, please contact Matt Thackston with the AANA Federal Government Affairs team at mthackston@aana.com or 202-484-8400.

AMERICAN ACADEMY
OF OPHTHALMOLOGY

20 F Street NW
Suite 400
Washington, DC
20001-6701

P.O. Box 7424
San Francisco, CA
94120-7424

T: +1 202.737.6662
aao.org

Michael X. Repka, MD, MBA
Medical Director for Governmental Affairs
American Academy of Ophthalmology
Statement for the Record
Senate Health, Education, Labor and Pensions Committee
February 16, 2023

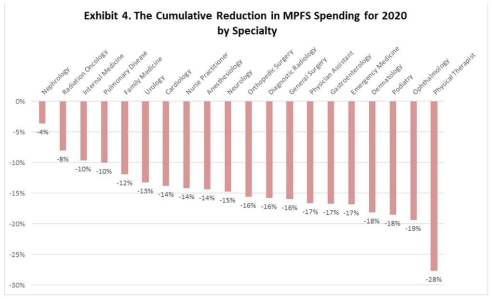
Chairman Sanders and Ranking Member Cassidy,

The Academy writes to share our perspective on workforce challenges facing the field of ophthalmology ahead of the Committee's hearing, *Examining Healthcare Workforce Shortages: Where Do We Go From Here?* The Academy is the largest national member's association of ophthalmologists—medical and osteopathic doctors who provide comprehensive eye care including medical, surgical, and optical care. The Academy seeks to protect sight and empower lives by setting the standards for ophthalmic education and advocating for our patients and the public. We applaud the Committee's focus on this important issue, as the impact of healthcare workforce shortages are being felt across the country and can be detrimental to patient care. We encourage you to work collaboratively on solutions that can reverse workforce trendlines and to ensure Americans continue to have access to high-quality medical care.

Promoting patient access to high-quality medical eye care has always been a top priority for the Academy. Currently, the Academy is focused on increasing the number of ophthalmology residents pursuing fellowships in pediatric-ophthalmology, neuro-ophthalmology, and uveitis. These subspecialties are responsible for treating some of the most vulnerable patients, many of which face debilitating eye disease or visual impairments. Many communities across the country would benefit from an increased supply of these highly trained providers in order to meet growing patient demand and ensure optimal patient outcomes. Unfortunately, all three subspecialties are impacted by fewer ophthalmology residents seeking fellowships in those fields, at least in part due to the economic challenges in those clinical practices. The Academy believes there are a multitude of options available to policymakers to grow the medical subspecialty workforce, including addressing educational debt via student loan relief, improving Medicaid reimbursement, reducing administrative burdens and elimination of other barriers that exacerbate physician burnout.

Ensuring Access to Pediatric Eye Care

Pediatric ophthalmology has experienced a decline in workforce in recent decades and, like elsewhere in medicine, these declines were exacerbated by the COVID-19 pandemic where ophthalmology practices had one of the most significant declines in revenue.



Maintaining and building a robust pediatric workforce is critical and the return on investment in addressing children's visual issues is high. It can promote increased academic and career success, as well as drastically improve long-term quality of life. Many states would benefit from an increased supply of pediatric ophthalmologists, as this highly specialized medical and surgical eye care cannot be absorbed by other providers in the community. The treatment of many pediatric visual impairments requires advanced medical decision-making and surgery. This includes surgical procedures to address misaligned eyes, congenital cataracts, pediatric glaucoma, and laser procedures for retinopathy of prematurity. For children with these types of advanced eye care needs, access to pediatric ophthalmologists is vital. The causes of these shortages are multifactorial, including limitations on residents pursuing pediatric ophthalmology fellowships and economic factors disincentivizing pursuit of the subspecialty. In pediatrics, patient volume is limited by the need to spend more time with young patients and their caregivers to ensure appropriate diagnosis and care. In addition, many children have insurance coverage through Medicaid, which has low reimbursement rates, amplifying the economic challenges of running a practice. For residents considering a fellowship in pediatric ophthalmology, the economic uncertainty can be prohibitive, especially as many residents face significant student loan debt.

Recommendation: Increase Funding for the Pediatric Subspecialty Loan Repayment Program

The Academy supports congressional action to significantly increase funding for the Pediatric Subspecialty Loan Repayment Program (PSLRP), which provides loan relief to pediatric subspecialists that work in medically underserved communities. Increased investment in the PSLRP could incentivize residents to go into pediatric subspecialties, as well as increase the pediatric workforce in rural and underserved communities that often face the brunt of impacts from workforce shortages.

Improving Workforce in Neuro-Ophthalmology & Uveitis

The Academy is also focused on growing the subspecialty fields of neuro-ophthalmology and uveitis. Neuro-ophthalmologists are highly trained subspecialists that are essential to diagnosing complex neurological conditions that impact visual function. Diagnoses include optic neuritis, multiple sclercsis, and diplopia, all of which have detrimental impacts on a patient's vision and overall quality of life. Unfortunately, many patients suffering from these diseases or disorders face extensive wait times to access a neuro-ophthalmologist in their communities. Expanded coverage and reimbursement for telehealth consultations during the COVID-19 Public Health Emergency (PHE) has been beneficial to neuro-ophthalmology, enabling them to expand their reach to communities where there is a shortage or absence of care.

Along with pediatric subspecialists, neuro-ophthalmologists have been particularly impacted by dramatic cuts for surgical procedures to treat strabismus, a condition that impacts vision due to misalignment between the eyes. Reimbursement for these procedures has been reduced by upwards of 20% with cuts phased-in across the CY 2022 and CY 2023 Medicare Physician Fee Schedules. Such drastic cuts threaten the sustainability of medical practices and ciscourage residents from pediatric and neuro-ophthalmology fellowships.

The subspecialty of uveitis faces equally significant challenges. Across the US, there are fewer than 200 uveitis subspecialists and an increase is critical to ensure quality care for the growing number of patients being diagnosed with the disease. The Academy is working to promote awareness of the subspecialty, the important role they play in advanced care for patients with uveitis, and key barriers that could be addressed. Because it is an auto-immune disorder that can involve multiple organ systems and require systemic immune modulation, patients with uveitis require complex care that includes coordination with outside providers and other medical specialists. The complexity of care involving ophthalmology can limit overall patient load, and reimbursement for complex non-surgical care remains limited. These patients often have extensive history and laboratory results that must be reviewed. Unfortunately, current CMS guidance only considers physician time the day of the encounter, which is inefficient for a physician in clinic and often does not reflect the totality of physician time spent on patient care.

Recommendation: Encourage CMS to include physician time used in preparation for the patient encounter, such as review of records when performed the day before the encounter, as well as time for test results review the day after the encounter to be included in physician time for coding the level of service.

During the COVID-19 pandemic, many uveitis specialists performed consultations with uveitis patients via telehealth. While in-office consultations and treatment needs remain, telehealth can serve as a useful tool for the remote treatment of patients with uveitis and to extend access in rural communities.

Recommendation: Make PHE-expansions to site-of-service requirements and the coverage and reimbursement for eye-visit telehealth services permanent

The Academy believes that telehealth can play a critical role in expanding access to subspecialty care, including access to neuro-ophthalmologists and uveitis specialists. It is important to increase access for patients in need of advanced ophthalmology specialty care through means outside a traditional in-office visit. Permanently removing the originating-site geographic restrictions for telemedicine services, currently

suspended for the duration of the PHE, would afford needed flexibility to uveitis, neuro-ophthalmologists, and other healthcare specialties experiencing provider shortages.

Additionally, eye-visit CPTs 92002, 92004, 92012, and 92014 are only included on the CMS list of services permitted for telemedicine delivery on a temporary basis. These services are scheduled to sunset from the list 151 days after the end of the PHE or on December 31, 2024. Making these codes permanent additions to the Telehealth Approved Services list would solidify these benefits to neuro-ophthalmologists and uveitis specialists.

Closing Remarks

We appreciate you and your colleagues on the Committee focusing on the current landscape of the healthcare workforce and the root causes of shortages that are impacting many communities across the country. For the Academy, ensuring a robust supply of ophthalmologists across all subspecialties is of paramount importance. In collaboration with ophthalmology subspecialty organizations, we are working to increase interest by residents into pursuing fellowships in pediatric ophthalmology, neuro-ophthalmology, and uveitis but we believe Congress and the Administration can play an integral role in solving some of the financial challenges that serve as a barrier to these fields. The Academy stands ready to work with you and your colleagues on these important issues to ensure Americans continue to have access to high-quality eye care.

DISCLOSURE OF FEDERAL GRANTS OR CONTRACTS

Between 2013 and 2015, the American Academy of Ophthalmology (AAO) received funding from the Agency for Healthcare Research and Quality (AHRQ) under the Developing Evidence to Inform Decisions about Effectiveness (DEcIDE) Program, to disseminate the Registry for Glaucoma Outcomes Research (RiGOR) study findings through the use of social media tools.

AAO is a 501c (6) educational membership association.

February 16, 2023

The Honorable Bernie Sanders
Chair
Health, Education, Labor, and Pensions (HELP) Committee
United States Senate
Washington, DC, 20510

The Honorable Bill Cassidy, M.D.
Ranking Member
Health, Education, Labor, and Pensions (HELP) Committee
United States Senate
Washington, DC 20510

RE: HELP Committee Hearing: ***Examining Health Care Workforce Shortages: Where Do We Go From Here?***

Dear Chairman Sanders, Ranking Member Cassidy, and Members of the HELP Committee,

On behalf of the 30 million Americans who utilize community health centers for their care, Advocates for Community Health (ACH) welcomes this opportunity to provide written testimony for today's hearing, "Examining Health Care Workforce Shortages: Where Do We Go From Here?"

ACH is a membership organization comprised of leading federally qualified health centers (FQHCs) focused on health equity and innovation to drive health care systems, policies, and health programs. Our members serve over 2.3 million people and provide high-quality, comprehensive primary health care, mental health services, preventive care, and social services to patients most in need, especially during the COVID-19 Public Health Emergency (PHE). Our members represent almost 23,000 full-time employees in health centers.

FQHCs are required to provide all services to everyone, regardless of ability to pay, and reinvest 100% of profits back into patient care. According to 2021 Uniform Data System (UDS) statistics, health centers serve over 30 million patients, of which 1 in 3 patients live in poverty, and about 30% of patients are children under 18 years of age. Additionally, health centers have played a key role during the PHE by increasing access to care, including virtually, and collaborating with communities to increase COVID-19 education, testing, and vaccinations to the most underserved areas.

We applaud the Committee for convening today's hearing on the health care workforce, an issue that is of great concern to ACH's members. At the 2023 ACH Annual Member Meeting on February 8, Chairman Sanders provided remarks and in doing so noted that, "During the pandemic, nearly 1 out of every 5 health care workers, including 100,000 nurses, quit their jobs and another third have contemplated doing so." The ability to attract, train, and retain a qualified and resilient health care workforce is paramount to health centers' ability to provide care, and we are grateful for the Chair and Ranking Member's attention and sensitivity to this issue and commitment to addressing it.

COVID-19 Supplemental Funding and Workforce

Health centers are indispensable safety net providers and have served as a lifeline to Americans throughout the COVID-19 pandemic, nimbly addressing ongoing demands. COVID-19 supplemental funding allowed FQHCs to continue to provide high quality, culturally competent care to our communities during a time of heightened strain on the health care system. UDS data shows that health centers provided nearly 23 million COVID-19 vaccinations to patients, among other vital services. However, as the data also demonstrates, health centers heavily relied on federal COVID-19 funding, especially from Health Resources and Services Administration (HRSA)'s supplemental funding.

We recently surveyed our members on how they spent supplemental COVID-19 funding, and they shared the following:

- All members primarily used COVID-19 funding for workforce needs as they performed duties relevant to the pandemic, including activities like outreach and education in communities and care coordination.
- Funding was often used for hiring, salary increases, benefits, and increased paid and/or sick leave in order to attract and retain the staff needed to address increased demand for services.
- ACH members tend to have lost revenue since the PHE began. According to our members, this is due to workforce shortages, an increase in uninsured patients, greater demand for case management, and increased use of telehealth/audio only visits negatively impacting payment.
- Since the pandemic, many centers have experienced an increase in patients. For example, one clinic in Washington state had almost 172,000 unique patients in 2020 (over 101,00 Medicaid), which increased to almost 191,000 unique patients in 2021 (over 121,000 Medicaid). Some centers worry about the increase of uninsured patients and resulting uncompensated care as the PHE unwinds and patients lose Medicaid eligibility.

Given CHCs use of supplemental COVID-19 funds for workforce needs and the impending expiration of those funds, all while patient levels remain the same, ACH strongly recommends Congress consider increasing funding for community health centers both through the appropriations process in fiscal year 2024 and through the upcoming Community Health Center Fund reauthorization.

Workforce Wellbeing

ACH endorses the National Academy of Medicine's Action Collaborative on Clinician Well-Being and Resilience. Our priorities and recommendations align with the Academy's Plan and their definition of health workforce to include support staff, allied health, and community health workers.

The plan lists 7 main areas:

1. Create and sustain positive work and learning environments and culture,
2. Invest in measurement, assessment, strategies, and research,
3. Support mental health and reduce stigma,
4. Address compliance, regulatory, and policy barriers,

5. Engage effective technology tools,
6. Institutionalize well-being as a long-term value, and
7. Recruit and retain a diverse and inclusive health workforce.

We strongly encourage the Committee to incorporate the Action Collaborative's work into any future legislation on the health care workforce.

Recommended Policies to Address Workforce Shortages

As the committee considers ways to promote a robust and diverse workforce, ACH recommends the following for a more resilient health workforce and ultimately for healthier patients:

1. **Strengthen frontline provider resilience**
   Similar to the National Academy of Medicine's recommendations, community health centers require evidence-based interventions so that providers are connected to behavioral health resources and peer support.
2. **Improve recruitment and retention for health center staff**
   This includes loan forgiveness for community health center providers and supporting staff.
3. **Increase workforce diversity at FQHCs through data and evaluation**
   FQHCs already provide comprehensive, linguistically and culturally competent care. FQHC workforce demographic data can help inform and improve quality improvement activities to ensure that the workforce reflects the needs of their patient communities.
4. **Build a more diverse workforce pipeline for FQHCs**
   We recommend partnerships (with community colleges, for example) and mentorship programs that are flexible in nature to meet the needs of centers and patients and also provide a career ladder for FQHC staff.
5. **Expand FQHC/hospital training partnerships**
   Many graduate medical residencies focus on inpatient care. Though important, we recommend a more community-based approach in which hospitals partner with FQHCs for training, particularly for underserved areas.
6. **Expand the behavioral health workforce available to treat FQHC patients**
   We recommend the implementation of incentives and pipeline programs that include behavioral health workforce at FQHCs, especially for paraprofessionals.
7. **Support and increase funding for the National Health Service Corps (NHSC) and the Teaching Health Center Graduate Medical Education (THCGME) program**
   Both the NHSC and the THCGME program are critical to helping attract and retain a diverse workforce for FQHCs. NHSC is an important recruitment and retention tool for CHCs and enables students and clinicians with the desire and commitment to work in underserved communities to access funds to support scholarship and loan repayment. As well, the THCGME program is crucial to training the next generation of FQHC workers, having already trained nearly 1,500 new primary care physicians and dentists, a majority of whom are now providers in underserved areas. These programs are valuable, have produced measurable results, and should be expanded and improved.
8. **Include FQHCs in key programs and opportunities related to the health care workforce**
   Although FQHCs are vital for the delivery of primary care in the United States, they are often left out of important policy and regulatory discussions and opportunities. We recommend FQHCs be included as sites for Graduate Medical Education and capacity building; as members in primary

care convening bodies and task forces; and in programs that support competitive salaries for existing staff and expanding the workforce pipeline.

Once again, thank you for this opportunity to provide insight into how Congress can start to address the workforce needs of FQHCs. We stand ready to work with the Committee as policy discussions continue.

For more information or to discuss these issues further, please contact me at apearskelly@advocatesforcommunityhealth.org and Stephanie Krenrich, our Senior Vice President of Policy and Government Affairs, at skrenrich@advocatesforcommunityhealth.org.

Sincerely,

Amanda Kelly
Chief Executive Officer
Advocates for Community Health


A Union of Professionals
AFT Nurses and
Health Professionals
HEALTHCARE
STAFFING SHORTAGE
TASK FORCE REPORT

Our Mission

The **American Federation of Teachers** is a union of professionals that champions fairness; democracy; economic opportunity; and high-quality public education, healthcare and public services for our students, their families and our communities. We are committed to advancing these principles through community engagement, organizing, collective bargaining and political activism, and especially through the work our members do.

LETTER FROM
RANDI WEINGARTEN, AFT PRESIDENT

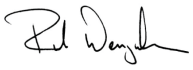
For nearly three years, our nation's health professionals have worked through unprecedented challenges. This has compounded the strain on an already exhausted workforce, leaving most emotionally drained and far too many in mental health distress. As a result, frontline healthcare workers have been leaving and are continuing to leave the health professions in record numbers.

This year, I convened a Healthcare Staffing Shortage Task Force comprised of AFT state and local union leaders, as well as frontline healthcare workers. The task force's charge was to examine the state of the healthcare workforce and to identify steps that policymakers, employers and unions can take to ensure that hospitals and healthcare facilities are appropriately staffed to provide high-quality care to all. I want to thank each member of the task force and our members who participated in listening sessions, responded to surveys and lent their perspective.

While the consequences of the chronic understaffing of our nation's healthcare facilities can be deadly, the problem is solvable. Our nation's healthcare employers must invest in the workforce, improve the working conditions, make healthcare facilities a safe place to work, and engage frontline workers in collaborative decision-making. Prioritizing patients over maximizing revenue means recruiting and retaining the workforce needed to deliver high-quality care.

The dedication of our frontline healthcare workers to their patients and to one another was a bright light during the darkest days of the pandemic. We, as a nation, owe our frontline health workers so much, and this report is intended to highlight ways we can do that and, in so doing, put patients over profits.

In unity,



AFT President

TASK FORCE MEMBERS

- Vicky Byrd, Montana Nurses Association, AFT vice president
- Debbie White, Health Professionals and Allied Employees, AFT vice president
- John Brady, AFT Connecticut, PPC chair
- Anne Goldman, United Federation of Teachers, PPC chair
- Julia Barcott, Washington State Nurses Association, PPC member
- Carolyn Cole, Public Employees Federation, PPC member
- Shannon Davenport, Alaska Nurses Association
- Rebecca Garrabrant, United Federation of Teachers
- Nora Higgins, Public Employees Federation, PPC member
- Joshua Holt, Oregon Federation of Nurses and Health Professionals
- David Keepnews, Washington State Nurses Association, PPC member
- Jamie Lucas, Wisconsin Federation of Nurses and Health Professionals, PPC member
- Sandra Nin, United Federation of Teachers
- Maria Paradiso, United Federation of Teachers
- Anne Tan Piazza, Oregon Nurses Association
- Howard Sandau, United Federation of Teachers
- Elvie Smith, United Federation of Teachers

Introduction

Any conversation over the last 24 months with a frontline healthcare worker quickly reveals the deep frustration and anger with their employers and sheer mental, physical and emotional exhaustion.

The stories from AFT members are heartbreaking: A nurse in Connecticut assigned to 11 patients, a healthcare worker in Oregon who spends 20 minutes before each shift in tears trying to muster the emotional strength to go to work, the nurse in Montana who sees a colleague walking away from bedside care, the healthcare worker in New Jersey grieving the death of a colleague who contracted COVID-19 at the hospital. These are dark days for the healthcare workforce.

The COVID-19 pandemic revealed a healthcare system woefully unprepared for the crisis, allowing the world to see a chronic understaffing of our nation's healthcare facilities that existed well before the pandemic. To be clear, this staffing crisis is not new, and it's a crisis of the healthcare employers' making. Their decisions to put revenue ahead of patients and frontline caregivers left the workforce without appropriate personal protective equipment, exposed their employees to increasing levels of workplace violence, stretched patient loads to unprecedented and unsafe levels, and left a workforce exhausted and for far too many in mental health distress. As a result of these exploitative working conditions, it comes as no surprise that frontline caregivers are leaving their jobs in record numbers.

As U.S. Surgeon General Vivek H. Murthy recently wrote, "Today, when I visit a hospital, clinic or health department and ask staff how they're doing, many tell me they feel exhausted, helpless and heartbroken. They still draw strength from their colleagues and inspiration from their patients, but in quiet whispers they also confess they don't see how the health workforce can continue like this. Something has to change, they say."[1]

There are profound long-term staffing consequences for our country's healthcare facilities. Frontline caregivers are experiencing unprecedented burnout and exhaustion from the trauma of working in perilous conditions. Now they are quitting in in record numbers. America's hospitals have failed to fulfill their most basic responsibility: providing a safe place for patients to receive medical care.

As one of our nation's largest unions representing healthcare workers, the AFT and our affiliates have been forced to reckon with dangerously inadequate staffing in our nation's hospitals and healthcare facilities, as well as colleagues who are planning to leave their jobs. Decades of understaffing has reached a crisis point, and it is a crisis of the healthcare industry's own making.

In response to the crisis of staff willing to endure the working conditions of our nation's healthcare facilities, delegates to the AFT's biennial national convention in July 2022, passed a pointed resolution "Addressing Staffing Shortages in the Healthcare Workforce" [2] adopting the recommendations made by the Healthcare Staffing Shortage Task Force and, among other things, specifically calling for:

- The passage of state and federal safe patient levels and securing staffing ratios in collective bargaining agreements;
- Banning mandatory overtime;
- Passage of federal and state workplace violence protection legislation, including the Workplace Violence Prevention for Health Care and Social Service Workers Act; and
- Adequate pandemic preparedness protections in the law through means such as an Occupational Safety and Health Administration infectious disease standard and updates to the Centers for Medicare & Medicaid Services emergency preparedness rule.

This report is the product of the AFTs Healthcare Staffing Shortage Task Force and the union's ongoing effort to improve our nation's healthcare system and the working conditions our members endure. It was informed by months of work by AFT's Healthcare Program and Policy Council, roundtable discussions between clinicians and policy experts, surveys of healthcare members, and anecdotal discussions and workgroups composed of healthcare union leaders.

This report examines various components of the staffing shortage crisis:

1. Barriers to Successfully Recruit and Retain the Needed Workforce.
2. Unsafe Working Conditions
3. Unsustainable Staffing Practices and Workload
4. Inadequate Compensation for Frontline Workers
5. Corporate Trends to Maximize Revenue and Decrease Cost
6. Insufficient Worker Voice and Trust

The staffing crisis in our nation's healthcare facilities is not some mysterious, intractable problem that we lack the tools to fix. Rather, given all that the nation's healthcare workforce endured through the pandemic and before, it is a completely understandable; and with a commitment from healthcare employers to put patients and their workforce above maximizing revenue, it is correctable. This report includes a menu of strategies that can be used to improve our nation's healthcare facilities and concrete examples of where they have been successfully used. It is intended to help frame the national discussion about the staffing crisis and to provide a road map to fixing the chronic problem.

Section 1: The Recruitment and Retention Problem

"So many nurses are shorthanded. It's critical to resupply as people leave the profession."
—a healthcare worker in Connecticut

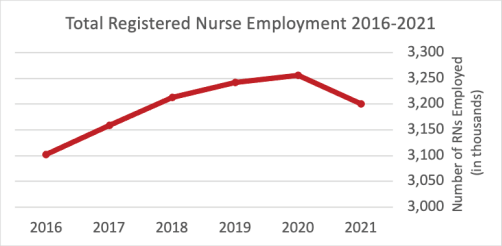
"When we circulate people out of nursing, we lose a lot of brain power."
—a healthcare worker in New York

"We are critically short of nurses and ancillary staff"
—a healthcare worker in New Jersey

The Great Resignation: Healthcare Workers Are Leaving Their Jobs in Record Numbers

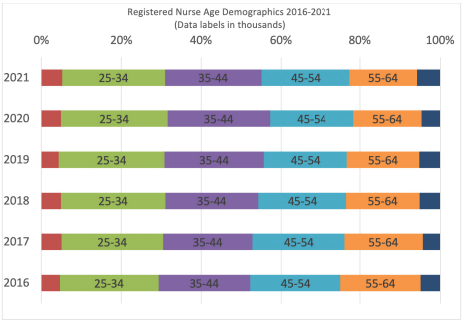
Almost universally, AFT leaders are hearing the same thing from frontline workers. Members working in already understaffed facilities are seeing their colleagues leave faster than they can be replaced.

These trends are not only anecdotal. In 2021, the U.S. Department of Labor Bureau of Labor Statistics (BLS) reported 55,000 fewer RNs employed than in 2020. This was the first decrease in total RN employment in more than five years.



Source: BLS 2016-2021

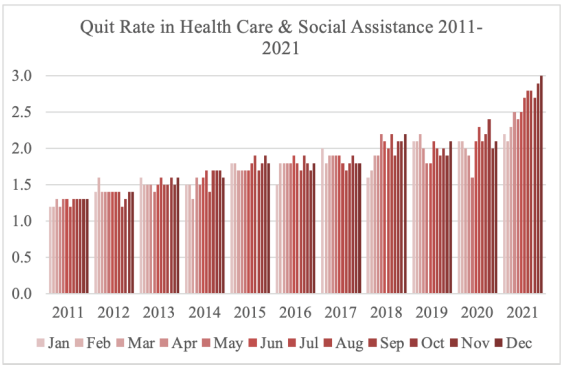
In this same year, the median age of RNs increased for the first time in more than five years, from 42.6 to 43.1. Looking more closely at the age demographics, we clearly see that this was driven by a reduction in total employment of RNs under the age of 44. Further, in 2021 there were 100,000 fewer RNs under the age of 44 than in 2020. This represents a significant reversal from the consistent trend of these workers making up a greater share of the RN workforce each year from 2016 to 2020.



Source: BLS 2016-2021

Looking at the rate of people quitting jobs in the healthcare and social assistance sector over time, we see just how historic this moment is.

In 2021, the healthcare and social assistance sector saw its highest quit rate in the last decade. In the graph below, we see the quit rate steadily increasing over the last decade until 2021 when it spikes to a record high at 3.0. In other words, a quit rate of 3.0 means that for every 100 workers in this sector, three quit their jobs in December 2021.



Source: BLS Job Openings and Labor Turnover Survey (JOLTS) data, 2011-2021

Workers represented by these numbers may have moved to a different employer in the healthcare industry, may have moved to a different segment of the industry, or may have left the industry altogether. BLS specifically excludes retirements from its calculation of the quit rate.

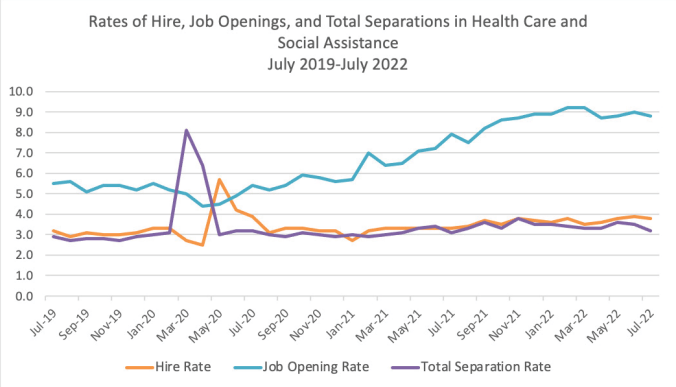
COVID-19 Has Exacerbated and Expedited the Staffing Crisis

In the wake of the COVID-19 pandemic, more and more healthcare workers have reported they were considering leaving their jobs or their professions altogether. A healthcare worker in Connecticut links this directly to short staffing, saying "You can only take care of so many people effectively. This is a recruitment/retention issue. Who's going to want to go into work when it's going to be horrible?"

In a February 2022 poll, 23 percent of healthcare workers—nearly 1 in 4—said they were likely to leave the healthcare field soon.

[3] While many factors could influence an individual worker's choice to leave, one cannot deny the overall impact of the pandemic on rates of workers leaving.

National data reflects the daily experience of our members too. Data from the Job Openings and Labor Turnover Survey (JOLTS) from the Bureau of Labor Statistics from March 2019 to October 2021 is demonstrative. The clearest inflection point happens in March 2020 when the World Health Organization declared COVID-19 a global pandemic. In this month, there is a drop in rates of job openings, hiring and people quitting their jobs. From this we know that the significant spike in the total separation rate in March was not driven by people quitting their jobs, but rather by layoffs and other factors.



There is also a critical second inflection point in the first months of 2021, when rates of job openings and quits begin to rise. Although it is impossible to attribute this increase to any single factor, the availability of vaccines and the loosening of pandemic restrictions present two logical explanations and ones that frontline stories support.

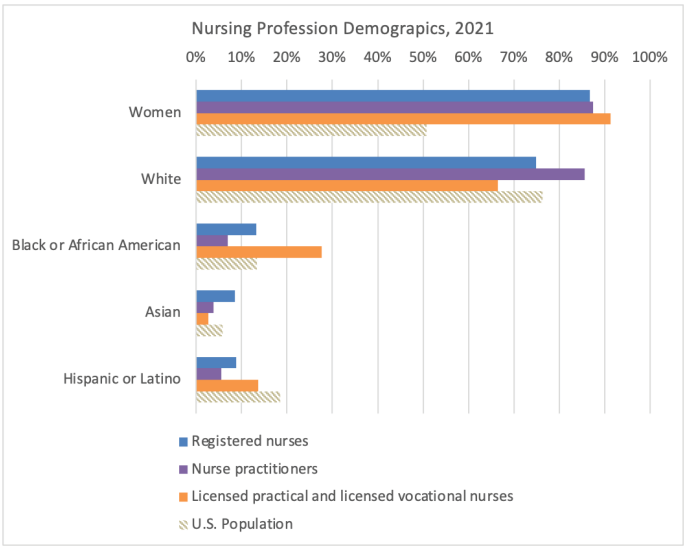
The "Great Resignation" comes as the nation's population ages and grows more diverse, requiring more workers in the health sector. However, in 2021, we see that employers in this sector are only able to hire at about the same rate as workers leave. Yet, we see the rate of job openings continue to increase because of this growing need as the population expands and ages, leaving our healthcare facilities with projected staff shortages.

Of course, when healthcare workers leave their employers, they do not immediately lose the skills to be healthcare workers. Regardless of whether a person quits to pursue other, less-taxing professional opportunities requiring their qualifications, or they leave the sector altogether, the imperative for our healthcare facilities is to recruit and retain their workforce. Doing so requires deep industry reflection on why their facilities have become such undesirable places to work and how to fix the crisis they have created.

It Is Time to Improve Diversity, Equity and Inclusion in the Workforce Through Targeted Recruitment and Training

As our nation's hospitals remain understaffed and the demand for healthcare professionals rises, there is an opportunity to make considerable progress toward greater workforce equity, which is a key component of truly centering health equity as the nation's population continues to diversify. When the healthcare workforce reflects the populations it serves and operates with a deeper cultural sensitivity and understanding of their patients' life situations, patient outcomes improve. This, in turn, increases the comfort level of patients seeking care. [4]

As the graphs of BLS data show, minority healthcare workers are underrepresented; and as the complexity of the positions and the salaries increase, the diversity of the workforce decreases.



Source: BLS 2021

For instance, while people identifying as Black or African American make up 13% of the U.S. population, they make up only 7% of Nurse Practitioners, a higher paying role requiring more formal education than other nursing roles. This clearly demonstrates a lack of racial equity in the nursing profession, but it also demonstrates an opportunity to "right the ship."

Examples of Strategic Approaches

Deploy new strategies to increase diversity in the local healthcare workforce, such as addressing racism in healthcare workplaces; developing program models that expand career outreach programs in communities of color that are underrepresented in healthcare jobs; and developing a workplace equity score that tracks healthcare facilities' workforce diversity numbers, and how many workers from underrepresented communities successfully advance up the career pathway to higher paying positions; and regularly review equity in compensation differences based on gender, race, sexual orientation, disability and all other protected classes.

Strengthen the Pipeline By Coordinating and Expanding Model Programs

To "right the ship" and create a steady flow of new skilled workers to fill vacant positions, the healthcare pipeline and career pathways must be strengthened. The pathway should have multiple entry points to ensure that individuals have ample opportunity to join this workforce and to advance as high up the skill pathways as they desire.

To accomplish this, the sector must conduct targeted outreach, expand stackable credentials (professional credentials that can be lined up sequentially), provide affordable access to the required training programs and, where possible, accelerate the training process. To maximize the impact of currently uncoordinated healthcare education and training programs nationwide that serve people at various levels of education and training, a nationally coordinated strategy organized around specific projected shortages is required.

One cannot, however, simply pipeline their way out of the current staffing crisis. Until the healthcare sector addresses the deplorable working conditions, dangerous patient levels and inadequate compensation, it will be unable to attract and train new workers quickly enough to replace those who leave. New approaches must be implemented, and proven training models could be expanded.

Examples of proven training models that could be expanded include:

Union Negotiated Joint Labor-Management Training Programs—When labor and management work together to identify shortage areas and provide paid time off and financial support for workers to access the training they need, an individual healthcare facility can successfully grow its own workforce. The Ben Hudnall Memorial Trust is one example. Established in 2005 by Kaiser Permanente, the AFT-affiliated Oregon Federation of Nurses and Health Professionals, and a coalition of union bargaining partners, the trust creates "a culture that values and invests in lifelong learning and enhanced career development opportunities for represented employees." The trust provides a diverse portfolio of programs and services to support its workers, ranging from career coaching and academic preparation to professional credentials and academic degrees that an individual worker needs to advance in their career to higher-paying positions.[5]

***Healthcare Professions Career and Technical Education (CTE) High School Programs*—**CTE programs are an invaluable way for students to have a head start on two- and four- year college programs and, in some cases, prepare students for immediate employment in some healthcare jobs that do not require a college degree. These programs are built upon rigorous and integrated instruction of academic and industry-specific content as well as work-based learning experiences like internships. Students receive not only a high school diploma but also have an opportunity to pass an industry-recognized certification or licensing examination that can lead to employment. In the healthcare sector, there are successful CTE programs, such as the one at Clara Barton High School in Brooklyn, N.Y. , staffed by AFT members, which offer curriculum concentrations in nursing, including a nursing assistant and practical nursing programs. Students in the nursing assistant program provide direct patient care under the supervision of a registered nurse. Graduates of both programs will be prepared to take the certification exam and begin entry-level employment upon graduation. Students in the practical nursing program can also go on to two- or four-year college programs to become a registered nurse.[6] Other programs around the county include dental assistant, dental lab technician, medical assistant, emergency medical technician and emergency medical responder, pharmacy technician and biotechnician assistant.

***Healthcare Registered Apprenticeship Programs*—**A limited but growing number of healthcare apprenticeship programs have developed around the country for various healthcare job titles. These programs pair high-quality training with paid clinical experience to allow students to earn money while they gain the skills needed to be fully credentialed and hirable upon graduation.

***Nursing Bridge Program*—**These programs allow current nurses to advance their careers by earning a higher-level nursing credential at an accelerated pace. The programs build on the candidate's existing nursing knowledge and allow them to work while enrolled. In select programs, there is also an option to test out of select courses. Bridge programs are available at all academic levels: associate, bachelor's, master's and doctoral degree programs. The programs require clinical experiences and placements, which are typically permitted to take place at the nurse's work site.

***Accelerated Nursing Program: Non-Nursing Graduates*—**These program options have been gaining momentum. Baccalaureate program graduates with a non-nursing degree can enroll in an accelerated bachelor's or master's nursing program. These fast-track programs typically take 11 to 18 months to complete, including prerequisites (for the bachelor's program). The master's level program generally takes three years to complete. Participants receive the same number of clinical hours as their counterparts in traditional nursing programs, and they must meet rigorous admissions standards. Accelerated nursing programs are available in 49 states and the District of Columbia, the U.S. Virgin Islands and Guam.

***RN Internships/RN Clinical Intern*—**Usually funded by a nursing program or healthcare facility, these programs give student nurses paid clinical experience while alleviating some of the work placed on RNs, nursing assistants and other healthcare positions. Working under a preceptor nurse, their duties can include evaluating patients' conditions; administering medication; and assisting patients with bathing, dressing and eating.

***Nursing Residency Programs and Fellowships*—**These programs, collectively known as the ANCC Practice Transition Accreditation Program support RNs with less than 12-months of work experience (Nurse Residency) and experienced RNs (Nursing Fellowship) and newly certified advanced practice nurses transition into new practice areas. These programs are accredited by the American Nursing Credentialing Center (ANCC) and are recognized by the U.S. Department of Labor as industry-recognized apprenticeship programs.[7]

Remove Barriers to Entry by Expanding Student Loan and Repayment Programs That Incentivize Joining the Healthcare Sector

A 2019 analysis of data from the U.S. Department of Education found the average graduate of an associate degree in nursing (ADN) program held $19,928 in student debt. For graduates with a Bachelor of Science in nursing (BSN), the average debt was $23,711 and for graduates with a Master of Science in nursing (MSN), the average was $47,321.[8]

No effort to recruit talent into the healthcare workforce can be complete until the cost barriers for accessing and completing higher education and training programs are addressed.

The proliferation of costly for-profit nursing programs that have lower NCLEX (National Council Licensure Examination) passage rates than nonprofit nursing programs exacerbates the problem.[9] To obtain a nursing license, you must pass the NCLEX exam, which assesses the competency of nursing school graduates. Failure leaves the student in debt without the credential needed to obtain the employment to pay off the debt.

While there is no publicly available data on debt burdens or education costs for other healthcare titles, one can make some educated guesses based on the average cost of the level of education required for certain roles. For example, the average cost of an associate degree at a public institution is $21,900 and $57,254 at a private institution.[10] Many healthcare roles, including lab technicians, surgical technologists, radiologic technologists, and respiratory therapists, require an associate degree.

Healthcare job titles that do not require a postsecondary degree are also not free of cost barriers because many require certification programs. For example, a program to become a licensed practical nurse can cost as much as $15,000, and training to become a certified nurse assistant averages about $2,000.

Education Barriers Disparately Impact Communities of Color

Sixty-two percent of 2019 college graduates were burdened by student loan debt,[11] disproportionately impacting women and people of color. In fact, 58 percent of outstanding federal student loan debt is owed by women.[12] Compared with their white peers, Black borrowers have higher total debt burdens and higher monthly payments. Four years after graduation, 48 percent of Black borrowers owe 12.5 percent more than their original balance, while 83 percent of white borrowers owe 12 percent less than their original balance in the same time period.[13] This has a particularly large impact on racial equity in the healthcare workforce and is especially poignant for healthcare workers who have made unimaginable sacrifices during the COVID-19 pandemic.

The AFT Is Addressing Educational Barriers by Working to Improve the Public Service Loan Forgiveness Program (PSLF)—The AFT has been leading the effort to make PSLF available for more people working in public service roles. Employees who work full time (30 hours or more a week for eight or more months of the year) for a non-profit or government employer, can qualify for full forgiveness of their federal student loan balance after 120 qualifying payments. This includes most hospital and public health workers. During the Trump administration, this program was woefully mismanaged with workers' time credit not being applied correctly and their loan status wrongly placed into default. The AFT successfully sued the Trump administration. Through a year-long waiver, borrowers who did not previously qualify or who were denied were able to get credit for past payments and get on track for full forgiveness. When properly managed and promoted, and when healthcare professionals and other workers are given the necessary information, the program can be a powerful tool for recruiting and retaining healthcare professionals.

AFT Local Unions Are Working with State Legislatures to Strengthen the Pipeline and Lower Healthcare Workers' Student Debt

AFT-affiliated unions have been working with state legislatures around the country on targeted strategies that increase the pipeline. This includes the Oregon Nurses Association winning passage of the Nursing Workforce Omnibus Bill (H.B. 4003) earlier this year, which, among other provisions, creates a nurse internship license to augment the workforce and offers practical experiences for nursing students. AFT affiliates in New York have been working on the New York State Nurse Employment, Enhancement and Dignity Act (A. 7385/S. 6424) to provide hazard pay to nurses during a state disaster emergency, an annual tax credit for nurses, a student loan forgiveness program for nurses, and preferential school admission for nurses. The AFT-affiliated Alaska Nurses Association has been working on legislation (S.B. 10) to provide free or reduced tuition for essential workers who attend state-supported postsecondary educational institutions. The AFT-affiliated Washington State Nurses Association has been working with its Legislature on a bill (H.B. 1452) that expands scholarship programs for RNs' education.

Nurse Faculty Wages Need to Be Raised so That Master's-Level Nurses Can be Recruited, Allowing Nursing Programs to Accept More Qualified Students

All of the previously stated barriers to postsecondary education notwithstanding, the healthcare industry and policymakers must reckon with the reality that nursing education programs do not have the funding, facilities or faculty needed to address the workforce shortage. While similar dynamics may exist in other healthcare training programs, it is a particularly acute problem in the nursing profession. For instance, in 2019, nursing programs turned away more than 80,000 qualified applicants because the programs lacked the necessary resources to educate these individuals.[14]

According to 2020 data from the American Association of Colleges of Nursing, the average salary for a master's-prepared assistant professor of nursing is $79,444. A nurse with a master's degree on the other hand, has many other career options, including nurse practitioner where the average salary across specialties is $110,000, according to the American Association of Nurse Practitioners.[15]

One driving factor of the nurse faculty shortage is the student debt crisis. The average nurse with a master's degree who is carrying student debt has more than $47,000 in debt, with monthly payments more than $500.[16] Nurses who want to teach the next generation of nurses may be unable to afford to do so. This is especially true for nurses of color who are more likely to have student loans and more likely to have higher loan balances, according to national debt statistics.[17]

Examples of Strategic Approaches

- The U.S. Department of Health and Human Services Department's Health Resources and Services Administration should convene an emergency task force to develop a national healthcare workforce strategy. The task force should include the U.S. Department of Education, Department of Labor, and both industry and labor representatives. The AFT is uniquely positioned to provide strategic input because our membership includes healthcare workers, career and technical education program teachers, nursing program and other healthcare professional program faculty.
- Targeted financial aid and loan repayment programs should be expanded, including the National Health Service Corps and the Nurse Faculty Loan program.

Section 2: Working Conditions Need to Be Improved to Recruit and Retain More Healthcare Workers

"I remember thinking during the first surge, 'if we just make it through this with none of our members dying, we will be lucky.' We made it until the third surge when we lost a beloved RN from the OR. We had over 75 percent of our members testing positive at one point during this pandemic. Many members were seriously ill, hospitalized, and some are still recovering with long COVID-19 symptoms. I watched my co-workers develop post-traumatic stress disorder in real time."

—Sheryl Mount, Health Professionals and Allied Employees, New Jersey

Inadequate Staffing Leads to More Worker Injuries

The impact of inadequate staffing on the occupational safety and health of healthcare workers has not been adequately addressed. Although there is a growing body of evidence on the patient-safety risks associated with poor staffing, much more research is needed on workers' injuries and illnesses. One of the few studies that looked at the relationship between occupational injuries and staffing found that shifts with fewer nursing care hours per shift, lower RN skill mix, and a lower percentage of experienced staff had higher rates of needlestick injury.[18]

The California nurse-to-patient staffing ratio law offers an opportunity to evaluate the impact of staffing on healthcare workers' health and safety. One study found that registered nurses in California hospitals suffered 55.57 fewer illnesses and injuries per 10,000 RNs, a rate 31.6 percent lower than the rate in all other states. The reduction for licensed practical nurses was 38.2 percent.[19]

Workplace Violence Makes Hospitals One of the Most Dangerous Places in America to Work, and Enforceable Standards Are Needed to Protect Workers

"The amount of bullying and unprofessional treatment is pushing people out of the profession. The professionalism and respect we once had has gone to the wayside."

—a healthcare worker in New Jersey

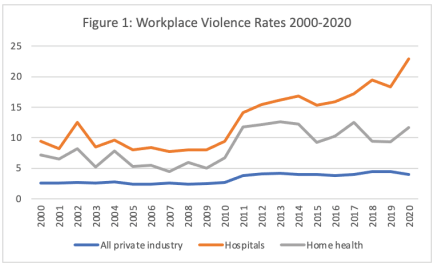
"I have experienced many assaults in my 17 years as an RN, including having a patient attempt to strangle me while his wife jumped on me and punched me. It is dangerous to work without enough staff in the psych unit. I developed PTSD when a patient held a gun to my chest in August 2020. I have taken care of many patients with PTSD, but I never realized how debilitating it is. I told management I was not OK–but they expected me to show up for my next shift."

—Carol Grant, AFT Connecticut

Violence to healthcare workers is a serious and growing problem exacerbated by inadequate staffing. Healthcare and social services workers experience 76 percent of all reported workplace violence injuries in the American labor force, and the number of actual incidents of workplace violence is likely to be much higher.[20] One study of staff working in psychiatric hospitals found that 85 percent of the incidents of workplace violence were never reported.[21]

Workplace violence in healthcare continues to rise in tandem with the staffing crisis. The rate of reported assaults grew by 144 percent in hospitals and 63 percent in home health agencies from 2000 through 2020. The rate of reported assaults increased by 95 percent in private sector psychiatric hospitals and substance

use treatment facilities between 2006 and 2020.[22] There were 87 workplace homicides from 2017 through 2019.[23],[24] Pandemic-related pressures on healthcare accelerated this trend—the rate of violence in hospitals increased by 25 percent in one year alone, from 2019 to 2020.[25]



Source: U.S. Bureau of Labor Statistics, Survey of Occupational Injury and Illness 2000-2020, Table R8

The Occupational Safety and Health Administration and National Institute for Occupational Safety and Health have both identified understaffing as a risk factor based on research from the 1990s.[26, 27] Descriptive studies of workplace violence demonstrate that poor staffing increases the risk of violence.[28, 29] Long wait times and inadequate attention can lead to escalating behavior in some patients and visitors. In some cases, workers are too busy to notice or respond. When there are too few workers available to safely restrain violent patients or when staff work in isolation, the risk of serious injury increases. More research is needed to investigate a causal relationship between understaffing and workplace violence. Two studies found that a higher staffing rate was associated with higher rates of assaults on staff and other patients in psychiatric units.[30, 31] Critics of the studies argued that the researcher was comparing reported incidents of workplace violence, not the actual number of assaults, noting the high probability of underreporting in poorly staffed facilities.

OSHA, NIOSH and researchers have emphasized the critical importance of workplace violence prevention programs that train frontline staff and managers to report all incidents of workplace violence and "near misses" in order to develop evidence-based prevention strategies.[32] Unfortunately, healthcare workers often do not report incidents of workplace violence because they find themselves blamed for their assault. More work is needed to identify the staffing issues at the root of workplace violence.

In 2016, the AFT led a coalition of unions petitioning OSHA for a workplace violence prevention standard for healthcare and social service workers. OSHA agreed to develop a standard, but the work stalled during the Trump administration. The Workplace Violence Prevention for Health Care and Social Service Workers Act was passed twice by the House of Representatives, requiring OSHA to develop an interim standard within one year and a final standard within 3.5 years. The bill was introduced in the Senate recently, but it has little chance of passing.

AFT Local Unions Have Been Working with State Legislatures to Make Their Workplaces Safer

AFT affiliates have been working with their state legislatures to create greater protections for healthcare workers. This includes the Montana Nurses Association; it has been working on A.B. 538, which requires reporting violence against healthcare workers. AFT affiliates in New York have been working on the Nurse Safety Work Act (A. 1639), which requires hospital staff to implement safety procedures when alone with a patient.

Examples of Strategic Approaches

Enact the federal Workplace Violence Prevention for Health Care and Social Service Workers Act

Fatigue Is Making Healthcare Jobs Unsustainable, and Healthcare Workers Need More Recovery Time

> *"Staffing was bad before, but now we have nine patients to a nurse, including patients being placed in hallways. We go 12 to 16 hours without a break to eat or drink. I have had nurses pass out because they haven't had time to eat or drink. We had 72 mandated overtime shifts in January 2022. It's particularly hard on night shift nurse; –we have had multiple cases of people working 36-hour shifts. People get so exhausted, they call out sick, which leads to more problems. At this point, financial incentives do not work, when people are this exhausted."*
>
> *—Sherri Dayton, AFT Connecticut*

Research on nurse fatigue has focused on the effects of shift work, including extended shifts and overtime, night shifts and rotating shifts, and insufficient recovery time between shifts. Chronic sleep deprivation has been linked to these factors. Chronic sleep deprivation causes fatigue; reduced cognitive function; increased risk of errors, such as needlestick injuries; unsafe driving; and patient safety errors in the short term. Chronic sleep deprivation can cause cardiac, gastrointestinal, and metabolic illnesses in the long run. Chronic lack of sleep has also been shown to foster proinflammatory activity and immunodeficiency, putting workers at higher risk for infection. [33]

More research on the relationship between understaffing and fatigue is needed. Nurses and other healthcare workers are under pressure to work overtime and accept additional shifts without adequate rest when facilities are understaffed. According to one study of hospital nurses working successive 12-hour shifts, the majority slept for less than six hours between shifts.[34] Other studies have found that people who work rotating shifts sleep up to four hours less when they work at night. [35]

In the past, research on the effects of mandatory overtime and extended work shifts aided in the passage of state laws prohibiting the practice. More research is needed to demonstrate how patterns of understaffing lead to increased demand for overtime. Additionally, research is needed to show the long-term mental health effects of fatigue and overwork.

Successfully Bargained Solutions

AFT local unions have been engaging in innovative bargaining to reduce fatigue among healthcare workers. This includes the Ohio Nurses Association, which secured "double back" language in its contract with Lima Memorial Hospital, requiring a certain number of hours between shifts. The ONA also achieved a ban on mandatory overtime at the hospital. The Oregon Nurses Association won double overtime for mandatory overtime at the Oregon Health & Sciences University, which puts financial pressure on the hospital to hire more nurses. Meanwhile, the Washington State Nurses Association secured an additional RN float position to ensure adequate coverage, allowing all staff to take meal and rest breaks. The Ohio Nurses Association won language in its contract with the Akron Medical Center allowing nurses to nap while on meal or rest break, showing how exhausted healthcare workers are.

AFT Local Unions Are Moving State Legislation to Reduce Fatigue at Work

AFT affiliates have been working with their state legislatures to reduce mandatory overtime. In New York, AFT affiliates have been working on A. 286A/S. 1997A, which imposes a civil penalty on an employer who requires a nurse to work more than their regularly scheduled work hours. The measure also provides the nurse with an additional 15 percent of the overtime payment from the employer for each violation. The Ohio Nurses Association was successful in passing legislation in 2021 that establishes a legislative study committee on RN staffing Issues to help legislators learn more about the issues and build support for better staffing.

Examples of Strategic Approaches

Ban mandatory overtime through federal and state legislation, regulation and collective bargaining agreements.

Inadequate Protections for Infectious Disease and Emergency Preparedness Risk the Lives of Healthcare Workers, and the Healthcare Industry Needs Greater Preparedness Requirements

"It was apparent that my hospital and others were not prepared. In April 2020, pregnant women started coming from New York into Connecticut hospitals to give birth. It was not until after we had COVID-positive moms and newborns that my hospital started testing these patients and giving N95s to labor and delivery staff. A psychiatric hospital in Connecticut was cited by OSHA for having no respiratory protection program at all after an outbreak among staff and patients."

—Sherri Dayton, healthcare worker, AFT Connecticut

"It is hard to put into words how hard it has been working as a nurse through the pandemic. I get emotional talking about what has transpired over the last two-plus years. I equate it to being like what I imagine a war zone must be like. Never in my 37 years of nursing have I been so horrified to be a nurse and at the same time so proud to be a nurse."

—Sheryl Mount, Health Professionals and Allied Employees

"COVID-19—you stole my life, wreaked havoc on my organ systems, wrecked my career, cost me thousands of dollars, made my sweet little boy cry in fear, almost shattered my soul, and took away something I can't get back, which is time. Time with my family, friends, loved ones and community. You robbed me of memories. You robbed me of the life, I loved and valued. You stopped me in my tracks, but you will NOT win."

—Jessica, Alaska Nurses Association member, suffers from long COVID

The healthcare industry's lack of preparedness for infectious disease outbreaks has had disastrous implications for staffing and for healthcare workers. For example, early in the pandemic, hospitals elected to save money by not stockpiling enough personal protective equipment (PPE). The needless exposure to infections contributed to the death of 3,600 healthcare workers.[36] Others left the bedside because they got sick or worried about infecting themselves and their loved ones. They were joined later by those who couldn't or wouldn't work in intolerable staffing conditions. Healthcare workers were lauded as heroes but treated as disposable by the healthcare industry.

Prior to the COVID-19 pandemic, annual outbreaks of seasonal influenza regularly swamped hospitals and created short-term staffing crises. Analysis of the handling of the H1N1 influenza pandemic in 2009 and the Ebola epidemic should have alerted the hospital industry to the imperative need to develop stronger infectious disease outbreak preparedness plans, including improving ventilation systems and stockpiling respirators.

The Centers for Medicare & Medicaid Services issued an emergency preparedness rule in 2016 but failed to include requirements that employers maintain robust PPE stockpiles. The Office for the Assistant Secretary for Preparedness and Response within the Department of Health and Human Services maintained the Strategic National Stockpile, but Congress and two administrations failed to adequately fund it.

The labor community first petitioned OSHA for an infectious disease standard in 2005, but the agency did not begin work on the standard until 2010 in the aftermath of the H1N1 outbreak. Labor unions petitioned OSHA for an emergency temporary standard early in the pandemic, but the Trump-appointed secretary of labor refused. The Biden administration agreed to issue an emergency temporary standard on COVID-19 for healthcare workers, but it was delayed until June 2021 and allowed to sunset after six months. The agency has promised to issue the permanent standard within six to nine months. Our efforts to influence the content of the standard are underway.

Examples of Strategic Approaches

Secure adequate pandemic preparedness protections in the law through means such as an OSHA infectious disease standard and updates to the Centers for Medicare & Medicaid Services emergency preparedness rule.

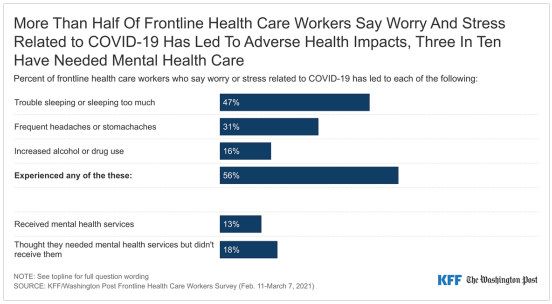
Addressing the Mental Health Crisis of Healthcare Workers Requires Funding for New Support Programs

Our nation's healthcare workforce's mental health is in shambles. For many years, healthcare workers, particularly those at the bedside, have been stressed and have suffered the moral injury of repeatedly being expected to make choices that transgress their long-standing, deeply held commitment to healing.[37] The scarcity of mental healthcare providers compounds the mental stress. Those who seek assistance are frequently unable to find providers or are placed on monthslong waiting lists.[38]

According to the U.S. Department of Health and Human Service's Health Resources and Services Administration and the Kaiser Family Foundation, there are over 5,800 designated mental health professional shortage areas in the country. More than 6,300 mental health practitioners, including adult psychiatrists, psychologists, social workers and mental health counselors, would be needed to meet the needs in the shortage areas.[3940]The pandemic has changed the rolling boil of the mental health crisis into an overflowing pot characterized by depression, anxiety and suicide. This crisis is deeply shaped by the unsafe patient limits that cause frontline caregivers to quit their jobs, leading to even more understaffing.

A survey conducted in March 2021 by the Kaiser Family Foundation (KFF) and the Washington Post asked healthcare workers whether they felt the worry or stress related to COVID-19 had a negative impact on their mental health. According to the survey, 61 percent said yes. The stress of the pandemic had clearly taken hold of the country's caregivers just one year into the pandemic. Three out of 10 people polled either received or thought they needed mental health services because of the pandemic. At least 49 percent said the pandemic had negatively impacted their physical health, as well as their relationships with family members (42 percent) and co-workers (41 percent). Many people reported difficulty sleeping, frequent headaches, increased use of alcohol or drug use, all of which were attributed to pandemic stress and

worry. According to another recent study, almost 40 percent of emergency healthcare workers screened positive for burnout, and nurses were significantly more likely to be experiencing burnout compared with attending physicians.[41]



Another recent study found that more than 70 percent of healthcare workers have symptoms of anxiety and depression, 38 percent have symptoms of post-traumatic stress disorder, and 15 percent have had recent thoughts of suicide.[42] As nurses and other healthcare professionals reach their breaking point, the deadly consequences of suicide have come to the forefront. This is what happened to Michael Odell, a 27-year-old travel nurse. Odell sought mental healthcare and medication after attempting suicide during the pandemic. For a time, Odell seemed to be fine but a year later, he left the hospital in the middle of his shift and committed suicide. Friends and colleagues in the nursing profession were shocked but understood how the pressures of seeing patients die every day, with little or no support and living with moral injury, drove him to do the unthinkable.

Although the height of the pandemic appears to have peaked, our healthcare workers continue to face mental health challenges. The staffing shortages put a tremendous amount of strain on tired and overworked bedside caregivers, who work long hours wondering if another wave of the pandemic will bring in more cases than they can handle. The workforce urgently needs support.

Examples of Strategic Approaches

- Increase funding, programming, and other legal protections at the federal level to support health professionals in the areas of mental health, burnout, and stress Management, including addressing shortages in the mental health professions.
- Work in partnering with other organizations and mental health experts devoting resources and activities aimed at developing clear demands for improving healthcare workplaces, ensuring mental health needs of the workforce are addressed, and to develop resources and education programming that provide meaningful support to healthcare professionals.

Section 3: Safe Staffing Requirements Are Needed

> *"Staffing requirements are key to stabilizing the workforce, reducing burnout and turnover; we are in a vicious cycle where years of inadequate staffing, made worse by the pandemic, are now leading to more and more people leaving."*
>
> *—a healthcare worker, Washington State Nurses Association*

One final question at the end of a Healthcare Staffing Shortage Task Force meeting: What do frontline healthcare workers need the most right now? The unanimous response was safe patient levels that put a limit on the number of patients that can be assigned to a single nurse. The appropriate limit varies depending on the department. For example, an ICU nurse can safely care for fewer patients than a med-surg nurse given the required level.

California is the only state that mandates safe patient levels for multiple hospital departments by law. Massachusetts mandates ratios only for ICUs by law and New Jersey mandates ratios for several departments through regulation of the hospital licensure process. A number of states also require healthcare facilities have staffing committees that include nurses. This is based on the idea that every hospital is different, and each should have the flexibility to develop staffing matrices that best fit their departments. Unfortunately, because they are often poorly enforced and lack a clear standard, staffing committees have not proven to be a successful strategy to achieve safe patient limits.

In contrast, safe staffing levels set by law in California have been shown to improve outcomes for patients and healthcare workers. (More on this in the "Unsafe Staffing Means Diminished Patient Outcomes" "Evidence of Patient Outcomes" section). Many experts argue that safe staffing levels are necessary because they provide hospital administrators and workers with a clear measurable standard. Setting the floor in law rather than collective bargaining agreements and staffing plans also allows for enforcement of these standards through state agencies rather than relying on hospitals to monitor their own compliance or on workers to file complaints after a plan has been violated.

Examples of Strategic Approaches

- Enact federal and state laws that mandate safe staffing levels and staffing ratios that include the whole care team and incorporate requirements into governmental regulations such as the Centers for Medicare & Medicaid Services Conditions of Participation.
- Include safe staffing levels in collective bargaining agreements.

Public Reporting Alone Is Not the Solution

The requirements for public reporting on hospital staffing levels vary greatly across the country, ranging from posting a daily staffing plan in plain view of patients at a hospital to public disclosure to a state agency. Public disclosure and other tools for transparency are important components of staffing solutions, but there is little evidence that reporting requirements alone directly improve staffing levels. [43] It is unrealistic and unfair to expect the public to possess sufficient industry knowledge to connect staffing levels to patient outcomes. Finally, while disclosure is an important part of enforcing safe staffing standards, it can't be the only way to keep patients safe.

Successful Collective Bargaining Strategies

AFT-affiliated unions around the country have been trying a variety of strategies at the bargaining table to reduce unsafe patient levels. For example, the Ohio Nurses Association at the Ohio State University Medical Center won safe patient staffing levels for its workers, including a nurse-patient ratio in the medical-surgical unit of 1:4, while the nurse-patient ratio for the critical care unit in the emergency department is 1:2. The nurses at OSUMC are now empowered to challenge patient care assignments that are unsafe because they exceed the established ratio. While nurses occasionally flex up to accommodate additional patients, it is rare and is only done when the nurse can safely care for all their patients. The Montana Nurses Association won important language at Deaconess Hospital that "recognizes the professional responsibility of nurses" and empowers nurses "to accept or decline overtime assignments based on their self-assessment of ability to provide safe care."

AFT Local Unions Around the Country Have Been Working on State Staffing Legislation

AFT-affiliated unions nationwide have been working with their state legislatures to require increased staffing levels in their facilities. This includes the Health Professionals and Allied Employees in New Jersey, which has been working on S. 304 that would establish minimum RN staffing ratios for hospitals and ambulatory surgery facilities and certain Department of Health facilities. The Washington State Nurses Association worked on H.B. 1868 during the recently concluded state legislative session, which would create RN staffing ratios for acute care hospitals; it also would also address overtime, meal and rest break issues, and enforcement. AFT Connecticut worked with its state Legislature last year on S.B. 1, which includes safe staffing requirements. AFT-affiliated unions in New York have been working on S. 1032/A. 2954, which establishes minimum nurse-to-patient ratios.

AFT-affiliated unions have also been pursuing state legislation to require staffing committees. For instance, in New York, our unions won language in their 2019 state budget that requires the Department of Health to study how staffing enhancements and other initiatives can improve patient safety and care. AFT locals in New York have been working to curtail mandatory overtime with S. 6311, originally introduced in 2019.

Unsafe Staffing Means Diminished Patient Outcomes

Most critically, unsafe patient levels for healthcare workers have been linked to poorer patient outcomes, including higher likelihood of death. Decades of research have established a major consensus among healthcare and workforce researchers that staffing ratios address these issues.

When AFT leaders hear from members about unsafe staffing, the first concern is never, "This makes my job more difficult." The biggest concern is always, "My patients aren't safe."

Every day, healthcare workers are forced to make impossible decisions due to unsafe staffing. Do they review the discharge instructions with a patient or respond to the flashing call button? Do they help a patient get to the bathroom safely or get another patient their medication on time? These are real decisions with real consequences for patient safety and having to face them every day all but guarantees workers will suffer moral injury.

Research reflects the impact of unsafe staffing on patient outcomes. Each additional patient added to the average nurse's workload on a med-surg unit increased each patient's chance of 30-day mortality by 16 percent.[44] In med-surg units, each additional patient per nurse was associated with a 5 percent lower likelihood of surviving in-hospital cardiac arrest.[45] Patients were 63 percent less likely to be readmitted within 30 days in hospitals where staffing in pediatric units was in line with the staffing limits (4:1) set in California state law.[46] Two-thirds of California staff nurses said the ratio law makes them more likely to stay at their jobs, and 74 percent say it has improved the quality of care in the state. [47]

Outsized Use of Staffing Agencies: A Symptom of the Broken Labor Market That Needs Greater Oversight

> *"It's difficult to depend on people when there are emergencies and crises when you don't know the names of the traveling nurses because they are brought in and leave so quickly."*
>
> *—a nurse in New York state*

> *"When you have a few travelers on a unit, they can definitely help augment staffing and help with an isolated crisis, but what we're seeing are units that are really dominated with travelers. Then for those units that are short, we also have a float pool, so there aren't regular staff; on specialty units, it's a particular problem."*
>
> *—a nurse in Ohio*

> *"When 70 percent of the staff are travelers and 30 percent are home staff, that is not good for continuity, for the history and the culture of the facility."*
>
> *—a nurse in Montana*

With healthcare worker shortages and increasing patient levels during the COVID-19 pandemic, hospitals and health systems have begun turning more to healthcare staffing agencies. Though these agencies are not new to the healthcare landscape, rapidly escalating rates and accusations of price gouging have thrust them to the forefront of public debate over the cost of healthcare.

Many reports on staffing agencies sensationalize the amount paid to health professionals in these travel roles. While it is certainly true that these workers have been able to demand significantly higher pay during a public health emergency, the headlines frequently overlook the windfall for the staffing agencies that employ these workers.

A November 2021 analysis by Staffing Industry Analysts projected revenue for healthcare staffing agencies to grow to nearly $25 billion—three times the level it was in 2011. But the study also notes this industry was experiencing rapid growth even before the pandemic. From 2009 to 2019, revenue tripled for the healthcare staffing industry, following larger economic trends toward gig work. [48]

Traveling healthcare workers are a valuable addition to a hospital's care team in many situations, including bringing workers with specialized skill sets into rural and underserved areas. Staff nurses and health professionals work alongside them, often exchanging valuable insight. The problem arises when hospitals and health systems stop investing in recruiting and retaining staff nurses and health professionals and the use of temporary workers becomes a more expensive replacement rather than a supplement.

In a 2022 report, the American Hospital Association evaluated the cost of the pandemic for hospitals, including the increased money spent on temporary workers through staffing agencies. According to data cited in this report, travel nurses now account for a much larger portion of total hours worked by nurses in hospitals. In January 2019, travel nurses accounted for 3.9 percent of total hours worked by nurses in hospitals. In January 2022, they accounted for 23.4 percent.[49]

As hospitals have relied more heavily on staffing agency workers, labor costs have skyrocketed. The AHA report also cites data showing a 213 percent increase in rates charged by staffing agencies between January 2019 and January 2022. As a result of increased prices from staffing agencies and hospitals' increased reliance on them, hospital labor expenses per patient at the end of 2021 were 36.9 percent higher than pre-pandemic levels.[50]

Related to staffing agencies and efforts of the healthcare industry to surge nursing services as needed are efforts to enact the Nurse Licensure Compact. States that join the compact agree to recognize the nursing license issued by any other compact state. However, the multistate license scheme, while sacrificing state-specific nursing standards such as continuing education requirements, has not alleviated the staffing crisis in our nation's healthcare facilities.

The nurse labor market in our country has been broken. Hospitals have had to scramble to hire nurses in a time of public health emergency because they used lean staffing models prior to the pandemic. Every hospital competing for the same limited pool of nurses at the same time drove up wages. Coupled with years of deteriorating working conditions and lack of fair compensation, many nurses quit their staff nursing position to follow the money.

Some, frustrated with their working conditions, are undoubtedly trying to cash out before they leave the hospital industry. Many have been able to accept positions at nearby hospitals. This has resulted in staff nurses working side by side with travelers (when the department is not staffed entirely by travelers) who make two and three times as much as staff nurses do for the same work.

As a result, more staff nurses are quitting and taking traveler positions. This is clearly an unsustainable labor market. Instead of complaining of the high rates charged by staffing agencies, hospitals should accept responsibility for creating a labor market in which dedicated staff are undervalued and underpaid; hospitals should reduce pay disparities and improve working conditions.

Exploitation of International Workers

The dark underbelly of international staffing agencies, where some agencies engage in nothing short of international labor trafficking, is one of the most insidious components of the staffing agency market. Many of these agencies require nurses to sign exploitative employment "contracts" with provisions that are so restrictive they are akin to indentured servitude. These contracts limit the mobility of international nurses' labor.

Some international nurses have been denied the wages they have earned alongside hospital staff because they are unaware of American labor protections, such as overtime laws. These contracts often include exorbitant financial penalties for a "breach of contract," including early termination. Workers who are trapped under these conditions are unable to report illegal labor practices and unsafe working conditions. Unfortunately, instead of these nurses being protected by labor law, staffing agencies have successfully sued for breach of contract and been able to garnish a nurse's future wages. While increasing the number of international workers is only a small part of the solution to the labor crisis in healthcare, special care must be taken to identify bad actors who exploit these workers. We must also recruit ethically from other nations, taking care not to extract labor desperately needed in those nations.

Examples of Strategic Approaches

Enact state legislation requiring staffing agencies to be specifically licensed by each state they operate in, publicly disclose their contracts with healthcare facilities, their employment contracts, their spending, who is working where, as well as require that at least 80 percent of their spending goes to direct patient care, and that they will be disbarred if they have been shown to violate state or federal labor laws.

AFT Local Unions Have Been Winning Contract Language That Puts Guardrails on the Use of Travel Agency Nurses

Before the pandemic, AFT-affiliated unions had been successfully bargaining language that limited their employers' use of travel nurses. The Washington State Nurses Association, for example, was successful in having the University of Washington Medical Center declare in their agreement that it "is the intent of the University of Washington Medical Center to minimize the employment of agency nurses." The Ohio Nurses Association successfully bargained with the Cuyahoga County District Board of Health that any "substitute or temporary nurse will not be used to avoid filling any vacancies." The Oregon Nurses Association successfully got the Sacred Heart Medical Center in Eugene, Ore., to jointly review the staffing pattern and use of per diem and other nurses in a unit and shift to determine whether additional regular positions/hours should be posted.

Section 4: Compensation of Healthcare Workers Needs to Be Increased

The healthcare industry as a whole was worth a staggering $8.45 trillion in 2018[51] and accounted for more than 19.7 percent of total U.S. gross domestic product in 2020.[52] Combined with the social services sector, in 2018 it was the largest employer in the country with over 20 million employees and more than $1 trillion in annual payroll.[53]

The compensation package for people at the top, including hospital executives, reflects this. However, the reality for the people who provide the direct care, provide food for patients, keep the facilities clean and hygienic, and otherwise support the operation of our nation's healthcare facilities is far different; and they are increasingly discovering that their wages aren't worth their working conditions.

While hospital CEOs earn an average $600,000 annually, the true compensation differential at specific facilities can be much greater. For example, in 2018, the CEO of Kaiser Permanente, a large nonprofit health-

care system, made nearly $18 million. In 2017, the top 10 highest-paid nonprofit health system executives earned $7 million or more. Even the bottom 25 percent of nonprofit hospital CEOs enjoyed annual compensation of about $185,000.[54]

In contrast, other healthcare professionals make significantly less:

2021 National Average Salaries for Healthcare Workers

Pharmacists	$ 125,690
Physician assistants	$ 119,460
Nurse practitioners	$ 118,040
Physical therapists	$ 92,920
Occupational therapists	$ 89,470
Registered nurses	$ 82,750
Respiratory therapists	$ 68,190
Clinical laboratory technologists and technicians	$ 56,910
Licensed practical and licensed vocational nurses	$ 51,850
Medical assistants	$ 38,190

Source: U.S. Bureau of Labor Statistics

The gap is only wider for those hospital employees whose jobs do not require specialized degrees, such as janitorial and kitchen staff, and medical-records personnel. For instance, the Lown Institute found that the ratio of CEO wages to the wages of these workers ranges from 26:1 to 2:1.[55]

	Hospital CEO Compensation per hour, on average (range)	Hourly Worker Wage on average (range)	Ratio of CEO wage to other workers on average (range
Top 50 ranked hospitals for pay equity	$65 ($22 - $104)	$30 ($17 - $45)	2:1 (0.8 – 2.7)
Bottom 50 ranked hospitals for pay equity	$923 ($458 - $3,289)	$34 ($21 - $61)	26:1 (18.9 – 60.2)

Source: Lown Institute Hospitals Index

To successfully recruit and retain staff, the healthcare industry must fix its compensation gap.

Examples of Strategic Approaches

Conduct compensation surveys on a recurring basis and raise entry level salaries for all hard-to-fill positions, precepting, mentoring and clinical advancement; and develop meaningful steps increases and retention bonus targeting mid-career professionals who are leaving hospital employment in record numbers.

Section 5: Corporate Trends

"At the end of the day, maintaining the budget is a bigger priority for employers. They are willing to talk the talk and not walk the walk when push comes to shove. This is a huge problem."

—a healthcare worker in Ohio

"Stop treating staff as something you can cut out to its lowest common denominator instead of treating staff as an asset."

—a healthcare worker in New Jersey

Driven by an insatiable desire for income, hospitals and health systems have systematically undervalued and underinvested in the healthcare workforce. While executives enjoy multimillion-dollar compensation packages, healthcare workers have been forced to do more with less. Lean staffing models that rely upon on-call, mandatory overtime, and travel nurses to flex staffing at peak census levels have resulted in dangerous patient loads, which stretched many healthcare workers beyond their limits long before the pandemic.

Reconfiguring Care Models Should Be Driven By Patient Outcome Standards

Following the adage "never let a good crisis go to waste," the healthcare industry has seized upon the COVID-19 pandemic to advance new cost saving strategies. One little-noticed provision of the CARES (Coronavirus Aid, Relief and Economic Security) Act gave the Centers for Medicare & Medicaid Services the authority to waive the requirement that hospitals provide 24-hour nursing services.

While this currently applies to only a limited total number of patients, the geographic footprint of these waivers is quite big with 206 hospitals run by 92 systems spanning 34 states have received temporary waivers to run what they call "hospital in the home" and "hospital without walls" programs. These models may foretell the future of care delivery, as evidenced by last year's announcement by Kaiser Permanente and the Mayo Clinic of a $100 million investment and joint partnership with at-home acute care company Medically Home.

Removing a patient from the hospital setting maximizes profit in the hospital industry by eliminating the need for ancillary services such as food services and environmental services and 24-hour nursing services. Instead, patients will care for themselves, and the hospitals will rely on occasional visits from other (typically lower-skilled and less-expensive) healthcare professionals, such as emergency medicine technicians or those employed by home health agencies. This does not address who is responsible for maintaining and monitoring the remote equipment, which is typically handled by a technician in the hospital.

Other "innovations" in healthcare include the "virtual ER," which allows doctors from hundreds of miles away to visit a hospital emergency room through webcam and speaker; the application of artificial intelligence (for example, to diagnose illnesses); and task automation.

There is also increased pressure, often driven by the healthcare industry, on scope of practice—essentially who is allowed to do what. In some instances, expanding scope of practice for a given discipline makes sense, such as allowing a highly trained advanced practice registered nurse to work independently and provide much-needed clinician care in rural America. However, expanding the scope of practice for less-skilled healthcare practitioners only to save money for the employer can impair the quality of treatment provided to patients. These decisions should be driven by increasing access to high-quality healthcare, and not from cost considerations as the healthcare industry tries to find new ways to increase revenue.

By investing in and expanding such programs, the healthcare industry shows that rather than trying to solve the staffing crisis, it is instead looking for ways to deliver cheaper care. To put it bluntly, the industry is sacrificing patient care to save money. Instead of degrading the standard of care, we would all be better served by appropriately staffed healthcare facilities.

Examples of Strategic Approaches

Secure federal and state protections for scope of practice and develop new patient care quality metrics for care delivered remotely that guide deployment and reimbursement levels.

A System That Values Safety and Accountability and Protects Healthcare Workers' Professional Practice Is Needed

Healthcare is a high-stakes environment with incredibly complex systems on both the clinical and the business sides. Factors like the evolution of different models of nursing care, reimbursement-driven documentation systems, and advances in research and treatment mean incessant change for direct-care clinicians.

The criminal conviction of a Tennessee nurse in 2022 following a deadly medication error sent chills throughout the nation's healthcare workforce. At a time when healthcare professionals feel beaten down and abandoned by their employers, there is now a great deal of anxiety about their personal liability if they make mistakes, which are more likely when they operate in unsafe facilities and manage unsafe patient levels. A renewed focus on just culture and other approaches that ensure administrators are held accountable is crucial. Not only does such fear of punishment hinder system improvement that requires reporting of errors, but it is also a further deterioration of working conditions. Exhaustion, mental health stress, fear of punishment and inadequate compensation make it hard to recruit and retain a workforce.

Examples of Strategic Approaches

Enact state and federal laws and regulations that protect the licenses, jobs and livelihoods of health professionals from unfair civil, administrative and criminal penalties that are the responsibility of an employer.

Consolidation Lowers Wages and Does Not Increase Quality

Consolidation has been a growing trend in the healthcare sector throughout the 21st century,[56] and the pandemic has only widened the economic gap between the large, prestigious healthcare networks and the remaining community-based hospitals and critical access hospitals, many of which are in rural America.

This widening gap leaves the community-based hospitals ripe for acquisition. During the peak of the pandemic, the finances of these two types of hospitals were legitimately stretched to the breaking point as they struggled to provide more expensive care, lost revenue from higher-yielding procedures that had been suspended and couldn't afford personal protective equipment (there were insufficient stockpiles of PPE). In fact, some facilities were merely days away from not being able to make payroll.

Meanwhile, the larger healthcare chains that have more diversified revenue streams were able to better mitigate the loss of revenue from the suspension of elective surgeries and had greater financial reserves

they could tap into to cover the growing costs. Indeed, during the peak of the pandemic, for-profit institutions like HCA Healthcare made record profits. Meanwhile, small, independent hospitals are now financially strapped and ripe for acquisition by larger, prominent systems, which have evolved into regional, multimarket systems. While advocates of consolidation often claim that it will ultimately improve the quality of care, there is no evidence to that effect. In fact, Dr. N.D. Beaulieu and Dr. Dafny Beaulieu found that, "Hospital acquisition by another hospital or hospital system was associated with modestly worse patient experiences and no significant changes in readmission or mortality rates. Effects on process measures of quality were inconclusive." Later, in 2020, E.S. Fisher and S.M. Shortell found that "greater financial integration was generally not associated with better quality."[57]

There is evidence however that consolidation imposes downward pressure on worker pay. Mergers that significantly reduce the number of hospitals in a local labor market have been found to lower wage growth for nurses and other skilled workers.[58] A recent study compared markets in which hospital mergers occurred between 2000 and 2010 to those that did not, and then looked at the effects on wages in the years afterward. According to the report "four years after these mergers greatly increased hospital concentration, nurses and pharmacy workers' wages were 6.8 percent lower, and skilled worker wages were 4 percent lower than they would have been absent the merger."

One possible explanation is that the hospital workforce has shifted toward lower-skilled, lower-wage workers within a category, for example from registered nurse to licensed practical nurse, following a merger.[59] This is consistent with "recent academic work has documented a negative relationship between labor market concentration and wages." [60] As a result, healthcare positions in those hospitals became less attractive and harder to fill.

The Unique Challenge of Rural Healthcare

Many of the healthcare workforce shortage areas identified by the Health Resources and Services Administration before the pandemic are located in urban and rural settings with significant percentages of minority and underserved residents.[61] This is particularly concerning because rural communities tend to have sicker, older and poorer residents than the country as a whole.[62]

Complicating the challenge of ensuring that rural communities have access to the healthcare professionals they need is the high rate of rural hospital closures that predate the pandemic. Since 2010, more than 120 rural hospitals have closed, 39 since 2018.[63] An additional 453 rural facilities can be considered "vulnerable" to closure based on performance levels, nearly one-quarter of all rural hospitals in the U.S.[64] Rather than closing, rural hospitals acquired by larger systems often have their services hollowed out as they become feeder facilities for larger hospitals located farther away. In Ohio, for example a number of rural labor and delivery departments have closed, forcing expectant parents to travel greater distances to give birth.

The community impact of rural hospital closures has been profound. As Mark Holmes, Ph.D., of the University of North Carolina found, "Rural hospitals are often an anchor institution, providing not only needed healthcare, but also a significant portion of jobs and billions of revenues in purchasing goods and services from other businesses. As a major employer in rural areas, hospitals and their closures have tremendous impacts on the economies of already vulnerable communities."[65]

Examples of Strategic Approaches

Increase oversight of merger and acquisitions practices in the healthcare industry, including examining the impact on patient access to quality care through the U.S. Federal Trade Commission, U.S Department of Justice and the Centers for Medicare & Medicaid Services, as well as greater state-level oversight.

AFT-Affiliated Unions Have Been Working on Aggressive Legislation to Curtail Corporate Practices in Healthcare

For example, the Oregon Nurses Association won legislation (H.B. 2362) in 2021 that requires approval from the Department of Consumer and Business Services or the Oregon Health Authority before any mergers, acquisitions, contracts or affiliations of healthcare entities and other entities if they are above a certain size in term of revenue or premiums. AFT Connecticut has been working on a variety of bills, including legislation to strengthen the state's Certificate of Need (CON) Program to prevent hospitals from unilaterally shutting down services like labor and delivery without going through the CON process. AFT Connecticut also has been working on legislation (H.B. 5575) that would establish community standards of health and hospital care for private for-profit hospital ownership in Connecticut as a means of prioritizing best-practice patient care over shareholder dividends and other unnecessary fee-for-service contracts. In New Jersey, the Health Professionals and Allied Employees is working on state legislation that would require contracts for sale of certain healthcare entities to preserve employee wages and benefits and honor collective bargaining agreements (NJ S. 315).

Section 6. Worker Voice and Trust

> *"It gives me hope that nurses haven't given up yet. Having a union, at least we have a voice and this week, we can speak up and have at least some protections against retaliation."*
>
> *—a healthcare worker in New Jersey*

Nurses ranked number one for the 20th year in a row in Gallup's annual public opinion survey on honesty and ethics in various professions in 2021. Following the COVID-19 pandemic, this same poll in 2021 found that 89 percent of Americans rated nurses' honesty and ethics as high or very high, a rating only surpassed by firefighters in 2001 following the terrorist attacks on 9/11.[66]

As frontline care providers, nurses and health professionals have invaluable insight into how each decision made by hospital administration impacts patient care. This expertise coupled with the trusted position healthcare workers hold in their communities should make it obvious to healthcare employers that healthcare workers are their greatest asset. Yet, too often health systems treat healthcare workers only as an expense to be controlled. When employers treat healthcare workers like disposable parts and not dedicated professionals, it is no surprise that workers experience burnout, hospitals experience turnover and, ultimately, patient care suffers.

Impact on Patient Outcomes

Once again, extensive research supports our frontline members' conclusions. Patients and staff both have better outcomes when healthcare workers have better work environments.

A 2019 meta-analysis of the association between nurse work environments and outcomes found that in hospitals with better nurse work environments, the odds of an adverse event or death were 8 percent

lower.[67] Additionally, a 2016 study found that in hospitals with poor nurse work environments, patients had a 16 percent lower likelihood of surviving an in-hospital cardiac arrest. The authors suggest that the link between safe staffing and in-hospital cardiac arrest survival might be especially strong because of the importance of quick intervention.[68]

When a nurse has an unsafe patient load or an otherwise unsafe work environment, the extra time it may take to get to a patient experiencing cardiac arrest could be fatal. AFT leaders hear devastating examples of these incidents from members who bear the consequences of unsafe staffing.

Meaningful Shared Governance Leads to Better Patient Outcomes

For nurses and health professionals, knowledge about patient outcomes does not only come from analytical research, but also from their direct care experience. It is not surprising then that research has also linked nurse involvement in meaningful shared governance with patient satisfaction.

The percentage of patients reporting they would definitely recommend the hospital was 14 points higher in hospitals where nurses were categorized as "most engaged" in shared governance based on an assessment of three measures in the Practice Environment Scale of the Nursing Work Index, according to a 2016 study. The same study found that nurses in hospitals where staff were most engaged in shared governance were 44 percent less likely to report overall quality of care was fair or poor and 48 percent less likely to report a lack of confidence that hospital management will resolve problems related to patient care.[69]

The best way to ensure a specific employer's shared governance is to make it part of a collective bargaining process that holds management accountable for including the perspective of direct care providers. The most successful model is the national partnership between the Kaiser Permanente systems and the AFT's Oregon Federation of Nurses and Healthcare Professionals and its other bargaining partners. Kaiser's shared governance is far from a panacea for all that ails the healthcare system, but it has proven to shape management decisions in a positive way, albeit not with complete employee satisfaction.

Committees Work Best When There Is a Robust, Meaningful Worker Voice

Knowing that nursing is the most trusted profession, that better working conditions for nurses result in better outcomes for patients, and that specifically involving nurses in shared governance increases patient satisfaction, hospitals and health systems should see obvious benefits to partnership. Robust staffing committees and other labor-management partnerships can pave the way forward, yet many committee structures serve only to silence workers' voices.

Union Contracts Are the Best Way to Ensure Workers' Voice

A collective bargaining agreement is the single most potent tool to ensure that healthcare professionals have a protected voice at their facility. CBAs create an accountable system where real discussion between labor and management takes place, giving workers more protection to speak up about difficulties. AFT-affiliated unions, like the Oregon Nurses Association, have successfully bargained for meaningful hospital committees. This includes Providence St. Vincent Medical Center where the ONA successfully bargained for clinical unit self-scheduling and the Oregon Health & Sciences University where ONA successfully bargained for unit-based nursing practices committees.

Examples of Strategic Approaches

The healthcare industry should respect the right of healthcare workers to form unions and immediately stop engaging in anti-union and union-busting tactics and, instead, develop labor-management partnerships that extend beyond the mandatory issues of bargaining.

Endnotes

[1] "Addressing Health Worker Burnout: The U.S. Surgeon General's Advisory on Building a Thriving Health Workforce (2022) https://www.hhs.gov/sites/default/files/health-worker-wellbeing-advisory.pdf

[2] https://www.aft.org/resolution/addressing-staffing-shortages-healthcare-workforce

[3] https://www.kff.org/report-section/kff-the-washington-post-frontline-health-care-workers-survey-toll-of-the-pandemic/

[4] Supplemental Health Care.(July 1, 2021) "5 Benefits of Fostering Diversity in Healthcare." Retrieved from https://www.shccares.com/blog/5-benefits-to-fostering-diversity-in-healthcare

[5] https://bhmt.org/who-we-are/

[6] https://www.clarabartonhs.org/apps/pages/index.jsp?uREC_ID=990599&type=d&pREC_ID=1306636

[7] https://www.nursingworld.org/organizational-programs/accreditation/ptap/

[8] Nerd Wallet analysis of 2019 federal student aid data from U.S. Department of Education: https://www.nerdwallet.com/article/loans/student-loans/average-nursing-student-debt

[9] https://www.insidehighered.com/quicktakes/2019/01/16/profit-nursing-graduates-more-likely-fail-licensure-test

[10] National Center for Education Statistics: https://nces.ed.gov/fastfacts/display.asp?id=76

[11] The Institute for College Access and Success: https://ticas.org/interactive-map/

[12] https://educationdata.org/student-loan-debt-by-gender

[13] https://educationdata.org/student-loan-debt-by-race

[14] https://www.aacnnursing.org/news-information/fact-sheets/nursing-faculty-shortage#:~:text=According%20to%20AACN's%20report%20on,%2C%20clinical%20sites%2C%20classroom%20space%2C

[15] American Association of Colleges of Nursing: https://www.aacnnursing.org/news-information/fact-sheets/nursing-faculty-shortage

[16] Nerd Wallet analysis of 2019 federal student aid data from U.S. Department of Education: https://www.nerdwallet.com/article/loans/student-loans/average-nursing-student-debt

[17] https://educationdata.org/student-loan-debt-by-race

[18] West, G., et al., "Staffing Matters—Every Shift: Data from the Military Nursing Outcomes Database Can Be Used to Demonstrate That the Right Number and Mix of Nurses Prevent Errors," *American Journal of Nursing*, December 2012; 112(12):22-27.

[19] Leigh J.P., et al., "California's Nurse-to-Patient Ratio Law and Occupational Injury," *Int Arch Occup Environ Health*, May 2015; 88(4):477-84. doi: 10.1007/s00420-014-0977-y. Epub 2014 Sep 13. Erratum in: Int Arch Occup Environ Health. May 2015 May;88(4):485-6.

[20] BLS, SOII, 2020, Table R8.

[21] Lillian Bensley, et al., "Injuries Due to Assaults on Psychiatric Hospital Employees in Washington State," *American Journal of Industrial Medicine* 31, no.1 (1997):92-99.

[22] BLS SOII, 2000, 2006, 2020, Table R8.

[23] Death on the Job: The Toll of Neglect, 2022 | AFL-CIO (aflcio.org)

[24] The Bureau of Labor Statistics did not report on the number of workplace homicides in healthcare and social assistance in 2020.

[25] BLS SOII, 2019, 2020, Table R8.

[26] Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health, "Violence," *Occupational Hazards in Hospitals*, 2002. Violence_10-03 (cdc.gov)

[27] U.S. Department of Labor, Occupational Safety and Health Administration, 2015, Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers (osha.gov).

[28] Lipscomb, Jane, "Violence in the Health Care Industry: Greater Recognition Prompting Occupational Health and Safety Interventions." In: Charney W, ed. *Essentials of Modern Hospital Safety.* Vol. 3. Boca Raton, Fla.: Lewis Publishers, 1994, pp. 29–104. 4

[29] Lipscomb, Jane, "Violence in the Workplace: a Growing Crisis Among Health Care Workers." In: Charney W., Fragala G., eds. *The Epidemic of Health Care Worker Injury*, 1999, Boca Raton, Fla.: CRC Press, pp.163–165. .

[30] Staggs, Vincent S. "Injurious Assault Rates on Inpatient Psychiatric Units: Associations with Staffing by Registered Nurses and Other Nursing Personnel," *Psychiatric Services*. November 2015, 66(11):1162-6.

[31] Geller, Jeffery L., "Reported Versus Actual Assault Rates,". *Psychiatric Services*. March 2016; 67(3):358.

[32] Arnetz J.E., et al., "Preventing Patient-to-Worker Violence in Hospitals: Outcome of a Randomized Controlled Intervention." *Journal of Occupational and Environmental Medicine*. January 2017; 59(1):18-27.

[33] Trinkoff, A.M. et al., Nurses Are More Exhausted Than Ever: What Should We Do About It?" *American Journal of Nursing, December* 2021; 121(12)18-28.

[34] Geiger-Brown, J. et al., "Sleep, Sleepiness, Fatigue, and Performance of 12-hour Shift Nurses." *Chronobiology International*, 2012; 29(2)211-9.

[35] Trinkoff, A.M. et al., "Nurses Are More Exhausted Than Ever: What Should We Do About It?" *American Journal of Nursing, December* 2021; 121(12)18-28.

[36] https://khn.org/news/as-coronavirus-spreads-widely-millions-of-older-americans-live-in-counties-with-no-icu-beds/

[37] WebMD, Feb. 1, 2021, Kathleen Doheny," Moral Injury: Pandemic's Fallout for Health Care Workers,"https://www.webmd.com/lung/news/20210201/moral-injury-pandemics-fallout-for-health-care-workers#:~:text=Moral%20injury%20occurs%20when%20health,to%20healing%2C%E2%80%9D%20Dean%20says

[38] KFF. (Sept. 30,2021). *Mental Health Care Professionals Shortage Areas (HPSAs)* Retrieved from https://www.kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[39] HRSA. (March 31, 2021) Designated Health Professional Shortage Area Statistics. Retrieved from file:///H:/Public_Mental%20Health%20mapping/BCD_HPSA_SCR50_Qtr_Smry.pdf

[40] KFF. (Sept. 30, 2021) *Mental Health Care Professionals Shortage Areas (HPSAs)* Retrieved from https://www.kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[41] https://onlinelibrary.wiley.com/doi/epdf/10.1111/acem.14519

[42] Chatterjee, R., (March 31, 2022) "A Nurse's Death Raises Alarm About the Profession's Mental Health Crisis." Retrieved from https://www.npr.org/sections/health-shots/2022/03/31/1088672446/a-nurses-death-raises-the-alarm-about-the-professions-mental-health-crisis?fbclid=IwAR0BQRhx5I7KVsmeX7URgDhppeRpJ6XJh7e-HlQErGRTtYU46pVLF5bNZMzY

[43] De Cordova et al., 2019: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6813777/pdf/nihms-1050516.pdf

[44] Lasater et al., 2021 https://pubmed.ncbi.nlm.nih.gov/34880022/

[45] McHugh et al., 2016 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4841621/pdf/nihms745619.pdf

[46] Tubbs-Cooley et al., 2013 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3756461/pdf/bmjqs-2012-001610.pdf

[47] Aiken et al., 2010 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2908200/pdf/hesr0045-0904.pdf

[48] https://www2.staffingindustry.com/Editorial/Daily-News/Healthcare-staffing-revenue-nearly-three-times-higher-than-three-years-ago-future-bright-Healthcare-Staffing-Summit-59628

[49] https://www.aha.org/costsofcaring

[50] https://www.aha.org/costsofcaring

[51] https://policyadvice.net/insurance/insights/healthcare-statistics/#:~:text=In%202018%2C%20this%20sector%20was,according%20to%20the%20latest%20estimates.

[52] https://policyadvice.net/insurance/insights/healthcare-statistics/#:~:text=In%202018%2C%20this%20sector%20was,according%20to%20the%20latest%20estimates.

[53] https://www.census.gov/library/stories/2020/10/health-care-still-largest-united-states-employer.html

[54] https://www.healthaffairs.org/do/10.1377/forefront.20220208.925255#:~:text=A%202021%20report%20from%20the,were%20paid%20on%20average%20%24600%2C000.

[55] https://www.healthaffairs.org/do/10.1377/forefront.20220208.925255#:~:text=A%202021%20report%20from%20the,were%20paid%20on%20average%20%24600%2C000.

[56] Beaulieu, N.D., Dafny, L.S., et al., "Changes in Quality of Care After Hospital Mergers and Acquisitions," *New England Journal of Medicine*, DOI: 10.1056/NEJMsa1901383, Jan. 2, 2020.

[57] Fisher, E.S., Shortell, S.M., et al., "Financial Integration's Impact on Care Delivery and Payment Reforms: A Survey of Hospitals and Physician Practices," *Health Affairs*, August 2020, 39:8.

[58] Prager, E., and Schmitt, M., "Employer Consolidation and Wages: Evidence from Hospitals," *American Economic Review*, February 2021, 111(2): 397–427, https://doi.org/10.1257/aer.20190690

[59] Prager, E., and Schmitt, M., "Employer Consolidation and Wages: Evidence from Hospitals," *American Economic Review,* February 2021, 111(2): 397–427, https://doi.org/10.1257/aer.20190690

[60] Prager, E., and Schmitt, M., "Employer Consolidation and Wages: Evidence from Hospitals," *American Economic Review*, February 2021, 111(2): 397–427, https://doi.org/10.1257/aer.20190690

[61] KFF. (Sept. 30, 2021). Mental Health Care Professionals Shortage Areas (HPSAs). Retrieved from https://www.kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[62] https://www.latimes.com/world-nation/story/2020-03-25/rural-coronavirus-hospitals-call-for-emergency-funding

[63] https://www.kff.org/coronavirus-covid-19/issue-brief/funding-for-health-care-providers-during-the-pandemic-an-update/

[64] National Rural Health Association, found at: https://www.ruralhealthweb.org/advocate

[65] Holmes, M.,Ph.D. (2022) "Rural Hospital Closure and Effect on Local Economies". Retrieved from https://www.ruralhealthresearch.org/projects/100002523

[66] Gallup, January 2022: https://news.gallup.com/poll/388649/military-brass-judges-among-professions-new-image-lows.aspx

[67] Lake, et al., 2019: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6615025/pdf/nihms-1024707.pdf

[68] McHugh, et al., 2016: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4841621/pdf/nihms745619.pdf

[69] Kutney-Lee, et al., 2016: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5117656/pdf/nihms-813280.pdf

A Union of Professionals

American Federation of Teachers, AFL-CIO
555 New Jersey Ave. N.W.
Washington, DC 20001
202-879-4400

aft.org AFTunion @AFTunion AFTunion

Statement for Hearing on
"Examining Health Care Workforce Shortages: Where Do We Go from Here?"

Senate Committee on Health, Education, Labor, and Pensions

February 16, 2023

Every American should be able to find a health care provider that is skilled in the type of care they need and able to work with them on a personal care plan together. Unfortunately, the current shortage of health care workers has negatively impacted a significant number of Americans' access to care. The implications of the health care worker shortage are wide-ranging, from the magnitude of provider burnout to the impact on patients in terms of cost and access.

AHIP[1] is pleased to see the Committee's focus on addressing the health care workforce shortage. Our members work every day with patients, providers, and communities to ensure that Americans have access to high-quality care and support. We are committed to enabling a strong and resilient health care workforce so health insurance providers may continue to deliver more choices, better quality, and lower costs for every American. We look forward to working with the Committee and other stakeholders to take decisive action to address this crisis and support the clinicians who care for patients.

Workforce Shortage
A strong workforce is essential to maintaining patients' access to high-quality care. COVID-19 placed a significant strain on our country's health system as providers dealt with the pandemic and patients delayed needed care, like preventive screenings and routine surgeries.

The effects of the COVID-19 pandemic and increased workloads on providers contributed to a trend of staffing shortages across the health system, which impacts the timeliness of patient care. The Association of American Medical Colleges projects that physician demand will grow faster than supply, leading to a shortage of between 54,100 and 139,000 physicians by 2033.[i] A recent nursing workforce analysis also found that total supply of registered nurses (RN) decreased by

[1] AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone.

more than 100,000 from 2020 to 2021 – the largest drop observed over the past four decades.[ii] And tragically, each year, roughly 400 physicians die by suicide.[iii]

Health care costs have increased due to the higher cost and decreased supply of health care workers. Provider shortages may mean clinicians have less time to spend with each patient, which can lead to worsening health disparities. Americans are feeling the impact of staffing shortages with longer wait times for routine preventive care, medical procedures, and emergency care.

Increasing the Workforce

One way that policymakers can help relieve overburdened clinicians and address the workforce shortage is to grow the pool of qualified providers. AHIP member organizations continue to work to provide incentives to increase the workforce. For example, L.A. Care has committed $8 million to medical school loan payment grants to make it easier for qualified students to train as providers.[iv]

Provider Burnout

A major contributor to health care workforce shortage is burnout, with more health care providers suffering from burnout than ever. A recent survey shows about 25% of clinicians are thinking about leaving the health care field entirely, primarily due to burnout.[v] According to the most recent U.S. Physician Burnout & Depression Report from Medscape, more than 50% of physicians report feeling burned out and nearly a 25% say they're depressed compared to 42% and 15% respectively five years ago.[vi]

Even before the COVID-19 pandemic, the National Academy of Medicine found that burnout had reached "crisis levels" in the U.S., with 35-54% of nurses and physicians and 45-60% of medical students and residents reporting symptoms of burnout.[vii] The U.S. Surgeon General, Dr. Vivek Murthy, also listed health care worker burnout in his top 5 urgent health care priorities.[viii]

Addressing provider burnout will require an all-hands-on-deck, multifaceted approach. Health insurance providers are committed to working with policymakers to adopt strategies for mitigation, including meeting mental health demands, growing telehealth, and investing in value-based care.

Meeting Mental Health Demands

One area where the health care workforce shortage is acute is in mental health care. Today, 130 million Americans live in places with fewer than one mental health care provider for every 30,000 people.[ix] An effective solution would be to create innovative programs to expand system capacity and increase the number of mental health care practitioners available.

AHIP encourages the Committee to promote proposals that expand our health care system's capacity and increase the number of mental health practitioners to meet and treat the growing

need. As demonstrated in AHIP Board of Directors' Statement of Commitment to improve access to mental health, when government resources are used to encourage people to enter the behavioral health field, health insurance providers will advocate for requirements that those providers participate in health plan networks, particularly in public programs – Medicare and Medicaid.[x]

Growing Telehealth

Telehealth and virtual care can also improve efficiency for health care providers to deliver care to patients. By delivering high-quality care through a convenient medium, providers view telehealth as an efficient and effective way to improve care outcomes, reduce unnecessary and costly visits to the emergency department, and make certain that patients get the right care at the right time and in the right setting.

As we seek to move past the COVID-19 public health emergency (PHE), we have the opportunity to permanently change the standard of care by retaining the policies that enabled recent telehealth advancements for patients and consumers. AHIP encourages the Committee to implement policies that support future telehealth innovation, such as making permanent flexibility around access and payment design, embracing audio-only telehealth, and allowing telehealth to be delivered across state lines.

In order to improve access to telehealth and reduce provider burden and burnout that contribute to workforce shortages, Congress should pass:

- The bipartisan *CONNECT for Health Act* (S. 1512 in the 117th Congress), which would expand access to telehealth services for Medicare-eligible Americans by promoting quality care and alternative payment models.
- The bipartisan *Ensuring Parity in MA and PACE for Audio-Only Telehealth Act* (S. 150 in the 117th Congress), which would allow diagnoses from audio-only telehealth services to count for Medicare Advantage (MA) risk adjustment. This will help ensure that health costs are adequately covered for seniors and people with disabilities.
- Policies that encourage access to telehealth by increasing flexibility for eligible providers, eligible services, and eligible technologies, and by allowing providers to practice across state lines for telehealth.
- Policies that increase broadband access in rural and other underserved areas.

Harnessing Measurement to Reduce Burden

The Core Quality Measures Collaborative (CQMC), a public-private multi-stakeholder initiative convened by AHIP and Centers for Medicare & Medicaid Services (CMS), can also play a crucial role in aligning payment measures and adopting standardized, evidence-based metrics that can improve provider decision-making and increase patient outcomes. By aligning quality measures across payers and supporting electronic reporting of measures, such as those recommended through CQMC, it can help reduce provider burden and increase job satisfaction.

CQMC recently released new reports that seek to reduce burden through digital measurement and fragmentation through voluntary alignment of measurement processes across payers. One report outlines a framework and action steps for leveraging data captured in digital sources like electronic health records and exchanging it using interoperable standards to maximize efficiency and reduce burden.[xi] The other report considers ways in which clinicians and payers could further collaborate on the broader measure model including existing best practices from around the country.[xii]

Performance measurement is an essential tool to improve the quality, safety, and equity of health care. AHIP encourages the Committee to promote policies, such as those outlined through CQMC, that harness technologies that enable access to new data sources and create efficiencies to permit the measurement of more facets of care that impact health while reducing the resources required.

Addressing Systemic Challenges

The workforce shortage issues extend beyond burnout. While a lot of work must be done to address the short-term challenges of health care worker shortages, we also recognize the need to address the long-term challenges, such as tackling health care prices that continue to escalate year after year or reducing health care disparities in underserved communities. These challenges can only be addressed if all health care stakeholders work collaboratively to ensure Americans have affordable access to the high-quality care they deserve.

Promoting Competition

Even with workforce demand outpacing supply, health care prices continue to escalate year after year, making coverage and care less accessible for everyone and exacerbating the effects of the shortage. As we seek to move past the COVID-19 pandemic, now is the time to take action to promote robust competition that is essential to providing all Americans with more health care choices and better quality at lower costs.

The Committee can work to improve health care affordability and access for every American by developing the following solutions affection provider staffing:

- Enact legislation to require public reporting of all private equity or hedge fund purchases of air or ground ambulance providers or facilities, emergency room physicians, and other specialty groups where there is evidence of high levels of concentration or low levels of network participation. These growing monopolies have the predictable effect of refusing to participate in networks in order to demand higher prices from health insurance providers, which results in higher premiums for everyone.
- Address anti-competitive contract terms, for example by enacting provisions such as those in the bipartisan *Healthy Competition for Better Care Act* (S. 3139 in the 117th Congress). Any legislative solution should also recognize that there are beneficial forms of integration of provider and payer functions, which should be outside the scope of such legislation and instead should be fostered to promote efficient, high-quality care models.

Engaging a Culturally Competent Workforce

Patient outcomes are based on access to high-quality providers. As such, there is a demand from patients for culturally competent care and a representative workforce. Diversifying and expanding the health care workforce with more community-focused staff, such as community health workers, peer support staff, and doulas, who have knowledge of communities and relevant lived experience to build trusting relationships with community members and help them address their needs. Moreover, engaging diverse talent pools can not only help improve workforce shortages, but also patient satisfaction.

While roughly 7% of U.S. physicians are Black or Hispanic/Latino, Black and Hispanic/Latino Americans account for over 30% of the total population. Over 25% of physicians serving through the National Health Service Corps identify as Black or Hispanic/Latino. More than 23.6 million patients in the United States receive care from National Health Service Corps and Nurse Corps providers, and the $1.5 billion will support over 22,700 providers committed to working in underserved communities. AHIP encourages the Committee to implement policies that facilitate and provide incentives to people of diverse backgrounds to enter the health care workforce, such as loan repayment and scholarship programs like the National Health Service Corps and Nurse Corps.

Health insurance providers are also implementing workforce development initiatives to address these issues and promote enhanced provider skills. For instance, Health Care Services Corporation (HCSC) is increasing the number of providers who receive value-based payments and including health equity as a core component of the quality program.[xiii] Blue Shield of California also is investing $7 million to create a new fellowship program at U.C. Berkeley School of Public Health to support graduate students from underrepresented communities.[xiv]

Health insurance providers are working hard to ensure everyone has an equal opportunity to thrive and achieve their best health. We will keep working every day to improve health equity by promoting diversity, equity, inclusion, and other factors that increase health care workforce participation and improve access to care for all patients.

Conclusion

AHIP appreciates the Committee's recognition of this important issue. We look forward to working with you to develop solutions that improve America's health care workforce shortage, reduce burden, and increase health care access and affordability for all Americans.

---

[i] https://www.aamc.org/news-insights/press-releases/new-aamc-report-confirms-growing-physician-shortage
[ii] https://www.healthaffairs.org/do/10.1377/forefront.20220412.311784/
[iii] https://www.aha.org/news/blog/2020-09-17-shining-light-physician-suicide
[iv] https://www.lacare.org/news/la-care-commits-nearly-8-million-medical-school-loan-repayment-grants
[v] https://www.bain.com/insights/a-treatment-for-americas-healthcare-worker-burnout/
[vi] https://www.medscape.com/slideshow/2023-lifestyle-burnout-6016058?faf=1#1.

[vii] https://nam.edu/systems-approaches-to-improve-patient-care-by-supporting-clinician-well-being/
[viii] https://www.hhs.gov/sites/default/files/health-worker-wellbeing-advisory.pdf
[ix] https://www.kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/
[x] https://www.ahip.org/resources/ahip-board-of-directors-statement-of-commitment-improving-access-to-and-quality-of-mental-health-and-addiction-support
[xi] https://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=98059
[xii] https://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=98063
[xiii] https://www.ahip.org/documents/202209-CoverageAtWork-Health-Equity-in-EPC-Issue-Brief.pdf
[xiv] https://news.blueshieldca.com/2022/05/19/blue-shield-of-california-to-invest-7-million-in-new-health-equity-fellowship-at-uc-berkeley-school-of-public-health

AMERICAN PHARMACISTS ASSOCIATION
STATEMENT FOR THE RECORD

BEFORE THE U.S. SENATE COMMITTEE ON HEALTH, EDUCATION, LABOR, & PENSIONS

EXAMINING HEALTH CARE WORKFORCE SHORTAGES: WHERE DO WE GO FROM HERE?

THURSDAY, FEBRUARY 16, 2023

2215 Constitution Ave. NW
Washington, DC 20037

800 237 2742
pharmacist.com

Chair Sanders, Ranking Member Cassidy, and Members of the Committee:

On behalf of our nations over 310,000 pharmacists, the American Pharmacists Association (APhA) is pleased to submit the following Statement for the Record to the U.S. Senate Health, Education, Labor, and Pensions (HELP) Committee for today's hearing, "Examining Health Care Workforce Shortages: Where Do We Go From Here?"

APhA is the largest association of pharmacists in the United States advancing the entire pharmacy profession. APhA represents pharmacists and pharmacy personnel in all practice settings, including community pharmacies, hospitals, long-term care facilities, specialty pharmacies, community health centers, physician offices, ambulatory clinics, managed care organizations, hospice settings, and government facilities. Our members strive to improve medication use, advance patient care, and enhance public health.

We share concerns identified by the Committee regarding health care workforce shortages across all sectors of the health care system. As you know, the U.S. Surgeon General issued an advisory in 2022 – Health Worker Burnout[1] – as a call for all health care organizations to support the mental health and well-being of health care workers so that they are able to best care for their patients. The pharmacy profession is not exempt from these concerns. Workload has increased over the course of the COVID-19 pandemic, but workforce issues were present prior to the pandemic, simply exacerbating an existing situation and shining a national spotlight on them. As a result, we are observing health care workers, including pharmacists and pharmacy technicians, leave the workforce.

Pharmacy Workforce Conditions
As early as the 1980s[2,3], articles were published describing pharmacist and pharmacy personnel working conditions and burn out. The practice of pharmacy has evolved since those initial articles were published, but workforce issues continue to permeate pharmacy practice settings. Pharmacists are highly trained medication experts providing accessible[4] direct patient care and medication distribution nationwide in all geographical areas to under-/uninsured[5], commercially insured, and Medicaid/Medicare eligible patients. Pharmacists and pharmacy personnel clearly demonstrated their essential role in our communities throughout the COVID-19 pandemic by administering 300+ million COVID-19 vaccines, conducting 42+ million COVID-19 tests, and contributing to billions of dollars in savings.[6,7]

---

[1] https://www.hhs.gov/surgeongeneral/priorities/health-worker-burnout/index.html
[2] https://doi.org/10.1016/S0160-3450(16)32767-2
[3] https://doi.org/10.1016/S0160-3450(16)31647-6
[4] https://pharmacist.com/Advocacy/Issues/Inequity-to-COVID-19-Test-to-Treat-Access-Pharmacists-can-help-if-permitted
[5] https://www.pharmacist.com/Publications/Pharmacy-Today/Article/serving-underserved-populations
[6] https://pharmacist.com/Practice/COVID-19/The-Essential-Role-of-Pharmacy-in-Response-to-COVID-19/Infographic
[7] https://pharmacist.com/Practice/COVID-19/The-Essential-Role-of-Pharmacy-in-Response-to-COVID-19

2215 Constitution Ave. NW
Washington, DC 20037
800 237 2742
pharmacist.com

Payment Issues Permeate Pharmacy
While the practice of pharmacy has evolved, payment and reimbursement models and mechanisms for pharmacist-provided patient care services and medication products have not. A lack of appropriate and equitable reimbursement for services, misaligned incentives, and harmful pharmacy benefit manager (PBM) business practices have negatively impacted pharmacy staffing and coverage models. These factors have contributed to an unsustainable payment model for medications under public and private health plans' pharmacy benefits and often a complete lack of a payment model for pharmacists' services under the medical benefit. A root cause of pharmacists not having the time they would like to spend with patients providing care is that staffing, coverage/overlap, and daily operating hours in many pharmacy locations continue to be decreased due to these payment model issues. These decreases in coverage and daily operating hours increase the pressures felt by pharmacists and pharmacy personnel to meet unrealistic quotas and metrics while still delivering the high-quality of care patients and providers have come to expect and deserve.[8]

Pharmacy Staff Concerns
Pharmacists and pharmacy personnel are fearful of speaking up about workplace conditions due to retaliation from employers and/or perceived unwillingness of employers to listen. The profession responded and pharmacy personnel are now using surveys fielded by state boards of pharmacy and pharmacy associations, in addition to the Pharmacy Workplace and Well-being Reporting (PWWR)[9] tool as ways to anonymously report what is happening in pharmacy practice. Categories for negative experience submissions to PWWR focus primarily on working conditions, staffing/scheduling, pharmacy metrics, and volume/workload expectation mismatched to hours available; a vast majority are indicated as recurring problems.[10]

Pharmacists rely on well-trained pharmacy technicians for many administrative responsibilities so that they have time to spend with providing care and services to their patients. Pharmacists cite that they are often alone in the pharmacy requiring them to do tasks that pharmacy technicians would normally do, and therefore not allowing them the time to spend with their patients. Why are they alone? Sometimes, it is due to scheduling formulas put in place by employers and sometimes it is due to shortages of pharmacy technicians. We have anecdotal reports that pharmacy technician pay[11] is less than what is being paid to those fulfilling online grocery orders – a position with less stress.

[8] https://www.pharmacist.com/APhA-Press-Releases/american-pharmacists-association-on-move-to-cut-pharmacy-hours
[9] https://pharmacist.com/Advocacy/Well-Being-and-Resiliency/pwwr
[10] https://www.pharmacist.com/DNNGlobalStorageRedirector.ashx?egsfid=KiyW2e6_98Y%3d
[11] https://www.ptcb.org/news/ptcb-releases-2022-pharmacy-technician-workforce-survey-results

Not a Pharmacist Shortage
Despite what is being purported in the media, there is not a shortage of pharmacists. There is a shortage of pharmacists willing to work in the current conditions, which are unsafe for them, their teams, and their patients.[12] Support of pharmacists and pharmacy personnel is needed from employers, insurers, lawmakers, and the public to ensure resource availability, address patient safety concerns, meet patient health care needs and expectations, and reduce stress and increase satisfaction of pharmacy personnel both now and in the future. As nearly 90% of the U.S. population lives within 5 miles of a community pharmacy[13], pharmacists are poised to support gaps in access to patient care services.

Pharmacists Can Ameliorate Health Care Worker Gaps
Recognizing that medically underserved areas exist and other types of health care workers are exiting their practice settings, pharmacists and pharmacy personnel are uniquely positioned to relieve some of the consequences of health care workforce shortages. Pharmacists' scope of practice has grown substantially across the country over the last 25 years, unlocking an array of new opportunities for pharmacists to provide added services and value to patients. Although there are similarities in the foundational services pharmacists provide to their patients, there is variability in the types of expanded services, collaboration potential, and spectrum of autonomy of practice between states due to differences in state laws and regulations. In order to leverage pharmacists to their full potential as a part of an interprofessional and collaborative health care team, there is a need to align their scope of practice with their education and training and cover pharmacists' services under the medical services side of Medicare Part B.

Pharmacists' foundational scope of practice traditionally has been limited to making medication therapy recommendations that require prescriber approval to make medication changes. Through expanded authorities, pharmacists can use their medication expertise to autonomously prescribe medications through various mechanisms. Pharmacists' prescriptive authority is variable from state-to-state and falls on a spectrum of how independently they may prescribe. Although pharmacists may have independent prescriptive authority for certain medications in rare instances, such as in Idaho, more commonly, pharmacists prescribe medications through collaborative practice agreements (CPAs), statewide protocols (SWP), and standing orders. SWPs and standing orders are commonly used to increase access to services provided by pharmacists in response to public health needs and disease states.

Foundational Scope of Practice is Generally Consistent Across States
- Assess medication therapies
- Recommend over-the-counter medications to patients and prescription products to prescribers
- Patient education
- Prevention and wellness services

[12] https://pharmacist.com/rewriting-narrative
[13] https://doi.org/10.1016/j.japh.2022.07.003

- Medication management services, including medication adherence, focused on optimizing the use of medications
- Safe dispensing of medications
- Pandemic authorities that are in effect until the public health emergency is lifted – order and administer COVID-19 tests, vaccinations, therapeutics

Collaborative Practice Agreements (CPAs)

- In all states except Delaware, pharmacists can enter into CPAs to provide certain services that expand the pharmacist's scope beyond foundational authorities.
- CPAs are voluntary agreements between pharmacist(s) and prescriber(s) where the prescriber delegates certain functions to the pharmacist, that often include initiating, modifying, and discontinuing therapy, and ordering and interpreting laboratory tests, according to the terms of the agreement.
- Examples of services that pharmacists provide under CPAs (per the individual agreement) include anticoagulation management, where the pharmacist orders or performs International Normalized Ratio (INR) tests and makes warfarin dosage adjustments; and hypertension management, where the pharmacist monitors the patient's blood pressure; manages medications, including initiating, modifying, and discontinuing therapy; and works with the patient on lifestyle modifications to achieve targeted clinical goals.

Statewide Protocols (SWPs) and Standing Orders

- In recent years, there has been an expansion in pharmacists' ability to provide services in response to public health needs and disease states.
- Examples of SWPs include HIV PrEP/PEP, hormonal contraceptives, tobacco cessation, naloxone provision/prescribing, test and treatment for minor ailments such as influenza and strep.

Expanded Scope of Practice

- Immunizations: Pharmacists have the authority to administer immunizations in every state, however, there is variability in pharmacist authority to prescribe immunizations independently or under SWPs or prescriptions from other prescribers, the type of immunizations pharmacists can administer, and to which patients.
- Medication Administration Services: In most of the U.S., pharmacists have broad authority to administer medications and support the self-administration of medications to patients. This authority positions pharmacists to be convenient access points for the administration of medications, such as long-acting injectables. However, in some states authority is limited to requiring administration be performed within a CPA and others limit the type of medications that can be administered, such as long-acting injectable antipsychotic medications.

Pharmacists Remain Ready to Help

APhA would like to thank the Committee for recognizing health care workforce shortages and taking steps to address the associated issues of workplace conditions, health care worker burnout, and general well-being. While pharmacists and pharmacy personnel are also subject to these issues, the profession remains steadfast in providing high quality, safe, accessible, and timely patient care and medications to our communities and can serve as a solution to addressing other health care worker gaps. Please contact Doug Huynh, JD, APhA Director of Congressional Affairs, at dhuynh@aphanet.org if you have any additional questions or additional information. Thank you again for the opportunity to provide comments on this important issue.

2215 Constitution Ave. NW
Washington, DC 20037

800 237 2742
pharmacist.com

A statement from the

American Society for Clinical Pathology and ASCP Board of Certification

Before the United States Senate

Committee on Health, Education, Labor, and Pensions

Hearing on "Examining Health Care Workforce Shortages: Where Do We Go from Here?"

February 16, 2023

The American Society for Clinical Pathology (ASCP) and ASCP Board of Certification (ASCP BOC) are submitting this statement urging the Committee to include medical laboratory professionals in its efforts to address healthcare staffing shortages.

ASCP represents more than 100,000 board certified pathologists, other physicians, and laboratory science professionals that lead the nation's efforts to diagnose and screen for diseases, such as diabetes; breast, lung, and prostate cancer; and more. ASCP is the world's largest organization representing pathology and laboratory medicine. In addition, the ASCP BOC's mission is to provide excellence in certification of laboratory professionals on behalf of patients worldwide. We provide the gold standard certification for medical laboratory professionals around the world and have certified more than 650,000 laboratory professionals in the United States and internationally.

The medical laboratory is in crisis, and its workforce has drastically diminished over the past several years, negatively affecting laboratories' abilities to deliver timely test results, which in turn affects the quality patient care. To address these problems, ASCP and the ASCP BOC urge the Federal government to broadly address the crisis affecting the entire healthcare workforce.

The Role of Laboratory Professionals in Patient Care

America's medical laboratory professionals form the backbone of our healthcare system. These individuals perform all manner of diagnostic, prognostic, and screening tests, from routine analysis of body fluids and tissue samples to highly complex genetic and molecular studies. They perform approximately 13 billion laboratory tests each year, the single highest-volume medical activity affecting Americans' healthcare. Laboratory professionals are also critical to efforts to identify and remediate the spread of infectious diseases, such as COVID-19.

The information these professionals provide is essential for patients to receive safe, effective, and efficient care from their providers. Recent surveys of physicians estimate that 60-70

percent of medical decisions regarding a patient's diagnosis and/or treatment are impacted by laboratory test results.[1,2] In addition, at least 80% of evidence-based medical guidelines developed to establish a diagnosis or manage disease depend on accurate and reliable laboratory information.[3]

The Shortage of Laboratory Professionals

Securing accurate, timely laboratory data, however, requires a robust, highly skilled workforce of medical laboratory scientists, technicians, and other laboratory professionals. Unfortunately, our nation's laboratory workforce, which has been dealing with persistent workforce shortages for years,[4] has been ravaged by the COVID-19 pandemic. During the pandemic, the demand for COVID-19 testing spurred a massive increase in overall test volume, more than doubling its pre-pandemic test volume for much of the Public Health Emergency.[5]

The demand for laboratory personnel outstrips supply. A recent ASCP survey found vacancy rates exceed 10 percent for many kinds of laboratory professionals, and that it often takes 6-12 months or longer to fill vacant positions. **The overwhelming majority of laboratories currently suffer from personnel shortages, and many are operating at or near crisis-mode**.

Factors Contributing to Laboratory Personnel Shortages

There are several factors contributing to laboratory staffing shortages, including stress, workload, burnout, and the high cost of education. According to a recent ASCP survey, approximately 85 percent of survey respondents reported burnout, with 37 percent citing inadequate staffing and intense workload as contributing factors. Many laboratory professionals (44 percent) indicated they were considering switching careers. These and other contributing factors are discussed in a recent report by the University of Washington's Center for Workforce Studies (UWCWS) and ASCP entitled, *The Clinical Laboratory Workforce: Understanding the Challenges to Meeting Current and Future Needs*, such as:

- Declining numbers of accredited laboratory education programs
- Fewer matriculating laboratory science students
- Increased professional workload
- Increased vacancy rates

Perhaps the key factor complicating the ability of medical laboratories to fill vacant positions is the high cost of college. According to the Education Data Initiative (EDI), the average total cost in 2022 of a bachelor's degree at a public college of university was $103K for in-state students, $174K for out-of-state students, and $219K for students at private colleges and universities.[6] When it comes to student loan debt, EDI estimates that the average totals are $132,268 for PhD holders, $80,494 for master's degree holders, $37,667 for bachelor's degree holders, and $20,000 for individuals with a two-year degree. That said, **student loan debt for healthcare professionals is $10,000 more than for any other profession**.[7]

The educational costs borne by health professionals also pose a considerable barrier to career entry for many underrepresented minority students, whose economic resources tend to be less than those of other students. On average, black college graduates have $25,000 more

academic debt while LGBTQ+ graduates have $16,000 more debt. Addressing the high costs of education is not only critical to addressing laboratory workforce shortages, but it is also key to improving diversity, equity, and inclusion in this workforce.

Recommendations
The UWCWS/ASCP report's accompanying *Blueprint for Action* outlines several recommendations necessary to strengthen the laboratory workforce including:

- Improving the visibility of public health and medical laboratory occupations
- Improving workforce recruitment and retention
- Improving diversity, equity, and inclusion within the laboratory workforce

One significant challenge, however, is that **medical laboratory professionals are generally not eligible for federal workforce development programs**, such as those administered by the Health Research and Services Administration (HRSA). With this in mind, ASCP and the ASCP BOC urge Congress to adopt the following policies to address the laboratory workforce shortage:

- Help aspiring laboratory professionals manage their educational costs through **funding and expanding eligibility for federal scholarship, fellowship, and loan repayment programs.**
- Utilize federal resources to **raise the visibility of careers like laboratory medicine** with support of career fairs, public service announcements, etc. Programs like the Centers for Disease Control and Prevention *OneLabVR*, for example, could be utilized at school career fairs to educate students about medical laboratory and other careers.
- Provide **funding to increase the availability and capacity of accredited laboratory training programs**. With the number of laboratory training programs dwindling, funding is needed to improve student access to training opportunities.
- Incentivize service as medical laboratory faculty by **increasing funding for the Faculty Loan Repayment Program**. Shortages of laboratory faculty stymie efforts to train the next cadre of laboratory professionals.
- **Expand the National Health Service Corps to include laboratory personnel.**
- **Increase access for laboratory and other health professionals to employment-based visas**.

In closing, ASCP and the ASCP BOC greatly appreciate the Committee's interest in the issue of healthcare workforce shortages. We recognize this is a complex problem, but it is one that must be tackled to meet the needs of patients. We believe there must be a private-public, collaborative approach to bolstering the laboratory workforce and improving its diversity. This is a challenge to which we are committed. At the same time, we believe there must be a

corresponding increase in the federal government's investments in workforce development. With college enrollments continuing to decline, the cost of inaction today poses serious challenges to the future of patient care.

ASCP and the ASCP BOC look forward to working with the Senate HELP Committee to address healthcare workforce shortages. If you have any questions, please contact Matthew Schulze, Director, ASCP Center for Public Policy at matthew.schulze@ascp.org.

[1] Sikaris, K. *Enhancing the Clinical Value of Medical Laboratory Testing*. Clin Biochem Rev. 2017 Nov; 38(3): 107–114. [Accessed 10/21/2021]. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5759162/
[2] *Rohr et al. The Value of In Vitro Diagnostic Testing in Medical Practice: A Status Report*. *PLoS One. 2016; 11(3): e0149856.* [Accessed 10/21/2021].
[3] The Lewin Group. *The value of diagnostic innovation, adoption, and diffusion into health care*. Jul, 2005. [Accessed 10/21/2021]. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5759162/
[4] Garcia, E. et. al, *The American Society for Clinical Pathology's 2018 Vacancy Survey of Medical Laboratories in the United States*. *American Journal of Clinical Pathology*, Volume 152, Issue 2, August 2019, Pages 155–168, https://doi.org/10.1093/ajcp/aqz046
[5] XIFIN Lab Volume Index. February 13, 2023.
[6] Hanson, Melanie. "Student Loan Debt Statistics" EducationData.org, October 26, 2022, https://educationdata.org/student-loan-debt-statistics.
[7] Sergeant, J. Health-Care Workers Struggle Most With Student Loan Debt, February 11, 2021. Financial Advisors Magazine. Accessed February 13, 2023.

CHILDREN'S HOSPITAL ASSOCIATION

Champions for Children's Health

Children's Hospital Association Statement for the Record

Senate Health, Education and Labor Committee Hearing
"Examining Health Care Workforce Shortages: Where Do We Go From Here?"
February 16, 2023

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, "Examining Health Care Workforce Shortages: Where Do We Go From Here?" It is vital that Congress act this year to address the health care workforce strains facing the nation and we urge you to pay particular attention to the pediatric workforce, which is experiencing significant challenges. The future of children's health in our nation is directly tied to the strength of our pediatric workforce and it is imperative that meaningful policy solutions are advanced to strengthen the pediatric workforce pipeline and to address recruitment, retention and diversity across the spectrum of pediatric providers and specialists.

In particular, the Children's Hospitals Graduate Medical Education (CHGME) program must be reauthorized this year. CHGME is the only national program focused on the training of pediatricians and pediatric subspecialists. Each year, CHGME-funded children's hospitals train thousands of general pediatricians, and pediatric specialists like child and adolescent psychiatrists, pediatric surgeons, pediatric cardiologists, dentists, podiatrists and more. This year's reauthorization of the National Health Service Corps is another opportunity for this committee to explore new and innovative policies to address the unique staffing challenges, especially for pediatric nurses, our nation's children's hospitals face to help ensure that the children, adolescents and young people we serve get the specialized care they need.

Children's hospitals are pediatric workforce training hubs, including training 50% of all pediatricians and a majority of the pediatric specialists in the United States as well as pediatric nurses, therapists, advance practitioners and technicians. Though they make up just 1% of all hospitals in the nation, CHGME-funded children's hospitals provide close to one-third of the inpatient hospital care received by children covered by Medicaid. We look forward to partnering with this committee to find workable and sustainable solutions to today's and tomorrow's pediatric workforce challenges.

Pediatric Provider Shortages

Over the last few years, most children's hospitals experienced unprecedented pediatric volumes driven by a substantial increase in childhood respiratory illnesses, like respiratory syncytial virus (RSV) and COVID-19 and compounded by the ongoing surge in mental health visits. The unparalleled numbers of children in need of specialized inpatient pediatric care have placed an extraordinary burden on our frontline providers, exacerbating persistent pediatric workforce shortages that have existed for years. Staff retention is a critical issue for children's hospitals and being chronically understaffed is restricting the care they can provide to pediatric patients. We are seeing nurses and other bedside staff reducing their work hours, with many others leaving health care completely. Most children's hospitals have been forced to rely on temporary staffing agencies to fill their workforce gaps at considerably higher costs than pre-pandemic levels, further straining financial resources. At the same time, some

Contact us: public.policy@childrenshospitals.org
600 13th St., NW | Suite 500 | Washington, DC 20005 | 202-753-5500
16011 College Blvd. | Suite 250 | Lenexa, KS 66219 | 913-262-1436
www.childrenshospitals.org | © Children's Hospital Association

children's hospitals have had to reduce their care capacity, with some forced to temporarily close entire pediatric intensive care units and other critical services.

Pediatric specialty care provided at a children's hospital requires extra time, monitoring, specialized medications and equipment, and specially trained health care providers who are compassionate and understand kids of all ages and from all backgrounds. Children's hospitals are increasingly the only places in their state and region with the breadth of pediatric specialists and subspecialists, the pediatric-appropriate medical equipment and other resources required to treat children, particularly those with rare and complex clinical conditions. Children with medical complexity or specialized health care needs rely on the care that they can only receive at a children's hospital by pediatric specialists.

The pediatric workforce shortages are happening across the hospital– from pediatric specialists, such as pediatric pulmonologists, to pediatric nurses and nurse practitioners to pediatric respiratory and speech therapists. Overall, we are seeing a decline in the number of medical students pursuing a career in pediatrics. In the last several years, there has been as significant decrease in the number of filled pediatric residency positions, with some pediatric specialty residencies having 20 to 40 percent fewer applicants. During that time, a number of adult specialties experienced an increase in applicants.[1] This decline is not a result of a decrease in positions or opportunities, but the result of inequities in reimbursement and the availability of targeted loan repayment programs, combined with the additional education and training needed to develop the unique skills needed to treat children.

The shortages we are experiencing amongst pediatric subspecialists is exacerbated by a severe pediatric nursing shortage, particularly nurses with the needed specialized training to work in a children's hospital. While nursing shortages occurred before the pandemic, they have been made worse by the COVID-19 pandemic, the more recent pediatric respiratory illness surges, and the mental health crisis facing our children and youth. Children's hospitals reported an increase of more than 76% in the quarterly turnover rate among registered nurses from the first quarter of 2019 to the third quarter of 2021.[2]

The pediatric nursing shortage is particularly problematic for children's hospitals, given the complexity of the health issues that they treat. Pediatric intensive care nursing requires a higher level of training and expertise, which limits the pool of nurses who can fill staffing gaps. Furthermore, pediatric nurses practicing at children's hospitals are at greater risk of burnout than nurses in other settings. Pediatric nursing is very labor-intensive and takes more time and emotional stamina than may be required for other patients. Pediatric nurses face multiple demands as they care for especially complex patients and try to balance the needs of their child patients and family members.

The drivers of the current nursing shortage that is confronting children's hospitals nationwide began prior to the pandemic. They include nursing school enrollment numbers that fell short of the projected demand for nursing services, coupled with a shortage of faculty to teach those seeking a nursing career. The additional training requirements that are needed to practice as a pediatric specialty nurse must be met through additional time in nursing school and onsite clinical training at a children's hospitals. In addition, a significant number of nurses are reaching retirement age, and COVID-19 led to a surge of nurses choosing to retire as a result of pandemic-related challenges and stress.

---

[1] *Pediatrics* (2021) 147 (6): e2020013292. https://doi.org/10.1542/peds.2020-013292

[2] Source: PROSPECT, the Children's Hospital Association and the nation's only financial and operational comparative data set for pediatrics.

We are also facing a severe shortage of pediatric home care nurses who have the very specialized skill set to care for children with medical complexity. Too often, children cannot be discharged home safely from the hospital because home care nursing support is not available, meaning they must remain in the hospital for weeks or even months until home support can be provided. Like the shortages affecting other types of pediatric nurses, these challenges are not new but have gotten worse in recent years.

The shortages of pediatric mental health providers are particularly troubling as our nation's children and youth continue to confront significant mental health challenges but are often unable to get the tailored care they need when they need it. There are too few pediatric mental health providers to ensure kids have access to the full continuum of care, from inpatient services to outpatient community-based services and supports. As a result, more and more children and families in crisis are suffering, waiting for beds in hospital emergency departments, while awaiting alternative placement options. 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, 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.

A key component of the future of pediatric care will be the development of a workforce that is responsive to the changing landscape of our communities while remaining focused on the goal of providing comprehensive and high-quality services required to deliver optimal child health. Solutions must be pediatric-specific and not based on Medicare metrics as children's hospitals operate outside of the Medicare program and care for very large numbers of pediatric Medicaid beneficiaries. Several key opportunities for congressional action to address our pediatric health and mental health workforce challenges are highlighted below.

Congressional Action Needed

Reauthorize CHGME. Congress must act this year to reauthorize CHGME. The program was established in 1999 because Congress recognized that a dedicated source of support for training in children's hospitals was necessary to strengthen the pediatric workforce. CHGME was created specifically to address the disparity between the funding that adult hospitals get through Medicare GME and the lack of federal funding for children's hospitals' training of the pediatric physician workforce. Children's hospitals do not care for Medicare-eligible adults so they are not eligible for Medicare GME support.

Since its inception, CHGME has enabled children's hospitals to dramatically increase pediatric training overall, and in particular, grow the supply of pediatric specialists. The 59 independent children's teaching hospitals that now receive CHGME support train more than 60% of all pediatric specialists – including 65% of all pediatric surgeons and most physicians in some fields like pediatric rehabilitation – and 50% of all pediatricians. In 2021, CHGME hospitals trained about 14,000 pediatric residents and fellows.

Beyond sustaining a critical supply of pediatricians, CHGME has enabled children's hospitals and their residents to provide significant value to the patients and communities they serve by advancing the quality of pediatric medical education, providing care for vulnerable and underserved children, and pioneering community-based pediatric

training. The residents and fellows whose training is supported by CHGME learn from experienced practitioners. They provide critical access to care for children in rural and urban underserved communities, provide medical homes, and address heath care disparities. Close to two-thirds of CHGME-funded physicians who completed their training programs choose to remain and practice in the state where they completed their residency. CHGME is critical to the national goal of ensuring comprehensive and timely access to care for America's children, including children in military families and those in underserved rural and urban communities.

Provide $738 million for CHGME in FY 2024. Funding CHGME at $738 million for FY 2024 is the critical step needed to help children's hospitals sustain their teaching missions and create a strong pediatric workforce pipeline for our children. Overall federal funding for CHGME currently represents just 2% of total federal spending on GME. CHGME funding support represents about half of the support provided to adult hospitals through Medicare GME and will decline to close to 46% of Medicare GME by 2026 if action is not taken. That gap in federal investments is contributing to worsening pediatric workforce shortages. CHGME funding needs to be better aligned with the funding provided to other types of provider training programs to ensure we can continue to take care of our nation's children, especially during health crises like we just experienced with RSV and flu and the ongoing mental health crisis.

Address the pediatric mental health workforce shortage. 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. Additional targeted funding for HRSA is needed to support training and development in children's hospitals, pediatric practice and clinical settings and related mental health disciplines providing pediatric behavioral health. These targeted programs can help mitigate the need for those interested in pursuing a career in the mental health field to take on a substantial amount of debt or front the cost of their education and training.

Expand existing HRSA programs to target pediatric clinicians. Existing loan forgiveness programs can sometimes be difficult for pediatric providers – physicians, nurses and allied health providers – to access. We, therefore, support strengthening the Pediatric Subspecialty Loan Repayment program, which provides loan forgiveness for pediatric subspecialists, including mental health providers, practicing in underserved areas.

Possible additional approaches to mitigate pediatric workforce challenges that we encourage the committee to explore include ways to expand access to current workforce development and loan relief programs – in addition to the Pediatric Subspecialty Loan Repayment Program – to ensure that they are accessible to providers in pediatric subspecialty fields. Examples include modifications to the National Health Service Corps and the Health Professions Shortage Areas requirements to expand their pediatric workforce footprint in vulnerable rural and urban settings; direct support to children's hospitals and related training entities to expedite the move of pediatric clinicians from the classroom to the bedside; and targeted funding to implement and expand pediatric nursing and other pediatric health professionals loan forgiveness programs. We also urge Congress to exercise its oversight responsibilities to monitor and assess workforce funding and initiatives for their impact on pediatrics, and to investigate private sector actions that are impacting children's hospitals' nurse retention and recruitment, such as those of nurse staffing agencies.

In addition, we encourage the committee to explore how to sustainably expand the reach of programs, such as the Minority Fellowship Program and similar efforts, to enhance support for the participation of fellows who plan to serve pediatric populations. The value of a diverse pediatric health and 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.

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.

Statement for the Record
American Nurses Association
Examining Health Care Workforce Shortages: Where Do We Go From Here?
U.S. Senate Committee on Health, Education, Labor & Pensions
February 16, 2023

The American Nurses Association (ANA), representing the interests of the nation's 4.4 million registered nurses (RN) and advanced practice registered nurses (APRN), commends the Committee on Health, Education, Labor & Pensions for convening this hearing on "Examining Health Care Workforce Shortages: Where Do We Go From Here?," and appreciates the opportunity to submit this statement for the record.

ANA is committed to advancing the nursing profession by fostering high standards of nursing practice, promoting a safe and ethical work environment, bolstering the health and wellness of nurses, and advocating on health care issues that affect nurses and the public. ANA is at the forefront of improving quality of health care for all. Nurses work in a variety of health care settings, including in rural, urban, and underserved areas. They also work in a variety of specialties, and, for many, they are the sole and trusted provider in a community.

Nursing is a complicated field requiring the RN to not only understand hard sciences but also develop the emotional intelligence to empathize with patients and families. They must have sound critical thinking skills, react to rapidly changing situations, be physically and mentally strong, and not fatigued to be successful. Patients go to hospitals for nursing care and hospitals cannot operate without RNs.

Current challenges with nurse staffing shortages are not new—this crisis has been growing for decades and was further exacerbated by the COVID-19 pandemic. The nursing shortage harms not only nurses, but patients as well, as studies show quality care decreases when nurses are stretched too thin.

ANA urges Congress to take meaningful action in the three areas highlighted below to increase the number of nurses educated and alleviate the burden on those who have served their communities throughout the pandemic. These actions will help to ensure a robust, appropriately valued workforce both now and in the future.

Increasing the Nursing Workforce Pipeline

ANA urges the Committee to address the nurse shortage crisis by considering and passing the Future Advancement of Academic Nursing (FAAN) Act (S.246/H.R.851 in the 117th Congress) which supports nursing educational programs to grow, hire more faculty, and strengthen the future workforce of nurses.

Expanding the number of nurses to respond to the current and future needs of the population is a critical step towards solving the shortage, especially in rural and underserved areas. A well-prepared nurse workforce that is adequately supported is critical now and in the event of any future public health emergencies to ensure patients have continued access to quality, needed services.

8515 Georgia Ave., Suite 400
Silver Spring, MD 20910
www.nursingworld.org

Addressing Workplace Violence

An important factor in addressing health care workforce shortages is ensuring protections in the workplace through a workplace violence prevention standard. Nurses are four times as likely to experience violence at work than other professions. All of this has increased significantly because of the COVID-19 pandemic. As such, ANA urges the Committee to consider and pass the Workplace Violence Prevention for Health Care and Social Service Workers Act (S. 4182/H.R. 1195 in the 117th Congress). This legislation has passed the U.S. House of Representatives twice with bipartisan support. It requires the Department of Labor (DOL) to issue an interim, and later final, occupational safety and health standard that requires employers to take actions to protect workers and other personnel from workplace violence within one year. DOL has said they are working on a standard for more than a decade. One in four nurses are assaulted at work. Nurses are more abused than police officers and prison guards. These statistics are unacceptable and workplace violence must be addressed as the Committee explores solutions to provider shortages.

Nurse Burnout

During the COVID-19 pandemic, everyday Americans saw thousands of stories about nurses quitting their jobs, retiring early, or leaving the profession altogether. The issues that caused nurses to leave are not new – they're decades in the making. They all contribute to "burnout" amongst nurses. The U.S. Bureau of Labor Statistics estimated that more than half a million RNs would retire by the end of 2022 and projects the need for 1.1 million new RNs. Burnout and resulting shortages will only get worse unless Congress, the Administration, and health care facilities act to place more value on RNs and improve their work environments.

Major contributing factors to nurse burnout include being forced to work more hours in a shift or over the course of a week than an individual nurse determines is safe for patients and their own mental and physical well-being.

As the Committee considers policy solutions to address mental well-being and burnout, ANA stands ready to work with Senators on this important topic.

Thank you for your leadership in holding this hearing and giving nurses the opportunity to provide input on the critical topic of ensuring the nursing workforce is robust today and in the future. ANA stands ready to work with the Committee to implement policy solutions to comprehensively address the nation's health workforce challenges. If you have any questions, please contact Tim Nanof, Vice President of Policy and Government Affairs, at (301) 628-5081 or Tim.Nanof@ana.org.

8515 Georgia Ave., Suite 400
Silver Spring, MD 20910
www.nursingworld.org

STATEMENT FOR THE RECORD:
LEADINGAGE

Senate Health, Education, Labor and Pensions (HELP) Committee Hearing:

"Examining the Health Care Workforce Shortages: Where Do We Go from Here?"

February 16, 2023

2519 Connecticut Ave., NW | Washington, DC 20008-1520
P 202.783.2242 | F 202.783.2255 | LeadingAge.org

We are pleased to submit this statement from LeadingAge. LeadingAge represents nearly 5,000 nonprofit, mission-driven aging services providers, including affordable senior housing, life plan communities, nursing homes, hospice, home health and home and community-based services. Alongside our members and 38 state partners, we applaud the Senate, Health, Education, Labor and Pensions (HELP) Committee for holding a hearing on February 16, 2023, titled, "Examining Health Care Workforce Shortages: Where Do We Go from Here?"

Exploring the shortage of health care providers is of tremendous importance to our organization. However, workforce shortages, exacerbated by the COVID-19 pandemic, has impacted most long-term care providers. The shortage of aging services professionals at all levels in long-term care is also truly a crisis, and aging services providers across the country need immediate support to expand and enhance the workforce.

These long-standing workforce challenges are punctuated by the fact that the population of the United States is rapidly aging. In fact, 10,000 people turn 65 every day, many of whom will need professional aging services at some point in their lives. By 2034, the United States will need 3.5 million caregivers working in the field of long-term services and supports (LTSS) to keep up with the growing needs of our rapidly aging population.

While there is no single solution to address the health care workforce shortage, LeadingAge encourages the Senate HELP Committee to simultaneously consider initiatives that would help mitigate the health care workforce crisis impacting aging services providers. America's current long-term care system needs a workforce sufficient to ensure older adults and families can access needed care and services. Solving this requires an all-of-government approach to help fund and build training programs, change policy to help build the prospective pipeline (aging population + increased demand) and, most importantly, increase reimbursement to improve wages.

What the Workforce Crisis Looks Like for LeadingAge Members

The top findings in a LeadingAge Poll, conducted in June 2022, using an opportunity sample, illustrated what the workforce crisis looked like on the ground for LeadingAge members on a variety of issues.

Staff Vacancies: Many of the Poll respondents indicated significant staff vacancies. Several respondents shared they needed to hire at least 50 percent more staff to become fully staffed. In one case, a member that has 35 full-time positions when fully staffed, currently has 20 vacancies. Another has 102 full-time positions when fully staffed and they had 49 vacancies. In many cases administrative and managerial staff were filling in to cover for staff vacancies. On-call staff are also filling positions, or existing staff work extra hours.

When we asked why staff were leaving at such high rates, three-quarters said staff were leaving for higher pay. Further, 72 percent of the respondents told us that staff were leaving because they are simply burned out. We also heard from members the pipeline is not getting stronger – CNA, home health care and nursing positions are especially difficult to fill.

Temporary Staffing Agencies: To assist with filling staff vacancies, the majority of LeadingAge members have relied more heavily on temporary or agency staff, especially since the pandemic. Fifty-seven percent of Staffing Poll respondents indicated they are filling vacant positions with temporary or agency staff. One nursing home respondent shared 75 percent of their shifts were filled with agency staff.
Several respondents commented they were unable to use temporary or agency staff, because agencies did not have available staff, or providers can't get contracts at a reasonable price. It was also noted that agency staff were also sadly not dependable; attendance issues are much more common and agency staff might not show up.

Staff Recruitment: The Poll responses reflected significant shortages for in demand workers who provide high-quality long-term services and supports (LTSS) for older adults. Certified Nurse Assistants (CNAs)

were the most difficult for 52 percent of the respondents to recruit; 24 percent had difficulty attracting Registered Nurses; and 9 percent had difficulty hiring Licensed Practical Nurses.

Employee Retention: Retention was also one of the top operational challenges for LeadingAge members. When asked about the reasons staff members were leaving their organization, an overwhelming 75 percent of the responses shared "seeking better pay" as a reason. Anecdotally, many LeadingAge providers said it was hard to compete with retail and food service businesses in the area when most aging services providers are dependent on public programs and must tie wages to reimbursement.

Inability to Admit Residents and Consumers: When asked whether respondents were unable to admit residents or consumers due to staffing shortages, 42 percent indicated they are experiencing significant challenges. Additionally, 25 percent of the respondents had challenges so significant that they had to shut down units or building or neighborhoods due to staffing shortages.

Nursing Homes Facing Staffing Shortages

It is tragically unfortunate that many older adults and their families are currently facing immediate challenges accessing care and services to remain independent, safe, and healthy. Longstanding workforce shortages in the aging services sector, exacerbated by the COVID-19 pandemic, mean families' requests for care go unfilled and countless nursing homes in communities across the country are closing their doors permanently. Data from the American Health Care Association and the National Center for Assisted Living (AHCA/NCAL) in 2021, determined 99 percent of U.S. nursing homes are facing staffing shortages and 96 percent of U.S. assisted living communities are facing staffing shortages. More recently, analysis prepared by LeadingAge New York, reflects nationwide there were at least 139 skilled nursing home closures in 2022.

Additional LeadingAge Member Experiences with the Workforce Crisis

During a LeadingAge Congressional Briefing held in the spring of last year, Mike King, LeadingAge Board Chair and President & CEO of Volunteers of America (VOA), Alexandria, VA, spoke about VOA's experiences with the workforce crisis. He noted there was a 35-45 percent turnover rate within VOA facilities, and many had a 25-30 percent vacancy rate and could not accept new clients who came in.

Tom Syverson, Director of Government Relations, Good Samaritan Society / Sanford Health, Sioux Falls, South Dakota, noted during the briefing, that the workforce crisis they were experiencing could not be overstated. In fact, it was nothing like what he ever experienced in his 35-year career in post-acute services. To address this crisis, the Good Samaritan Society supported their staff by making historic investments in wages ($15 million in 2021 and more than $5 million in June 2022), created an online CNA training course. Additionally, Sanford Health had a goal to recruit 500 international nurses, as their hospitals also battled this healthcare staffing crisis. While their turnover rate was below the national average, but staffing challenges remained a real concern, and it was even more challenging in rural areas. In June 2022, they had more than 2,540 open positions, which meant about 1 in 4 positions were not filled. It also took on average 60 to 65 days to fill an open position.

Throughout the last two years, Sanford Health had to increase the number of agency staff across all of their locations to maintain the level of quality care their residents deserved. And, in some cases, they were paying physician wages for RNs in their buildings (instead of paying around $40 per hour they are paid $120 or more per hour). Additionally, in half of their 22 states where they operated, Medicaid reimbursement rates did not even cover their staffing costs and staffing accounted for only two thirds of their total costs.

Rob Lahammer, Vice President of Engagement and Advocacy, Presbyterian Homes and Services, Roseville, MN, highlighted how their turnover ran anywhere from 40-120 percent. As a result, Presbyterian Homes implemented an International Nurse Recruitment program, which has deployed over 450 people into its organization, by mostly recruiting nurses from the Philippines.

What Are the Solutions?

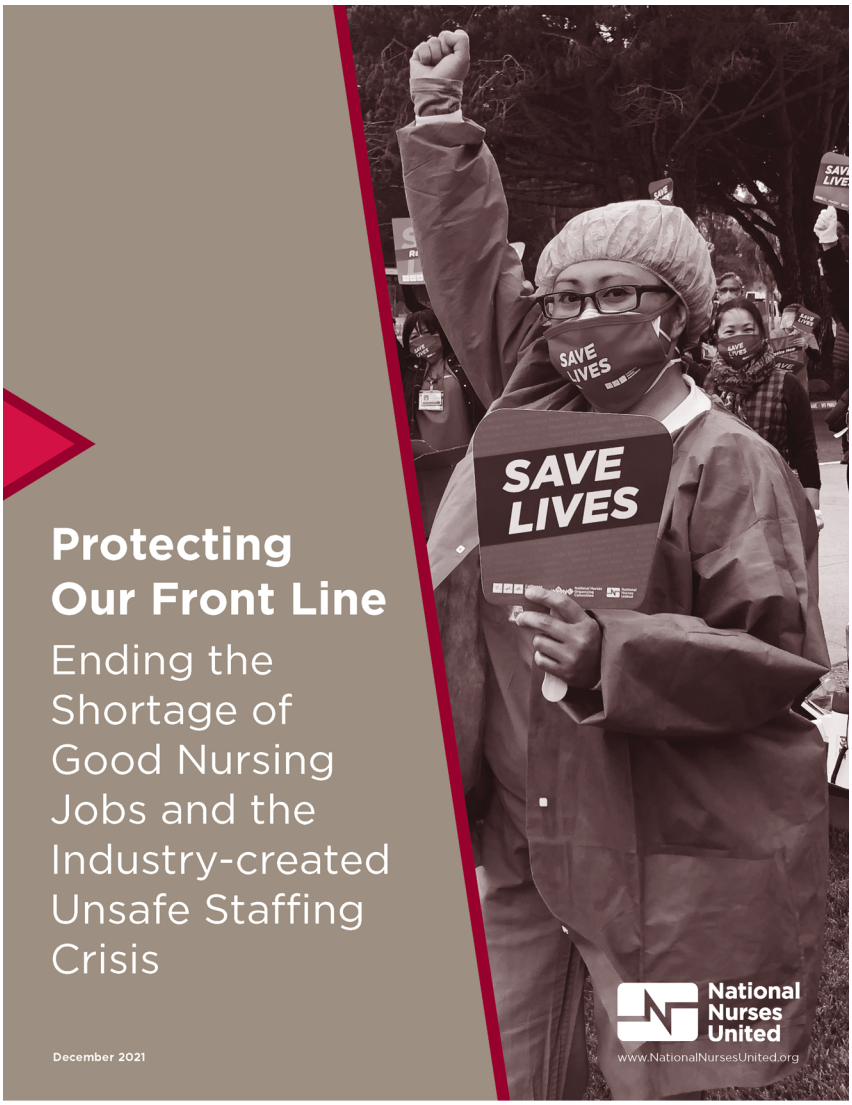
LeadingAge looks forward to working with the Senate HELP Committee to provide the high-quality care our nation's older adults need to live with dignity and respect. We also encourage careful consideration be given to policies that would:

1. Bolster wages for dedicated aging services professionals, to allow aging services professional to increase pay for direct care staff to at least a living wage (a wage that matches state/local living expenses and conditions).
2. Offer incentives and federal grants to expand training and advancement opportunities, specifically those that hold promise for aging services professionals career opportunities.
3. Mitigate temporary nurse staffing agencies price gouging and empower the Federal Trade Commission and state attorneys general with enforcement tools to ensure their rates are not in violation of federal antitrust or consumer protection laws.
4. Establish and retain a pipeline of foreign aging services workers, and support the enactment of a temporary guest worker program for aging services providers, and improve the process for allowing registered nurses to permanently enter the U.S.
5. Implement common sense proposals, that must be met, prior to the Center for Medicare and Medicaid Services mandating staffing ratios in nursing homes.
6. Enact meaningful, equitable long-term care financing.

To learn more about our association's 2023 Workforce Policy Platform, visit: https://leadingage.org/2023-policy-platform/.

You can also access a LeadingAge fact sheet, "Workforce Crisis: America Needs Caregiving Professionals Now" here

If you have any questions or would like to discuss these issues further, please contact Andrea Price-Carter, Director of Workforce and Technology Policy, Aprice-carter@LeadingAge.org.


SAVE LIVES
SAVE LIVES
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

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.

TABLE OF CONTENTS

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,[1] 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.[2] 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.[3] Moreover, HHS projected that most states (43) would have surpluses in 2030.[4] **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.[5]

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 117th Congress)
- Pass the Workplace Violence Prevention for Health Care and Social Service Workers Act (H.R. 1195 in the 117th Congress)
- Pass the Protecting the Right to Organize (PRO) Act (S. 420, H.R. 842 in the 117th Congress)
- Pass the VA Employee Fairness Act (S. 771, H.R. 1948 in the 117th 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.[6]

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 117th 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,[7] 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.[8] 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.[9] 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,[10] 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,[11] back and other musculoskeletal injuries,[12] and infectious diseases, including Covid-19.[13] 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.[14]

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.[15] 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.[16] Compared to pre-pandemic violence-related injury rates, the rate of workplace violence injuries for RNs in private industry has increased by 30 percent.[17] 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.[18]

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.[19]
- The risk for workplace violence injuries was twice as high for lower-staffed hospitals as compared to higher-staffed hospitals.[20]
- 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.[21]

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.[22] 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.[23] As the name suggests, scripting requires nurses to use specific language when talking to patients.[24] 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."[25] 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".[26] According to one description of the AIDET model: "Staff members trained in AIDET are encouraged to use the words 'excellent' and 'thank you' liberally."[27] 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.[28] 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."[29]

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.**[30]

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.[31]

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.[32] 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.[33] 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.[34] 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.[35]

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.[36]

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.[37] 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.[38] 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."[39] 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.[40]

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.[41] 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.[42] 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.[43]

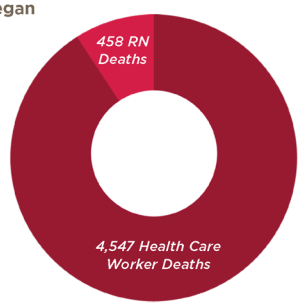
The hospital industry's "just-in-time" model that tightly manages inventory has been disastrous during the Covid-19 pandemic.[44] Although infectious disease surges are unpredictable, they are inevitable. Hospitals should have been better prepared, especially in the instance of Covid-19 because the initial 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,[45] 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.[46]

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.

Figure 1. **Known Covid-19 Deaths of RNs and Health Care Workers Since Pandemic Began**



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.[47] 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,[48] to notify nurses of a Covid-19 exposure,[49] 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.[50]

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.[51] In sum, nurses of color comprise 49.9 percent of the nurse deaths[52] but only 24.1 percent of the RN workforce.[53] In addition, only 4.0 percent of the RN workforce are Filipinx[54] and only 12.4 percent are Black, thus these nurses are dying at far greater rates than their white colleagues.[55] 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.[56]

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.[57] 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.[58] 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.[59] 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[.]"[60] 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.[61] Yet since the pandemic began, numerous studies have demonstrated that the virus is airborne,[62] thus making respirators critical to preventing infections among health care workers.[63] 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.[64] The hospital industry's active opposition to providing nurses with respiratory protection exemplifies a failure to recognize nurses' innate value as human beings.

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.

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[65] and fired workers for doing so.[66] Other employers went so far as to prohibit RNs from bringing in their own respirators[67] and even "yank[ed] masks off workers' faces[.]"[68] 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.[69] Contrary to scientific consensus, the AHA denied the need for respirators as recently as March 11, 2021 in Congressional testimony:

> 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.[70]

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,[71] 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[.]"[72]

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.[73] 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.[74] 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.[75]

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.[76] 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.[77] 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.[78]

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.[79] 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."[80]

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.[81] 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.[82] Even after taking these precautions, she maintained her distance by staying "6 feet away from everyone [she] love[s.]"[83] 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.[84]

Regardless of whether they sleep at home, many nurses have been separated from their families for extended periods of time.[85] 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.[86]

Many nurses sent their children away voluntarily to protect them.[87] 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.[88]

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.[89] 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[.]"[90] Family members — especially children — may ask health care workers to leave their jobs.[91]

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.[92] 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.[93] 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.[94] 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
Infecting 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.[95] This study did not link these scores to specific work- or home-related experiences.

NNU has been conducting surveys of RNs throughout the pandemic.[96] 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.[97] 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.[98] 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,[99] particularly Filipinx and Filipinx-American nurses.[100] Similarly for Black health care workers, the anti-Black racism and white supremacy espoused by President Trump, and rampant 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.[101] Taken together, the cumulative effects are causing some Black health care workers to experience debilitating depression and trauma.[102]

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%

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.[103] 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."[104] 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."[105] 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[.]"[106]

Large percentages of hospital RN respondents across multiple NNU surveys have reported worsening staffing conditions during the pandemic.[107] 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.[108] 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.[109] 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.**[110]

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.[111] 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).[112]

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.[113] 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).[114] 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."[115] She adds that many nurses "are scared they'll make a deadly mistake."[116] Research confirms the detrimental effect working under crisis standards of patient 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[.]"[117]

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.[118] 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.[119] Drawing on work by subject matter experts,[120] 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.[121] 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.[122] 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.[123]

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.[124] 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.[125]

Table 4. **Moral Injury Risk Factors Experienced by Nurses**

Moral injury risk factors[126]	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)	» A child, vulnerable family member, or friend dies, particularly if infected by the nurse or if the person dies without the nurse being present. » A patient or coworker dies because a nurse wearing contaminated PPE infects them with Covid-19. » 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: › Working in an area outside of the nurse's competency due to Covid-19-related crisis staffing; or › Working under crisis standards of patient care in which insufficient staffing, medical equipment, or supplies are a proximate cause of the death.
Increased risk of moral injury if leaders are perceived to not take responsibility for the event(s) and are unsupportive of staff	» A nurse works without appropriate health and safety protections (e.g., insufficient PPE or poor patient isolation protocols) because: › Employer denies the need for airborne protections; or › Employer prioritizes profits over worker safety.
Increased risk of moral injury if staff feel unaware or unprepared for emotional/ psychological consequences of decisions	» 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. » A nurse caring for patients who are separated from their families because of visitor restrictions.
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)	» A nurse, family member, friend, or coworker develops a severe case of Covid-19. » A family member, coworker, or friend dies from Covid-19. » Racism, racial and police violence, or death in the society in which the nurse lives. » A nurse experiences stigma and discrimination.
Increased risk of moral injury if there is a lack of social support following the PMIE.	» A nurse is isolating from family and friends to avoid transmitting Covid-19. » An excessive workload keeps a nurse from accessing social support.

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 117th 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.[127]

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.[128] 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.[129]
- 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).[130]
- 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.[131]
- 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.[132]
- 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."[133]

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.[134] 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."[135] 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.[136] 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.[137]

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.[138] (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 117th 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.*[139]
- *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.[140]

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."[141]

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.[142] 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.[143] 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.[144]

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.[145] 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.[146]

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 117th Congress).*
- *Passing the VA Employee Fairness Act (S. 771, H.R. 1948 in the 117th 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.[147] 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.[148] 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.[149] 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.[150] Despite the hospital industry's reliance on federal health care dollars for its continued existence,[151] 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 combating 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.[152] 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.[153]

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.[154] 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."[155]

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."[156]

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.[157] 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."[158] 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.[159]

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.[160] 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."[161] 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[.]"[162] 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.[163] 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.

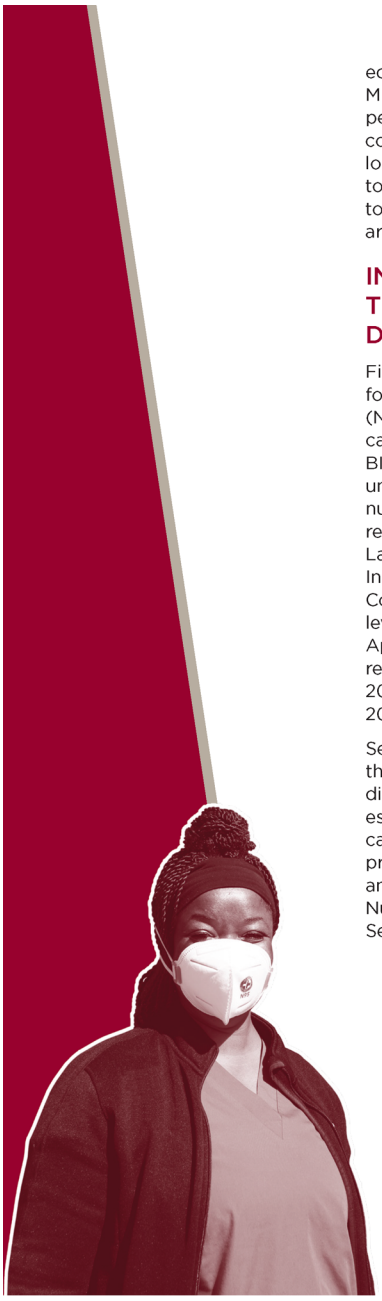
NNU has long advocated for more funding for public nursing schools and incentives to recruit nursing faculty. To ensure a diverse and sustainable nursing workforce, Congress should increase funding for nursing workforce programs that reduce the financial barriers to becoming a nurse imposed by the exorbitant 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,[164] 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.[165] 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.[166]

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.[167] 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.[168] 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.[169] 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)."[170] 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.[171]

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.[172]

» **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.[173] 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.[174]

- **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.[175] 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[176] 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.

ENDNOTES

1 National Council of State Boards of Nursing. Nov 6, 2021. "Active RN Licenses, A Profile of Nursing Licensure in the U.S." National Council of State Boards of Nursing. **https://www.ncsbn.org/6161.htm** As the National Council of State Boards of Nursing data excludes Michigan RNs, the number reflects the number of RNs employed in Michigan. The Michigan data comes from U.S. Bureau of Labor Statistics. 2021. "May 2020 Occupational Employment and Wages." U.S. Department of Labor. **https://www.bls.gov/oes/home.htm**.

2 U.S. Bureau of Labor Statistics. 2021. "May 2020 Occupational Employment and Wages." U.S. Department of Labor. **https://www.bls.gov/oes/home.htm**.

3 Health Resources and Services Administration. 2017. "National and Regional Supply and Demand Projections of the Nursing Workforce: 2014-2030." U.S. Department of Health and Human Services. **https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/nchwa-hrsa-nursing-report.pdf**.

4 Ibid.

5 Agency for Healthcare Research and Quality. 2019. "National Healthcare Quality and Disparities Report." U.S. Department of Health and Human Services. **https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrdr/2019qdr-cx061021.pdf**.

National Advisory Council for Nurse Education and Practice. 2013. "Achieving Health Equity through Nursing Workforce Diversity." U.S. Department of Health and Human Services. **https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/nursing/reports/2013-eleventhreport.pdf**.

Phillips J, Malone B. 2014. "Increasing Racial/Ethnic Diversity in Nursing to Reduce Health Disparities and Achieve Health Equity." *Public Health Rep*. 129 Suppl 2(Suppl 2):45-50. **https://pubmed.ncbi.nlm.nih.gov/24385664/**.

6 National Nurses United. 2020. "Deadly Shame: Redressing the Devaluation of Registered Nurse Labor Through Pandemic Equity." National Nurses United. **https://www.nationalnursesunited.org/sites/default/files/nnu/graphics/documents/1220_Covid19_DeadlyShame_PandemicEquity_WhitePaper_FINAL.pdf**.

7 For example, see article by Bean M, Masson G. Oct 4, 2021. "The less-discussed consequence of healthcare's labor shortage." Becker's Hospital Review. **https://www.beckershospitalreview.com/patient-safety-outcomes/the-less-discussed-consequence-of-healthcare-s-labor-shortage.html**. S

8 Aiken L et al. 2000. "Hospital Restructuring: Does it Adversely Affect Care and Outcomes? *J Nurs Adm*. 30(10):457-65. doi:10.1097/00005110-200010000-00003.

DeMoro D. 2000. "Engineering a Crisis. How Hospitals Created a Shortage of Nurses." *Revolution*. 1(2):16-23. PMID: 12018079.

Gordon S. 1997. "What Nurses Stand For." *Atlantic Monthly*. 279(2):81. **https://www.theatlantic.com/magazine/archive/1997/02/what-nurses-stand-for/376776/**.

Norrish B, Rundall T. 2001. "Hospital Restructuring and the Work of Registered Nurses." *Milbank Q*. 79(1):55-79. doi:10.1111/1468-0009.00196.

Shogren E et al. 1996. "Issues Update: Restructuring May Be Hazardous to Your Health." *Am J Nursing*. 96(11):64-66.

9 Lasater K et al. 2021. "Chronic Hospital Nurse Understaffing Meets COVID-19: An Observational Study." *BMJ Quality & Safety*. 30:639-647.

10 Pajer N. Jan 26, 2021. "What Frustrates Nurses the Most Right Now in the COVID-19 Pandemic." *Huffington Post*. **https://www.huffpost.com/entry/what-is-frustrating-nurses-covid-pandemic_l_600f0a4fc5b6a46978d3844c**.

Silver-Greenberg J et al. Jun 8, 2020. "Hospitals Got Bailouts and Furloughed Thousands While Paying C.E.O.s Millions." *New York Times*. **www.nytimes.com/2020/06/08/business/hospitals-bailouts-ceo-pay.html**.

11 National Nurses United. 2021. "Injury to None: Preventing Workplace Violence to Protect Health Care Workers and Their Patients." National Nurses United. **https://www.nationalnursesunited.org/sites/default/files/nnu/documents/0221_HS_WPV_InjuryToNone_Brief.pdf**.

12 Zwerdling D. Feb 18, 2015. " Hospital to Nurses: Your Injuries are not Our Problem." *NPR*. **https://www.npr.org/2015/02/18/385786550/injured-nurses-case-is-a-symptom-of-industry-problems**.

13 National Nurses United. "Deadly Shame..." (2020).

14 See ibid. and the results from NNU's sixth survey of RNs on Covid-19. National Nurses United. Sep 27, 2021. "National Nurse Survey Reveals That Health Care Employers Need to Do More to Comply with OSHA Emergency Temporary Standard." National Nurses United. **https://www.nationalnursesunited.org/press/national-nurse-survey-reveals-health-care-employers-need-to-do-more-to-protect-workers**..

15 U.S. Bureau of Labor Statistics. 2020. "Occupational Injuries and Illnesses and Fatal Injuries Profiles." U.S. Department of Labor. **https://www.bls.gov/iif/oshwc/osh/case/cd_r100_2020.htm**.

16 In 2020, the violence-related injury rate for workers overall in the U.S. was 4.0 per 10,000 full-time employees compared to the rate for RNs at 18.2 per 10,000 full-time employees. Ibid.

17 In 2019, the violence-related injury rate for RNs in private industry in the U.S. was 14.0 per 10,000 full-time employees. U.S. Bureau of Labor Statistics. 2019. "Occupational Injuries and Illnesses and Fatal Injuries Profiles." U.S. Department of Labor. **https://www.bls.gov/iif/oshwc/osh/case/cd_r100_2019.htm**. For a discussion of the increase in workplace violence during the Covid-19 pandemic, see National Nurses United. Nov 2021. "Workplace Violence and Covid-19 in Health Care: How the Hospital Industry Created an Occupational Syndemic." National Nurses United. **https://www.nationalnursesunited.org/sites/default/files/nnu/documents/1121_WPV_HS_Survey_Report_FINAL.pdf**.

18 In 2020, the musculoskeletal disorder rate for workers overall was 26.9 per 10,000 full-time employees and the back injury rate for workers overall was 13.6 per 10,000 full-time employees. U.S. Bureau of Labor Statistics. "Occupational Injuries..."(2020).

19 Lipscomb J et al. 2004. "Health Care System Changes and Reported Musculoskeletal Disorders Among Registered Nurses." *Am J Public Health*. 94(8):1431-36. **https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1448467/**.

20 Lee S et al. 1999. "Work-related Assault Injuries Among Nurses." *Epidemiology*. 10(6):685-91. **https://pubmed.ncbi.nlm.nih.gov/10535781/**.

21 Aiken L et al. 2002. "Hospital Nursing Staffing and Patient Mortality. Nurse Burnout, and Job Dissatisfaction." *JAMA*. 288(16):1987-93. **https://pubmed.ncbi.nlm.nih.gov/12387650/**.

22 Johansen M. 2014. "Conflicting Priorities: Emergency Nurses Perceived Disconnect Between Patient Satisfaction and the Delivery of Quality Patient Care." *Journal of Emergency Nursing* 40(1):13-19.

Moffatt-Bruce S et al. 2015. "Facing the Tension between Quality Measures and Patient Satisfaction." *American Journal of Medical Quality* 30(5):489-490.

Numerous articles have been written about the conflicts between patient satisfaction scores and quality health care. For example, see Tevis S et al. 2014. "Can Patients Reliably Identify Safe, High Quality Care?" *Journal of Hospital Administration* 3(5):150.

23 Ibid.

24 Nelson R. 2012. "Patient Satisfaction Metrics: Customer Service or Quality Care?" *Am J Nursing*. 112(8):18-19.

25 Studer Group. 2021. "AIDET Patient Communication." **https://www.studergroup.com/aidet**..

26 Welch S. Dec 15, 2015. "AIDET: A Popular Way of Improving Patients' Care Experience." *ACEP Now*. **https://www.acepnow.com/article/aidet-a-popular-way-of-improving-patients-care-experience/**.

27 Ibid.

28 Nelson R. "Patient Satisfaction Metrics..." (2012).

29 Welch S. "AIDET..." (Dec 15, 2015).

30 Tardiff C. 2012. "Patient Satisfaction Metrics." Letter to the editor. *Am J Nursing*. 112(12):12.

31 Miller J. 2012. "Patient Satisfaction Metrics." Letter to the editor. *Am J Nursing*. 112(12):12.

32 Hospitals' restriction of professional judgment affects other clinicians besides RNs. For example, physicians at a California hospital contend that the system to which the hospital belongs has standardized clinical guidelines through a shared electronic health record system that are "often driven by cost considerations" and that the guidelines "often [conflict] with their own judgment of best medical practices." Wolfson B. Apr 13, 2012. "Orange County Hospital Seeks Divorce From Large Catholic Health System." *Kaiser Health News*. **https://khn.org/news/article/orange-county-hospital-seeks-divorce-from-large-catholic-health-system/**.

33 Hong J et al. 2021. "Disappearing Expertise in Clinical Automation: Barcode Medication Administration and Nurse Autonomy." *J Am Medical Informatics Association: JAMIA* 28(2):232-238. doi:10.1093/jamia/ocaa135.

34 See discussion of the literature, MacKinnon K, Butcher DL, Bruce A. 2018. "Working to Full Scope: The Reorganization of Nursing Work in Two Canadian Community Hospitals." *Global Qualitative Nursing Research*. 11. doi:10.1177/2333393617753905.

35 See ibid.

Pine A. 2014. "On Caring: Solidarity Anthropology (or, How to Keep Health Care from Becoming Science Fiction)." In Stryker R, González R. "Up, down, and Sideways: Anthropologists Trace the Pathways of Power." *Berghahn Books*.

36 Counter-intuitively, the hospital industry's insistence on hiring nurses with bachelor's degrees rather than nurses with associate degrees seems to have been replaced hypocritically with a willingness to use licensed practical nurses with less education and clinical experience. For example, the American Hospital Association (AHA) offers the following solution to the RN staffing crisis: "Team-based staffing: One RN supervises a team of licensed practical nurses, aides and other support staff caring for a group of patients." Although AHA mentions both ADNs and BSNs in this white paper, nowhere does AHA advocate hiring more ADNs, yet the report seems to celebrate the expansion of BSN programs. However, that discussion is beyond the scope of this report. American Hospital Association. 2021. "2022 Health Care Talent Scan." American Hospital Association. 14. **https://www.aha.org/system/files/media/file/2021/10/AHA-Health-Care-Talent-Scan-2022.pdf**.

37 Smiley R. 2019. "Survey of Simulation Use in Prelicensure Nursing Programs: Changes and Advancements, 2010–2017." *J Nurs Reg*. 9(4):48-61.

38 National Council of State Boards of Nursing. 2013. "Member Board Profiles: Educational Programs." National Council of State Boards of Nursing. **https://www.ncsbn.org/Educational_Programs_Entry_into_Practice.pdf**.

39 Spector N et al. 2018. "Board of Nursing Approval of Registered Nurse Education Programs. *J Nursing Regulation*. 8(4):22-31.

40 Ibid.

41 NNU calculations based on Health Resources and Services Administration, National Center for Health Workforce Analysis. 2019. "2018 National Sample Survey of Registered Nurses: Brief Summary of Results." U.S. Department of Health and Human Services. **https://data.hrsa.gov/DataDownload/NSSRN/GeneralPUF18/nssrn-summary-report.pdf**; and

U.S. Census Bureau. 2019. "QuickFacts." **https://www.census.gov/quickfacts/fact/table/US/PST045219-nc-est2019-sr11h**.

42 National Nurses United. Feb 28, 2020. "Nation's Hospitals Unprepared for COVID-19." National Nurses United. **https://www.nationalnursesunited.org/press/nations-hospitals-unprepared-covid-19**.

43 National Nurses United. Mar 27, 2020. "National Nurses United is Stepping Up Pressure On Hospital Employers Across the United States to Provide Safer Facilities." National Nurses United. **https://www.nationalnursesunited.org/press/national-nurses-united-stepping-pressure-hospital-employers-across-united-states-provide**.

44 O'Leary L. Mar 19, 2020. "The Modern Supply Chain is Snapping." *The Atlantic*. **https://www.theatlantic.com/ideas/archive/2020/03/supply-chains-and-coronavirus/608329/**.

45 Jewett C. Nov 4, 2021. "Patients Went Into the Hospital for Care. After Testing Positive There for Covid, Some Never Came Out." *Kaiser Health News*. **https://khn.org/news/article/hospital-acquired-covid-nosocomial-cases-data-analysis/**.

46 This definition is a composite that comes primarily from Morley G et al. May 2019. "What is 'Moral Distress'? A Narrative Synthesis of the Literature." Nurs Ethics. 26(3): 646–62. doi:10.1177/0969733017724354. Citing Jameton A. 1984. Nursing Practice: The Ethical Issues. Prentice-Hall. With additional material from Varcoe C et al. Mar 2012. "Moral Distress: Tensions as Springboards for Action." HEC Forum. 24(1): 51–62. doi:10.1007/s10730-012-9180-2.

47 Coleman J. Mar 26, 2020. "Photo Shows NY Hospital Staff Using Trash Bags as Protective Gear." *The Hill*. **https://thehill.com/policy/healthcare/489622-photo-shows-staff-using-trash-bags-as-protective-gear-in-hospital-system**.

Sanchez T. Apr 2, 2020. "Coronavirus: Nurses are Wearing Trash Bags at One Bay Area Hospital Facing a Protective Equipment Shortage." *San Francisco Chronicle*. **https://www.sfchronicle.com/bayarea/article/Coronavirus-Nurses-are-wearing-trash-bags-at-one-15172777.php**.

48 Jewett C. Nov 4, 2021. "Patients Went Into the Hospital for Care. After Testing Positive There for Covid, Some Never Came Out." *Kaiser Health News*. **https://khn.org/news/article/**

hospital-acquired-covid-nosocomial-cases-data-analysis/.

49 Gold J, Hawryluk M. May 13, 2020. "Hospital Workers Complain of Minimal Disclosure After COVID Exposures." *Kaiser Health News*. **https://khn.org/news/hospital-workers-complain-of-minimal-disclosure-after-covid-exposures/**.

50 The data on infection and death rates in this paragraph is from an unpublished update as of November 29, 2021, of National Nurses United. Updated Mar 2021. "Sins of Omission: How Government Failures to Track Covid-19 Data Have Led to More Than 3,200 Health Care Worker Deaths and Jeopardize Public Health." National Nurses United. **https://www.nationalnursesunited.org/sites/default/files/nnu/documents/0321_Covid19_SinsOfOmission_Data_Report.pdf**.

51 Ibid.

52 Ibid.

53 U.S. Bureau of Labor Statistics. Jan 2020. "Household Data, Annual Averages, Employed Persons by Detailed Occupation, Sex, Race, and Hispanic or Latino Ethnicity." U.S. Department of Labor. **https://www.bls.gov/cps/cpsaat11.pdf**.

54 The U.S. Bureau of Labor Statistics does not disaggregate Filipinx RNs from Asian RNs. This statistic comes from McFarling U. Apr 28, 2020. "The Pandemic is Taking an Outsized Toll on Filipino American Nurses." *STAT*. **https://www.statnews.com/2020/04/28/coronavirus-taking-outsized-toll-on-filipino-american-nurses/**.

55 U.S. Bureau of Labor Statistics. "Household Data..." (Jan 2020).

56 McFarling U (Apr 28, 2020).

57 Wingfield A. May 14, 2020. "The Disproportionate Impact of Covid-19 on Black Health Care Workers in the U.S." *Harvard Business Review*. **https://hbr.org/2020/05/the-disproportionate-impact-of-covid-19-on-black-health-care-workers-in-the-u-s**.

58 Nguyen L et al. Jul 31, 2020. "Risk of COVID-19 Among Front-Line Health-Care Workers and the General Community." *Lancet*. 5(9): E475-E483. doi:10.1016/S2468-2667(20)30164-X.

59 Ibid.

60 Grimm CA. Apr 3, 2020. "Hospital Experiences Responding to the COVID-19 Pandemic: Results of a National Pulse Survey March 23–27, 2020." Office of the Inspector General. U.S. Department of Health and Human Services. **https://oig.hhs.gov/oei/reports/oei-06-20-00300.pdf**.

61 American Hospital Association. Mar 11, 2021. "Statement of the American Hospital Association for the Workforce Protections Subcommittee of the Committee on Education and Labor of the U.S. House of Representatives 'Clearing the Air: Science-Based Strategies to Protect Workers from COVID-19 Infections.'" American Hospital Association. **https://www.aha.org/testimony/2021-03-11-aha-statement-clearing-air-science-based-strategies-protect-workers-covid-19**.

62 Studies on COVID-19 airborne transmissibility include:

Bourouiba L. Mar 26, 2020. "Turbulent Gas Clouds and Respiratory Pathogen Emissions: Potential Implications for Reducing Transmission of COVID-19." *JAMA*. 323(18):1837–38. doi:10.1001/jama.2020.4756.

Lednicky et al. 2020. "Viable SARS-CoV-2 in the Air of a Hospital Room With Covid-19 Patients." *International J Infectious Diseases*. 100:476-482. doi: 10.1016/j.ijid.2020.09.025.

van Doremalen N et al. Apr 16, 2020. "Aerosol and Surface Stability of SARS-CoV-2 as Compared with SARS-CoV-1." *N Engl J Med*. 382:1564–67. doi:10.1056/NEJMc2004973.

Santarpia et al. Jul 21, 2020. "The Infectious Nature of Patient-Generated SARS-CoV-2 Aerosol." Preprint. *medRxiv*. doi: 10.1101/2020.07.13.20041632.

Wolfel R et al. Apr 1, 2020. "Virological Assessment of Hospitalized Patients with COVID-2019." *Nature*. 581: 465–69. doi:10.1038/s41586-020-2196-x.

For additional studies, see National Nurses United's COVID-19 bibliography at this link: **https://www.nationalnursesunited.org/covid-19-bibliography**.

63 Studies on the need for respirators to protect health care workers from COVID-19 infections include:

Chen W et al. Jul 2020. "To Protect Healthcare Workers Better, To Save More Lives." *Anesth & Analg*. 131(1): 97–101. doi:10.1213/ANE.0000000000004834.

Feldman O et al. Apr 27, 2020. "Exposure to a Surrogate Measure of Contamination from Simulated Patients by Emergency Department Personnel Wearing Personal Protective Equipment." *JAMA*. 323(20): 2091–93. doi:10.1001/jama.2020.6633.

Liu M et al. Jun 10, 2020. "Use of Personal Protective Equipment Against Coronavirus

Disease 2019 by Healthcare Professionals in Wuhan, China: Cross Sectional Study." *BMJ*. 369:m2195. doi:10.1136/bmj.m2195.

For additional studies, see National Nurses United's COVID-19 bibliography at: **https://www.nationalnursesunited.org/covid-19-bibliography**.

64 An open letter to the World Health Organization from 239 scientists also invokes the precautionary principle but does not make any recommendations for health care settings. See Morawska L, Milton D. Jul 6, 2020. "It Is Time to Address Airborne Transmission of Coronavirus Disease 2019 (COVID-19)." *Clinical Infectious Diseases*. 71(9):2311-2313. doi:10.1093/cid/ciaa939.

65 Gallegos A. Mar 25, 2020. "Hospitals Muzzle Doctors, Nurses on PPE, COVID-19 Cases." *Medscape*. **https://www.medscape.com/viewarticle/927541**.

Scheiber N, Rosenthal B. Apr 27, 2020. "Nurses and Doctors Speaking Out on Safety Now Risk Their Job." *The New York Times*. **https://www.nytimes.com/2020/04/09/business/coronavirus-health-workers-speak-out.html.**

66 Perkins T. Apr 27, 2020. "These Workers Spoke Out. Their Hospitals Fired Them." *HuffPost*. **https://www.huffpost.com/entry/hospitals-fire-doctors-nurses-covid-19_n_5ea2fcb1c5b6f9639813d50b**.

Scheiber N, Rosenthal B (Apr 27, 2020).

67 Lacy A. Mar 24, 2020. "Kaiser Permanente Threatened to Fire Nurses Treating COVID-19 Patients for Wearing Their Own Masks, Union Says." *The Intercept*. **https://theintercept.com/2020/03/24/kaiser-permanente-nurses-coronavirus/**.

68 Whitman E. Mar 20, 2020. "'Taking Masks Off Our Faces': How Arizona Hospitals Are Rationing Protective Gear." *Phoenix New Times*. **https://www.phoenixnewtimes.com/news/arizona-hospitals-rationing-masks-protective-gear-banner-11459400**.

69 American Hospital Association. May 14, 2020. "Letter to Nancy Pelosi." American Hospital Association. **https://www.aha.org/system/files/media/file/2020/05/web-AHALettertoHouseonHEROESAct051420final.pdf**.

Mason D, Friese C. "Protecting Health Care Workers Against COVID-19 — and Being Prepared for Future Pandemics." *JAMA Health Forum*. Mar 19, 2020. **https://jamanetwork.com/channels/health-forum/fullarticle/2763478**. Citing Kopp E. "Hospitals Want to Kill a Policy Shielding Nurses from COVID-19 Because There Aren't Enough Masks." *Roll Call*. Mar 3, 2020. **https://www.rollcall.com/2020/03/13/hospitals-want-to-kill-a-policy-shielding-nurses-from-covid-19-because-there-arent-enough-masks/**..

70 American Hospital Association. Mar 11, 2021. "Statement of the American Hospital Association for the Workforce Protections Subcommittee of the Committee on Education and Labor of the U.S. House of Representatives 'Clearing the Air: Science-Based Strategies to Protect Workers from COVID-19 Infections.'" American Hospital Association. **https://www.aha.org/testimony/2021-03-11-aha-statement-clearing-air-science-based-strategies-protect-workers-covid-19**.

71 California Hospital Association. Mar 12, 2020. "Letter to the California Congressional Delegation." California Hospital Association. **https://www.calhospital.org/sites/main/files/file-attachments/ca_delegation_-_covid-19_requests_-_final.pdf**.

Gollan J, Shogren E. May 12, 2020. "31,000 and Counting." *Reveal*. https://revealnews.org/article/31000-and-counting/. Cites to Letter from Washington Congressional Delegation to CDC Director Redfield. March 4, 2020. **https://www.documentcloud.org/documents/6884965-WA-Delegation-Letter-to-Redfield.html**.

For an in-depth discussion of CDC's problematic position on airborne transmission of Covid-19 and health care workers' need for respiratory protection, see NNU's white paper: National Nurses United. "Deadly Shame..." (2020).

72 Centers for Disease Control and Prevention. Updated Sep 16, 2021. "Strategies for Optimizing the Supply of N95 Respirators." Centers for Disease Control and Prevention. **https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html**.

73 Frederick J. Jun 28, 2021. "AHA letter to OSHA on COVID-19 Health Care Emergency Temporary Standard." American Hospital Association. **https://www.aha.org/lettercomment/2021-06-29-aha-letter-osha-covid-19-health-care-emergency-temporary-standard**.

74 For additional information on hospitals' ongoing failure to protect employees and patients, see National Nurses United. "National Nurse Survey..." (Sep 27, 2021).

75 For example, see Hanna J, Kaufman E. Mar 27, 2020. "More than 150 employees at 4 Boston Hospitals Have Tested Positive for Coronavirus." *CNN*. **https://www.**

cnn.com/2020/03/26/health/boston-coronavirus-hospitals-employees-test-positive/index.html and

Pohl J et al. Apr 2, 2020. "Medical Employees Say They're Getting COVID-19 on the Job. Here's Why Hospitals Push Back." *Sacramento Bee*. **https://www.sacbee.com/article241692061.html**.

76 Cox J. Apr 28, 2020. "What Happens if You and Daddy Die?" *The Washington Post*. **https://www.washingtonpost.com/graphics/2020/local/children-doctors-nurses-coronavirus-death/**.

Cox J et al. Mar 18, 2020. "'Dad, Are You Okay?': Doctors and Nurses Fighting Pandemic Fear Infecting Their Families?" *The Washington Post*. **https://www.washingtonpost.com/local/dad-are-you-okay-doctors-and-nurses-fighting-pandemic-fear-infecting-their-families/2020/03/18/8beefc66-689b-11ea-b313-df458622c2cc_story.html.**

Forgrave R. Mar 21, 2020. "Mask Shortage Hits Home: One Nurse's Story of Looking for Protective Masks." *Star Tribune*. **https://www.startribune.com/mask-shortage-hits-home-one-nurse-s-story-of-looking-for-protective-masks/568983442/**.

Greenberg N et al. Mar 26, 2020. "Managing Mental Health Challenges Faced by Healthcare Workers During COVID-19 Pandemic." *BMJ*. 368:m1211. doi:10.1136/bmj.m1211.

Luis C, Vance C. May/Jun 2020. "A Pandemic Crisis: Mentoring, Leadership, and the Millennial Nurse." *Nursing Economic$*. 38(3):152–63.

McConnell D. Jun 2020. "Balancing the Duty to Treat with the Duty to Family in the Context of the COVID-19 Pandemic." *J Med Ethics*. 46(6):360–63. doi:10.1136/medethics-2020-106250.

Sacharczyk T. Mar 25, 2020. "Nurse Seeks Balance Between Caring for Patients and Her Family." *NBC 10 News*. **https://turnto10.com/news/local/nurse-seeks-balance-between-caring-for-patients-and-her-family.**

77 Greenberg N et al (Mar 26, 2020).

Jannsen S. Apr 6, 2020. "Moral Injury in Health Care and COVID-19." *Social Work Today*. **https://www.socialworktoday.com/archive/exc_040620.shtml.**

Stoycheva V. "For Health Workers, COVID-19 Can Be a Moral Injury Pandemic." *Psychol Today*. Apr 13, 2020. **https://www.psychologytoday.com/us/blog/the-everyday-unconscious/202004/health-workers-covid-19-can-be-moral-injury-pandemic.**

78 McFarling U (Apr 28, 2020); Sacharczyk T (Mar 25, 2020).

79 Ibid.

80 Guarino B. Apr 16, 2020. "Nurses, Doctors Take Extreme Precautions to Avoid Infecting Family Members." *The Washington Post*. **https://www.washingtonpost.com/health/2020/04/16/nurses-doctors-are-taking-extreme-precautions-avoid-bringing-coronavirus-home/**.

81 Ibid.

82 McConnell D (Jun 2020).

83 Ibid.

84 Cox J (Apr 28, 2020).

Cox J et al. (Mar 18, 2020).

Forliti A. Apr 5, 2020 "Doctors, Nurses Leave Homes to Protect Families from Virus." *Associated Press*. https://apnews.com/8697a4883bf8799aa235c393ed505bfe.

Guarino B (Apr 16, 2020).

Lee YJ. Apr 4, 2020. "Sleeping in the Attic: How a NYC Nurse is Trying to Keep Her Family Safe from the Coronavirus as She Works on the Front Lines." *Business Insider.* **https://www. businessinsider.com/nyc-nurse-shieldingfamily-coronavirus-exposure-2020-4**.

McFarling U (Apr 28, 2020).

85 Forliti A (Apr 5, 2020).

Hardin T. May 21, 2020. "Written Testimony." Briefing, Heroes of the Coronavirus Crisis: Protecting Front-line and Essential Workers During the Pandemic, before Select Subcommittee on the Coronavirus Crisis of the House Oversight Committee. **https://coronavirus.house.gov/subcommittee-activity/briefings/heroes-coronavirus-crisis-protecting-frontline-and-essential-workers**.

McFarling U (Apr 28, 2020).

86 Hardin T (May 21, 2020).

87 Ibid.

Nguyen J. Mar 17, 2020. "Nurse Sends Her Kids to Live with Grandparents While She Fights Coronavirus." *Channel 933*. **https://channel933.iheart.com/content/nurse-sends-her-kids-to-live-with-grandparents-while-she-fights-coronavirus-new-york/.**

White D. Apr 8, 2020. "Hospital Workers Send Kids Away, Live in Campers to Protect Family During Coronavirus." *The Kansas City Star*. **https://www.kansascity.com/news/coronavirus/article241859741.html.**

88 Twohey M. Apr 7, 2020. "New Battle for Those on Coronavirus Front Lines: Child Custody." *The New York Times*. **https://www.nytimes.com/2020/04/07/us/coronavirus-child-custody.html.**

89 Cox J (Apr 28, 2020); Cox J et al. (Mar 18, 2020); Forgrave R (Mar 21, 2020); Hardin T (May 21, 2020).

90 Cox J (Apr 28, 2020).

91 For example, see Hardin T (May 21, 2020) and Kunkle F. Jul 27, 2020. "Head of Baltimore ICU Dies of Coronavirus, Surrounded by His Staff and Husband." *The Washington Post*. **https://www.washingtonpost.com/local/head-of-baltimore-hospitals-icu-dies-of-coronavirus/2020/07/27/3831bfb8-d052-11ea-8d32-1ebf4e9d8e0d_story.html**.

92 American Public Health Association. May 11, 2020. "APHA Sounds Alarm over Mental Health in Midst of COVID-19 Pandemic." American Public Health Association. **https://www.apha.org/news-and-media/news-releases/apha-news-releases/2020/apha-sounds-alarm-on-mental-health**.

Panchal N et al. Aug 21, 2020. "The Implications of COVID-19 for Mental Health and Substance Abuse." Kaiser Family Foundation. **https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/**.

American Psychological Association. May 2020. "Stress in America™ 2020." American Psychological Association. **https://www.apa.org/news/press/releases/stress/2020/report**.

93 Studies of health care workers in other countries had similar findings as studies of U.S. health care workers.

94 Shanafelt T et al. Apr 07, 2020. "Understanding and Addressing Sources of Anxiety Among Health Care Professionals During the COVID-19 Pandemic." *JAMA*.323(21): 2133–34. doi:10.1001/jama.2020.5893.

95 Hernandez J et al. 2021. "Traumatic Stress Among Frontline American Nurses During the COVID-19 Pandemic: A Survey Study." *Traumatology*. Advance online publication. doi:10.1037/trm0000320.

96 Press releases with survey information are available online. See:

National Nurses United. Mar 05, 2020. "Survey of Nation's Frontline Registered Nurses Shows Hospitals Unprepared For COVID-19." National Nurses United. **https://www.nationalnursesunited.org/press/survey-nations-frontline-registered-nurses-shows-hospitals-unprepared-covid-19**.

National Nurses United. May 20, 2020. "New Survey of Nurses Provides Frontline Proof of Widespread Employer, Government Disregard for Nurse and Patient Safety, Mainly Through Lack of Optimal PPE." National Nurses United. **https://www.nationalnursesunited.org/press/new-survey-results**.

National Nurses United. Jul 28, 2020. "National Nurse Survey Reveals Devastating Impact of Reopening Too Soon." National Nurses United. **https://www.nationalnursesunited.org/press/national-nurse-survey-reveals-devastating-impact-reopening-too-soon**.

National Nurses United. Nov 12, 2020. "National Nurse Survey Exposes Hospitals' Knowing Failure to Prepare for a Covid-19 Surge During Flu Season." National Nurses United. **https://www.nationalnursesunited.org/press/national-nurse-survey-4-exposes-hospitals-knowing-failure-prepare-covid-19-surge**.

National Nurses United. Mar 10, 2021. "National RN Survey Highlights Continued Hospital Failures to Prioritize Nurse and Patient Safety During Pandemic." National Nurses United. **https://www.nationalnursesunited.org/press/fifth-survey-of-national-nurses-highlights-continued-hospital-failures**.

National Nurses United. "National Nurse Survey..." (Sep 27, 2021).

97 National Nurses United. "National Nurse Survey..." (Nov 12, 2020).

98 Centers for Disease Control and Prevention. Last Reviewed Jul 22, 2021. "Reducing Stigma." U.S. Department of Health and Human Services. **https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/reducing-stigma.html**.

Ruiz N et al. Jul 1, 2020. "Many Black, Asian Americans Say They Have Experienced Discrimination Amid the COVID-19 Outbreak." *Pew Research Center.* **https://www.pewsocialtrends.org/2020/07/01/many-black-and-asian-americans-say-they-have-experienced-discrimination-amid-the-covid-19-outbreak/**.

99 Hawkins D. Jun 15, 2020. "Differential Occupational Risk for COVID-19 and Other Infection Exposure According to Race and Ethnicity." *Am J Ind Med*. 1–4. doi:10.1002/ajim.23145.

100 David E. Apr 15, 2020. "Five Ways COVID-19 Might Be Affecting Filipino Americans." *Psych*

Today. **https://www.psychologytoday.com/us/blog/unseen-and-unheard/202004/5-ways-covid-19-might-be-affecting-filipino-americans**.

Lee J, Yadav M. May 21, 2020. "The Rise of Anti-Asian Hate in the Wake of Covid-19." *Items, Insights from the Social Sciences, Social Science Research Council.* **https://items.ssrc.org/covid-19-and-the-social-sciences/the-rise-of-anti-asian-hate-in-the-wake-of-covid-19/**.

101 Wingfield A. (May 14, 2020).

102 Wiley M. Jun 24, 2020. "'I Feel So Overwhelmed': COVID-19 and Police Violence Takes a Toll on Black Health Care Workers." *KQED*. **https://www.kqed.org/news/11825898/i-feel-so-overwhelmed-covid-19-and-police-violence-takes-a-toll-on-black-health-care-workers**.

103 Kadri S et al. 2021. "Association between caseload surge and COVID-19 survival in 558 US hospitals, March to August 2020." *Annals of Internal Medicine* 174.9:1240-1251. **https://www.acpjournals.org/doi/10.7326/M21-1213**.

104 Morley G et al. May 2019. "What is 'Moral Distress'? A Narrative Synthesis of the Literature." *Nurs Ethics.* 26(3): 646–62. doi:10.1177/0969733017724354. Citing Jameton A. 1984. *Nursing Practice: The Ethical Issues.* Prentice-Hall.

105 Ibid.

106 Varcoe C et al. Mar 2012. "Moral Distress: Tensions as Springboards for Action." *HEC Forum*. 24(1): 51–62. doi:10.1007/s10730-012-9180-2.

107 National Nurses United. "National Nurse Survey…" (Jul 28, 2020).

National Nurses United. "National Nurse Survey…." (Nov 12, 2020).

National Nurses United. "National RN Survey…" (Mar 10, 2021).

National Nurses United. "National Nurse Survey…" (Sep 27, 2021).

108 Griffin K et al. Jul 1, 2020. "Hospital Preparedness for COVID-19: A Practical Guide From a Critical Care Perspective." *Amer J of Resp and Crit Care Med*. 49(4):342–43. doi:10.1164/rccm.202004-1037CP.

Rosenbaum L. Mar 18, 2020. "Facing Covid-19 in Italy — Ethics, Logistics, and Therapeutics on the Epidemic's Front Line." *N Engl J Med*. 382:1873–75. doi:10.1056/NEJMp2005492.

Greenberg N et al. (Mar 26, 2020).

Williamson V et al. Apr 2, 2020. "COVID-19 and Experiences of Moral Injury in Front-Line Key Workers." *Occup Med (Lond.)*. 70(5):317-319. doi:10.1093/occmed/kqaa052.

109 Rosenbaum L (Mar 18, 2020).

Ridderbusch K. Apr 22, 2020. "For Hospital Chaplains, Coronavirus Has Shifted Spiritual Care." *U.S. News and World Report*. **https://www.usnews.com/news/healthiest-communities/articles/2020-04-22/coronavirus-shifts-spiritual-care-for-hospital-chaplains.**

110 Berlinger N et al. Mar 16, 2020. "Ethical Framework for Health Care Institutions and Guidelines for Institutional Ethics Services Responding to the Coronavirus Pandemic." *The Hastings Center*. **https://www.thehastingscenter.org/ethicalframeworkcovid19/**.

111 Kane R et al. Dec 2007. "The Association of Registered Nurse Staffing Levels and Patient Outcomes: Systematic Review and Meta-Analysis." *Medical Care*. 45(12):1195–204. doi:10.1097/mlr.0b013e3181468ca3.

National Nurses United. Jun 2019. "RN Staffing Ratios: A Necessary Solution to the Patient Safety Crisis in U.S. Hospitals." National Nurses United. **https://act.nationalnursesunited.org/page/-/files/graphics/0619_Ratios_Booklet_NNU.pdf.**

Sakr Y et al. Mar 2015. "The Impact of Hospital and ICU Organizational Factors on Outcome in Critically Ill Patients." *Crit Care Med*. 43(3):519–26. doi:10.1097/CCM.0000000000000754.

112 Halpern NA, Tan KS. May 13, 2020. "United States Resource Availability for COVID-19." *Soc Crit Care Med*. **https://sccm.org/Blog/March-2020/United-States-Resource-Availability-for-COVID-19**.

113 Jansson M et al. Jun 2, 2020. "The Proportion of Understaffing and Increased Nursing Workload are Associated with Multiple Organ Failure: A Cross-Sectional Study." *J Adv Nurs*. 76:2113–24. doi:10.1111/jan.14410.

Kane R et al. (Dec 2007); National Nurses United. "RN Staffing Ratios…" (Jun 2019); Sakr Y et al. (Mar 2015).

114 Lin Z et al. Apr 23, 2020. "Psychological Burden in Health Care Professionals in Chinese Cities During the Coronavirus Disease 2019 (COVID-19) Outbreak." *SSRN* preprints with *The Lancet*. doi:10.2139/ssrn.3576782. **https://ssrn.com/abstract=3576782**. Citing Chen R et al. Feb 2006. "Effects of a SARS Prevention Programme in Taiwan on Nursing Staff's Anxiety, Depression and Sleep Quality: A Longitudinal Survey." *Int J Nurs Stud*. 43: 215.

O'Halloran J. May 6, 2020. "I'm a Nurse in a COVID-19 Unit. My Hospital's Leaders Frighten Me More Than the Virus." *STAT*. https://www.statnews.com/2020/05/06/nurse-frightenedhospital-administrators-more-than-covid-19.

Zaka A et al. Jun 2020. "COVID-19 Pandemic as a Watershed Moment: A Call for Systematic Psychological Health Care for Frontline Medical Staff." *J Health Psychol*. 25(7):883–87. doi:10.1177/1359105320925148.

115 O'Halloran J (May 6, 2020).

116 Ibid.

117 Pattison N. Apr 2, 2020 "End-of-Life Decisions and Care in the Midst of a Global Coronavirus (COVID-19) Pandemic." *Intensive Crit Care Nurs*. 58:102862. doi:10.1016/j.iccn.2020.102862. Citing Vincent L et al. Nov 2019. "Burnout Syndrome in UK Intensive Care Unit Staff: Data from All Three Burnout Syndrome Domains and Across Professional Groups, Genders and Ages." *J. Intensive Care Soc*. 20(4):363–69. doi:10.1177/1751143719860391 and Colville G et al. Aug 2019. "A Survey of Moral Distress in Staff Working in Intensive Care in the UK." *J. Intensive Care Soc*. 20(3):196–203.

118 Emanuel E et al. May 28, 2020. "Fair Allocation of Scarce Medical Resources in the Time of Covid-19." *N Engl J Med*. 382:2049–55. doi:10.1056/NEJMsb2005114.

119 Litz B, Kerig P. Jun 2019. "Introduction to the Special Issue on Moral Injury: Conceptual Challenges, Methodological Issues, and Clinical Applications." *J Traumatic Stress*. 32(3):341–49.

120 Farnsworth J et al. Oct 2017. "A Functional Approach to Understanding and Treating Military-Related Moral Injury. *J Contextual Behav Sci*. 6(4):391–97. doi:10.1016/j.jcbs.2017.07.003.

Litz B et al. Dec 2009. "Moral Injury and Moral Repair in War Veterans: A Preliminary Model and Intervention Strategy." *Clin Psychol Rev*. 29:695–706. doi:10.1016/j.cpr.2009.07.003.

Litz B, Kerig P (Jun 2019).

Shay J. 2014. "Moral Injury." *Psychoanalytic Psychology*. 31(2):182–91. doi:10.1037/a0036090.

Varcoe C et al. (Mar 2012).

121 Litz B, Kerig P (Jun 2019).

122 Williamson et al. distinguish between moral injury and mental health issues, including PTSD. They acknowledge that potentially morally injurious events "can lead to negative thoughts about oneself or others (e.g., 'I am a monster' or 'my colleagues don't care about me') as well as deep feelings of shame, guilt or disgust." In their view, these types of thoughts and feelings may be partially responsible for psychological problems such as PTSD, depression, and anxiety, but moral injury in and of itself is not a psychological disorder. Williamson V et al. (Apr 2, 2020). Citing Williamson V et al. 2018. "Occupational Moral Injury and Mental Health: Systematic Review and Meta-Analysis." *The British Journal of Psychiatry.* 212(6):339-346.

123 Jewett C. (Nov 4, 2021).

Le Mignot S. Jun 23, 2020. "Suburban Nurse Gets COVID-19, Infects Her Family After Hospital Says Don't Wear Mask." *CBS Chicago*. **https://chicago.cbslocal.com/2020/06/23/suburban-nurse-gets-covid-19-infects-her-family-after-hospital-says-dont-wear-mask/.**

Worcester S. Jul 31, 2020. "Higher Death Rate in Cancer Patients with Nosocomial COVID-19." *Medscape*. **https://www.medscape.com/viewarticle/934977.**

124 Williamson V et al. (Apr 2, 2020). Citing Griffin B et al. Jun 2019. "Moral Injury: An Integrative Review." *J Trauma Stress*. 32:350–62. doi:10.1002/jts.22362 and Williamson V et al. (Jan 9, 2020).

125 Mantri S et al. Jul 17, 2020. "Identifying Moral Injury in Healthcare Professionals: The Moral Injury Symptom Scale-HP." *J Relig Health*. doi:10.1007/s10943-020-01065-w.

Greenberg N et al. (Mar 26, 2020); Jannsen S (Apr 6, 2020); Stoycheva V (Apr 13, 2020); Williamson V et al. (Apr 2, 2020).

126 Williamson et al. (Apr 2, 2020).

127 See National Nurses United. 2021. "Nurse Staffing and Standards for Hospital Patient Safety and Quality Care Act." Fact Sheet. National Nurses United. **https://www.nationalnursesunited.org/sites/default/files/nnu/documents/0421_Ratios_Federal_FactSheet.pdf**.

128 Aiken L et al. 2010. "Implications of the California Nurse Staffing Mandate for Other States." *Health Services Research*. 45(4):204-21. **https://onlinelibrary.wiley.com/doi/10.1111/j.1475-6773.2010.01114.x**.

129 Ibid.

130 Harless D. 2019. "Reassessing the Labor Market Effects of California's Minimum Nurse Staffing Regulations." *Health Economics*. 28(10):1226-31. **https://onlinelibrary.wiley.com/doi/abs/10.1002/hec.3924**.

131 Leigh J et al. 2015. "California's Nurse-to-patient Ratio Law and Occupational Injury." *Int Arch Occup Environ Health*. 88(4):477-84. **https://pubmed.ncbi.nlm.nih.gov/25216822/**.

132 Spetz J. 2008. "Nurse Satisfaction and the Implementation of Minimum Nurse Staffing Regulations." *Policy Polit Nurs Pract*. 9(1):15-21. **https://pubmed.ncbi.nlm.nih.gov/18390479/**.

133 Shah M et al. 2021. "Prevalence of and Factors Associated with Nurse Burnout in the US." *JAMA Netw Open.* 4(2):e2036469. doi:10.1001/jamanetworkopen.2020.36469.

134 Han X et al. Oct 2021. "Alternative Approaches to Ensuring Adequate Nurse Staff: The Effect of State Legislation on Hospital Nurse Staffing." *Medical Care*, 59(10):S463-S470. **https://journals.lww.com/lww-medicalcare/Fulltext/2021/10001/Alternative_Approaches_to_Ensuring_Adequate_Nurse.11.aspx**. (Note that while the study correctly notes that California's RN-to-patient ratios statute allows for RN and licensed practical nurse staffing ratios, implementing regulations effectively permit only RNs to fulfill nurse staffing ratios because of limitations in licensed practical nurse scope of practice).

135 42 CFR § 482.23(b).

136 Centers for Medicare & Medicaid Services. Feb 21, 2020. "State Operations Manual, Appendix A – Survey Protocol, Regulations and Interpretive Guidelines for Hospitals." U.S. Department of Health and Human Services. Rev. 200 at A-0392. **https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf**.

137 For a detailed analysis of conflicts of interests of Medicare-approved Accrediting Organizations, see National Nurses United's comments to CMS's Request for Information on "Medicare Programs: Accrediting Organizations Conflict of Interest and Consulting Services; Request for Information," 83 Fed. Reg. 65,331 (Dec. 20, 2018). National Nurses United. Feb 2021. "NNU Comments, Medicare Program: Accrediting Organizations Conflict of Interest and Consulting Services; Request for Information." Comment ID CMS-2018-0158-0122, **https://www.regulations.gov/comment/CMS-2018-0158-0122**.

138 See Centers for Medicare & Medicaid Services. Nov 5, 2021. "Medicare and Medicaid Programs; Omnibus COVID1-9 Health Care Staff Vaccination." U.S. Department of Health and Human Services. Fed. Reg. 61,555-627.

139 See National Nurses United. "Injury to None..." (2021).

140 Occupational Safety and Health Act, 29 U.S.C. § 651.

141 29 U.S.C. § 655(a).

142 See World Health Organization. 2021. "Weekly Epidemiological Update on COVID-19 - 17 August 2021." World Health Organization. **https://www.who.int/publications/m/item/weekly-epidemiological-update-on-covid-19---17-august-2021**.

143 See National Nurses United. Nov. 3, 2021. NNU Letter to U.S. Secretary of Labor and Assistant Secretary of Labor for OSHA. **https://www.nationalnursesunited.org/sites/default/files/nnu/documents/NNU_Letter_to_DOL_Permanent_Health_Care_Covid-19_Standard_11032021.pdf**.

144 Ritchie H et al. 2021. "Coronavirus Pandemic (COVID-19)." **https://ourworldindata.org/covid-vaccinations. Citing Mathieu, E et al. 2021. "A Global Database of COVID-19 Vaccinations."** *Nat Hum Behav*.

Lal E. Jan 2, 2021. "Fragmented Health Systems in COVID-19: Rectifying the Misalignment Between Global Health Security and Universal Health Coverage." *The Lancet*. 397(10268):61-7. **https://www.thelancet.com/article/S0140-6736(20)32228-5/fulltext**.

145 See NNU Letter to U.S. Secretary of Labor and Assistant Secretary of Labor for OSHA (Nov. 3, 2021).

146 Under the Biden administration, as of November 7, 2021, federal OSHA received 3,794 complaints from workers and reported as having opened 493 inspections in response to complaints (13%). Occupational Safety and Health Administration. Nov 8, 2021. "COVID-19 Response Summary." U.S. Department of Labor. **https://www.osha.gov/enforcement/covid-19-data**.

147 Protecting the Right to Organize Act of 2021, S. 420, 117th Cong. (Sen. Murray); Protecting the Right to Organize Act of 2021, H.R. 842, 117th Cong. (Rep. Scott).

148 VA Office of the Inspector General. 2021. "OIG Determination of Veterans Health Administration's Occupational Staffing Shortages Fiscal Year 2021." Department of Veterans Affairs. **https://www.va.gov/oig/pubs/VAOIG-21-01357-271.pdf**.

149 See, e.g., Dube A et al. 2016. "Nurse Unions and Patient Outcomes." *ILR Rev.* 69(4):803–33. doi: 10.1177/0019793916644251.

Ash M, Seago J. 2004. "The Effect of Registered Nurses' Unions on Heart Attack Mortality." *ILR Rev*. 57(3):422–42. doi:10.1177/001979390405700306; and

Dean A et al. 2020. "Mortality Rates from COVID-19 Are Lower in Unionized Nursing Homes." *Health Affairs*. 39:11. doi:10.1377/hlthaff.2020.01011.

150 A hospital's commitment to labor/management partnership should not suffice to demonstrate a hospital's commitment to labor peace, as such a partnership should only occur once a union has been selected by hospital employees, to determine whether employees wish to establish such partnership through collective bargaining.

151 Definitive Healthcare. 2020. "2020 Trend Report: Breaking Down U.S. Hospital Payor Mixes" Definitive Healthcare. **https://www.definitivehc.com/resources/healthcare-insights/breaking-down-us-hospital-payor-mixes**.

152 Bureau of Labor Statistics. Mar 2021. "Employee Benefits in the United States, March 2021." U.S. Department of Labor. **https://www.bls.gov/ncs/ebs/benefits/2021/employee-benefits-in-the-united-states-march-2021.pdf**.

153 Ibid.

154 White House. Sep 7, 2015. "Executive Order: Establishing Paid Sick Leave for Federal Contractors." **https://obamawhitehouse.archives.gov/the-press-office/2015/09/08/executive-order-establishing-paid-sick-leave-federal-contractors**.

155 National Nurses United. "Deadly Shame..." (2020).

156 Ibid.

157 National Nurses United. May 2021. "Scientific Brief: Multiple Measures, Including Masks, Needed to Curb Covid-19." National Nurses United. **https://www.nationalnursesunited.org/sites/default/files/nnu/documents/0521_Covid19_H%26S_MultipleMeasures_ScientificBrief.pdf**.

158 20 U.S.C. § 1082(a)(6). Although this section is specific to the HEA Federal Family Education Loan Program (FFELP), the Education Secretary has long relied on this statutory authority to carry out all Direct Loan Programs under Title IV of the HEA, and Congress has acquiesced to such interpretation of the statute. For a more detailed analysis of the Education Secretary's authority to "compromise" federal educational debt, see the Letter from Legal Services Center of Harvard Law School To Senator Elizabeth Warren. Sept. 2020. "Cancelation of Federal Student Loan Debt." Available at **https://policymemos.hks.harvard.edu/links/letter-legal-services-ctr-harvard-law-school-sen-elizabeth-warren-re-cancelation**.

159 For example, see: Cox J et al. (Mar 18, 2020); Lee YJ (Apr 4, 2020); McFarling U (Apr 28, 2020).

160 See 5 CFR § 550.902 et seq.

161 5 U.S.C. § 5545(d).

162 5 Code Fed. Reg. Part 550, Subpart I, Appendix A.

163 The exception is the tuition-free nursing programs in public community colleges which would be a new program. Both the Biden administration and Congressional Democrats support two years of tuition-free community college. See, for example, in the House Build Back Better Act, House Committee on Labor and Education. 2021. Build Back Better Act: Investing in Students, Families, and Workers." Fact Sheet. **https://edlabor.house.gov/imo/media/doc/2021-09-09%20E&L%20BBB%20Mark%20Up%20Fact%20Sheet%202.pdf**; and

Biden's American Families Plan, White House Press Release. Apr 28, 2021. "FACT SHEET: The American Families Plan." **https://www.whitehouse.gov/briefing-room/statements-releases/2021/04/28/fact-sheet-the-american-families-plan/**.

NNU has long supported tuition-free education for all at public colleges and universities. For example, NNU is a long-time supporter of the Inclusive Prosperity Act introduced most recently in 2019 which would impose a small tax on stock market speculation to pay for social programs including free college tuition. National Nurses United. May 22, 2019. "RNs Applaud Reintroduction of Robin Hood Tax Act to Raise Money for Education, Health Care, and Vital Social Programs." National Nurses United. **https://www.nationalnursesunited.org/press/rns-applaud-reintroduction-robin-hood-tax-act-raise-money-education-health-care-and-vital**.

164 Health Resources & Services Administration. Feb 2021. "What is Shortage Designation?" U.S. Department of Health and Human Services. **https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation**.

Taylor J. 2019. "Racism, Inequality, and Health Care for African Americans." The Century Foundation. **https://tcf.org/content/report/racism-inequality-health-care-african-americans/**.

165 Probst J et al. Oct 2019. "Rural Registered Nurses: Educational Preparation, Workplace, and Salary." Rural and Minority Health Research Center. **https://www.sc.edu/study/colleges_schools/public_health/research/research_centers/sc_rural_health_research_center/documents/ruralregisterednurses.pdf**.

166 U.S. House of Representatives. Committee on Appropriations. Jul 19, 2021. "Report Together with Minority Views to Accompany HR. 4502." 117th Cong. **https://www.congress.gov/117/crpt/hrpt96/CRPT-117hrpt96.pdf**.

167 Health Resources and Services Administration. 2021. "Justification of Estimates for Appropriations Committees, Fiscal Year 2022." U.S. Department of Health and Human Services. **https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2022.pdf**.

Health Resources and Services Administration. 2019. "Justification of Estimates for Appropriations Committees, Fiscal Year 2020." U.S. Department of Health and Human Services. **https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2020.pdf**.

Health Resources and Services Administration. 2017. "Justification of Estimates for Appropriations Committees, Fiscal Year 2018." U.S. Department of Health and Human Services. **https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-2018.pdf**.

168 Health Resources and Services Administration. 2021. "Nurse Corps Scholarship Program, School Year 2021-2022, Application & Program Guidance." U.S. Department of Health and Human Services. **https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/funding/nursecorps-sp-guidance.pdf**.

169 Health Resources and Services Administration. 2021. "Nurse Corps Loan Repayment Program, Fiscal Year 2021, Application & Program Guidance." U.S. Department of Health and Human Services. **https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/funding/nursecorps-lrp-guidance.pdf**.

170 42 U.S.C. § 296m(a).

171 Health Resources and Services Administration. "Nurse Corps Scholarship Program..." (2021).

172 Health Resources and Services Administration. 2020. "Nurse Corps Loan Repayment and Scholarship Programs Report to Congress for Fiscal Year (FY) 2019." U.S. Department of Health and Human Services. **https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/about-us/reports-to-congress/nurse-corps-report-congress-fy19.pdf**.

173 Yoo B et al. 2016. "The Effect of Prior Healthcare Employment on the Wages of Registered Nurses." *BMC Health Services Research*. 16(1):1-12. doi:10.1186/s12913-016-1667-0.

174 American Association of Colleges of Nursing. Sep 2020. "Nurse Faculty Shortage." Fact Sheet. **https://www.aacnnursing.org/Portals/42/News/Factsheets/Faculty-Shortage-Factsheet.pdf**.

175 National Nurses United. "Deadly Shame..." (2020).

176 See NNU's sixth survey of RNs on Covid-19 which included the effects on nurses of stressors and mental health impacts of the pandemic. National Nurses United. Sep 27, 2021. "National Nurse Survey Reveals That Health Care Employers Need to Do More to Comply with OSHA Emergency Temporary Standard." National Nurses United. **https://www.nationalnursesunited.org/press/national-nurse-survey-reveals-health-care-employers-need-to-do-more-to-protect-workers**.


SAVE
Safe Staffing NOW
LIVES
California Nurses Association
National Nurses Organizing Committee
National Nurses United
RN
National Nurses United
www.NationalNursesUnited.org

National Nurses United
The National Voice for Direct-Care RNs

WASHINGTON DC
8455 Colesville Road
Suite 1100
Silver Spring MD 20910
phone: 800-287-5021
fax: 240-235-2019

OAKLAND
155 Grand Avenue
Suite 100
Oakland CA 94612
phone: 800-504-7859
fax: 510-663-1625

February 15, 2023

Senator Bernard Sanders, Chairman
Senator Bill Cassidy, Ranking Member
Committee on Health, Education, Labor and Pensions
U.S. Senate
428 Senate Dirksen Office Building
Washington D.C. 20510

Dear Chairman Sanders, Ranking Member Cassidy, and Members of the Committee,

National Nurses United is the largest union and professional association of registered nurses (RNs) in the United States, representing nearly 225,000 nurses across the country. Our members have been on the frontlines of the Covid-19 response for three years and are dealing first-hand with the repercussions of the nurse staffing crisis that the health care industry is facing today. We write to you today in advance of your hearing titled, "Examining Health Care Workforce Shortages: Where Do We Go from Here?" to provide you with frontline worker 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.

First and foremost, it is imperative that we clarify there is not a national shortage of trained and licensed RNs in the United States. According to statistics from the National Council of State Boards of Nursing and the U.S. Bureau of Labor Statistics, there are at least 1.3 million actively licensed registered nurses who are not currently employed as RNs. We don't have a "nurse shortage," but **we do have a staffing crisis, brought on by the lack 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.**

Throughout the Covid-19 pandemic, nurses have been dealing with dangerous working conditions, including intentional 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.**

The hospital industry is using the false narrative of a "nursing shortage" to propose interventions that will reduce labor costs and maximize revenue without regard for health care workers or patient care. For several decades, the hospital industry has attempted to deskill the nursing profession by inappropriately pushing care to the lowest-cost and least-regulated setting, including substituting nursing care provided by licensed RNs for unlicensed, or lower-licensed, care to reduce labor costs. The attack on nursing practice and patient advocacy also includes displacing RNs and RN professional judgment with health information technology, automation, remote monitoring

tools and, ultimately, abandoning the patient by leaving complex clinical care to be provided in the home by family or even by the patient alone. Additionally, the industry has lobbied for bringing in more immigrant nurses into the U.S. to solve the staffing crisis. We know that recruiters and employers have long used abusive and deceptive practices to force immigrant nurses to work in unfair or unsafe working conditions, which is why we must ensure that all immigrant nurses are guaranteed the strongest labor protections, including the right to organize.

Hospital industry mistreatment and neglect of RNs and other health care workers has led many health care workers to leave their respective facilities in order to protect their health, wellbeing, and licenses. The hospital industry's own actions have created the staffing crisis in health care.

To that point, the first step to address this staffing crisis is to revitalize the workforce by increasing nurse retention and bringing licensed nurses who have left the bedside 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 so nurses can avoid workplace musculoskeletal injuries.

Hospital employers have created a vicious cycle of deteriorating workplace conditions that has exacerbated the staffing crisis. Although working conditions have been deteriorating for decades, the problems intensified during the pandemic. Hospital employers showed their utter disregard for nurses' health and safety by failing to implement proper infection control practices and failing to provide appropriate PPE. Nurses working on the pandemic's front lines have been 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. 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 117th 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, including passing the VA Employee Fairness Act and the PRO Act which both passed the House of Representatives in the 117th Congress.

While there is not a national 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.[1] 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 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.[2] Similarly, students from rural areas are more likely to practice in rural communities.[3]

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 four-year bachelor's degrees of nursing (BSNs). Nurses with ADN and BSN degrees typically must fulfill the same education and clinical experience requirements, with the exception of courses primarily geared toward research, teaching, and management, 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 attempting 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

[1] There was a big one-time bump of $200 million in workforce funding in the FY 2021 COVID-19 Supplemental funding.

[2] 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

[3] 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

educate more RNs in two-year nursing programs, which enable nurses to enter practice in two years rather than four, 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 safe 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 wellbeing 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,

Bonnie Castillo, RN
Executive Director, National Nurses United

Zenei Cortez, RN
President, National Nurses United

Deborah Burger, RN
President, National Nurses United

Jean Ross, RN
President, National Nurses United

Nancy Hagans, RN
President, National Nurses United

PA EDUCATION ASSOCIATION
655 K Street NW, Ste. 700, Washington, DC 20001
PAEAonline.org • 703-548-5538

Statement for the Record
Submitted to
U.S. Senate Committee on Health, Education, Labor & Pensions
"Examining Health Care Workforce Shortages: Where Do We Go From Here?"
February 16, 2023

The PA Education Association (PAEA), representing the 300 accredited PA programs in the United States, welcomes the opportunity to submit a statement for the record regarding federal policy options to mitigate health care provider shortages.

This hearing comes at a time of both great challenges and significant opportunities for the future of our nation's health workforce. As health systems across the country adapt to a new, post-pandemic normal, one of the most pressing issues that must be addressed by policymakers is a critical shortage of health care professionals exacerbated by the pandemic. According to the Association of American Medical Colleges, the U.S. is anticipated to face a shortage of up to 124,000 physicians by 2034.[1] While this projection is daunting, the PA profession is committed to playing a critical role in addressing workforce gaps, particularly in our nation's most rural and underserved communities.

The PA profession was founded in the mid-1960s specifically to address projected shortages of primary care physicians. Based upon the fast-track model of training physicians used during World War II, PA education provides high-quality, medical model-based training to all

[1] Association of American Medical Colleges. (2021). *The Complexities of Physician Supply and Demand: Projections from 2019 to 2034.* https://www.aamc.org/media/54681/download.

students in a manner that allows them to quickly enter the clinical workforce. The typical PA program lasts approximately 27 months and is divided into a didactic, or classroom-based phase, followed by a clinical phase. During students' clinical year, they complete a series of clinical rotations in primary care, behavioral health, obstetrics and gynecology, surgery, and emergency medicine, among other specialties. This intensive training provides PA graduates with the education necessary to switch specialties over the course of their careers based upon the workforce needs of their communities.

While the PA profession has significant potential to address projected workforce shortages, this potential can only be fulfilled if PA programs have the resources necessary to produce practice-ready graduates and if graduates have appropriate financial support to practice in high-need capacities. As the Health, Education, Labor and Pensions committee works to strengthen the health workforce in the 118th Congress, PAEA would like to offer the following recommendations for the committee's consideration.

National Health Service Corps Reauthorization

One of the most critical health workforce priorities that Congress must address in 2023 is the upcoming expiration of mandatory funding for the National Health Service Corps (NHSC) on September 30. For over 50 years, the NHSC has been one of the federal government's largest investments in workforce distribution, making loan repayment and scholarship agreements with clinicians and students in exchange for a practice commitment in an underserved community. In 2021, Congress took historic action to address workforce shortages in underserved communities through the American Rescue Plan Act by investing $800 million in supplemental funding for the NHSC's scholarship and loan repayment programs. This unprecedented funding level for the NHSC resulted in field strength growing from 13,053 providers in fiscal year 2019 to 20,215 providers in fiscal year 2022, an increase of nearly 55%.[2]

[2] Health Resources and Services Administration. (2022). *Bureau of Health Workforce Field Strength and Students and Trainees Dashboards.* https://data.hrsa.gov/topics/health-workforce/field-strength.

While this investment led to a remarkable increase in the number of clinicians fulfilling service commitments in underserved communities, the exhaustion of the supplemental appropriation and the upcoming expiration of the NHSC's mandatory authorization threaten to limit access to care as workforce shortages continue to grow. **As such, PAEA urges the HELP Committee to reauthorize the NHSC at a funding level that allows HRSA to fund 100% of eligible applicants for at least five years.**

Palliative Care and Hospice Education and Training Act

While extending the mandatory authorization for the NHSC is critical, Congress must also make new investments to strengthen the capacity of health professions education to meet national demand for graduates. Specifically, Congress must ensure that PA programs have a sufficient supply of faculty equipped to provide comprehensive education in specialty areas anticipated to be in high demand and the clinical training opportunities necessary to produce practice-ready graduates. According to a recent survey of PA programs, over 50% of respondents indicated that they are having increased difficulty securing clinical rotations in family medicine and other high-need settings, indicating the importance of congressional intervention to strengthen educational capacity.[3]

In recognition of the unique health care needs of older Americans and the capacity of the PA profession to provide this care, PAEA has been proud to support the bipartisan Palliative Care and Hospice Education and Training Act. This legislation would support faculty development, clinical training experiences, and didactic curriculum development for students in interprofessional palliative and hospice care. **Given the particularly acute elder care workforce shortage, PAEA urges the committee to advance this legislation in the 118th Congress.**

[3] PA Education Association. (2021). *COVID-19 Rapid Response Report 4.* https://paea.edcast.com/insights/covid-19-rapid-response-report-4.

Black Maternal Health Momnibus Act

Beyond the value of investing in palliative care training, ensuring a robust, well-trained workforce also requires Congress to examine opportunities to promote workforce diversity. Historically, across health professions, individuals from racially and ethnically underrepresented communities have faced formidable barriers to entering and completing a health professions program. This lack of representation among graduates impacts the ability of the future workforce to deliver culturally competent care, and breaking down barriers to a diverse PA student body is a top priority for PAEA. In alignment with this goal, PAEA has endorsed the Black Maternal Health Momnibus Act – critical legislation that would work to address maternal health disparities by expanding perinatal health professional programs and providing scholarships to students interested in pursuing careers in obstetrics and gynecology. **As part of a broader health workforce strategy, PAEA supports the continued advancement of the Black Maternal Health Momnibus Act in the 118th Congress.**

PA Higher Education Modernization Act

Fully leveraging the capacity of the PA profession to mitigate health workforce shortages requires reforms that address long-standing exclusions of the profession from key federal programs. As such, PAEA has endorsed the PA Higher Education Modernization Act. This comprehensive legislation would address key components of the Higher Education Act, including investments in program development at historically Black colleges and universities, Hispanic-serving institutions, and other minority-serving institutions that have previously excluded PA programs. The bill would further reduce financial barriers to students by restoring access to subsidized direct loans for PA and other graduate-level health professions students to limit long-term borrowing costs. **As a final component of a comprehensive workforce solution, PAEA urges the HELP committee to support the PA Higher Education Modernization Act.**

PAEA appreciates the opportunity to provide the Association's perspective on effective policy interventions to respond to national health workforce shortages and looks forward to serving

as a resource to members and staff throughout the 118th Congress. Should you require additional information or have questions, please contact Tyler Smith, Senior Director of Government Relations, at tsmith@PAEAonline.org or 703-667-4356.

February 16, 2023

The Honorable Bernie Sanders
Chairman
Senate Health, Education, Labor
and Pensions Committee
428 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Bill Cassidy, MD
Ranking Member
Senate Health, Education, Labor
and Pensions Committee
428 Dirksen Senate Office Building
Washington, DC 20510

RE: Health Care Workforce Shortages – Palliative Care

Dear Chairman Sanders and Ranking Member Cassidy:

The undersigned members of the Patient Quality of Life Coalition (PQLC) write to thank you for prioritizing health care workforce shortages as the Senate Health, Education, Labor and Pensions (HELP) Committee begins the 118th Congress. As the Committee considers testimony during the hearing "Examining Health Care Workforce Shortages: Where Do We Go From Here?" and works to address workforce shortages, we respectfully request your consideration of the *Palliative Care and Hospice Education and Training Act* (PCHETA). This bipartisan legislation was introduced by Sens. Tammy Baldwin and Shelley Moore Capito as S. 4260 in the 117th Congress and seeks to address interdisciplinary workforce shortages for the care of patients with serious illness.

The PQLC was established to advance the interests of patients and families facing serious illness. The coalition includes over 40 organizations dedicated to improving quality of care and quality of life for all patients from pediatrics to geriatrics, as well as supporting public policies that improve and expand access to quality palliative care and appropriate pain management. PQLC members represent patients, caregivers, health professionals, and health care systems.

There is a significant gap between the number of health professionals with palliative care training and the number required to meet the needs of the expanding population of patients with serious illness throughout the continuum of care. The COVID-19 pandemic exposed and exacerbated the palliative care workforce shortage and amplified the need for our nation's health care workforce – beyond those who will specialize in the field – to have training in basic palliative care to ensure all patients, including those facing serious illness or at the end of life, receive high-quality care.

Palliative care is specialized care that focuses on preventing and treating the debilitating effects of serious illness throughout the continuum of care, with clinicians trained to assess and manage physical, psychological, and other sources of suffering. This includes relieving pain and other distressing symptoms, such as shortness of breath or unrelenting nausea. Palliative care seeks to anticipate, prevent, and treat physical, emotional, social, and spiritual suffering, as well as to help facilitate and support the goals and values of patients. This education is also important for the health professionals who do not have palliative care training but directly care for patients with serious illness. Dr. Sean Morrison of the Icahn School of

Medicine at Mount Sinai in New York previously testified in support of PCHETA before the House Energy and Commerce Committee. A goal of any future workforce development legislation should be to support and train health care workers and improve patient care.

The *Palliative Care and Hospice Education and Training Act* (PCHETA) would address the palliative care workforce shortage and help respond to pressing issues including appropriate pain management and pandemic preparedness. PCHETA will work to address the critical shortage of health professionals with knowledge and skills in palliative care, build the evidence base for serious illness care, and educate all who care for patients. PCHETA will not only help strengthen the palliative care workforce but also help ensure that, going forward, patients and providers are aware of the benefits of palliative care so that patients can receive palliative care as appropriate. According to the Institute of Medicine, there is a "need for better understanding of the role of palliative care among both the public and professionals across the continuum of care."

Congress has long worked on a bipartisan basis to support and advance PCHETA. The House has twice passed it with overwhelming support. PCHETA is supported by more than 60 national and state organizations. We urge you to ensure that all Americans facing serious illness have access to palliative care and to support the development of needed training programs in this area for our health care professionals.

As Congress considers measures to improve our nation's workforce development, our organizations welcome the opportunity to discuss our views with you. If you have any questions, please contact Daniel E. Smith, coalition manager for the PQLC at dan.smith@advocacysmiths.com.

Sincerely,

Alzheimer's Association
Alzheimer's Impact Movement
American Academy of Hospice and Palliative Medicine
American Cancer Society Cancer Action Network
American Heart Association
Association for Clinical Oncology
Association of Pediatric Hematology/Oncology Nurses
Catholic Health Association of the United States
Center to Advance Palliative Care
Children's National Hospital
CSU Shiley Haynes Institute for Palliative Care
GO2 for Lung Cancer
Hospice Action Network
Hospice and Palliative Nurses Association
Motion Picture & Television Fund
National Coalition for Hospice and Palliative Care
National Hospice and Palliative Care Organization
National Palliative Care Research Center
Oncology Nursing Society
PAs in Hospice and Palliative Medicine
Pediatric Palliative Care Coalition
St. Baldrick's Foundation

HEALTHCARE LEADERSHIP COUNCIL

February 16, 2023

The Honorable Bernie Sanders
Chair
Senate Committee on
Health, Education, Labor and Pensions
Washington, D.C. 20510

The Honorable Bill Cassidy, MD
Ranking Member
Senate Committee on
Health, Education, Labor and Pensions
Washington, D.C. 20510

Dear Chair Sanders and Ranking Member Cassidy:

On behalf of the Healthcare Leadership Council (HLC), we thank you for holding a hearing on, "Examining Health Care Workforce Shortages: Where Do We Go From Here?"

HLC is a coalition of chief executives from all disciplines within American healthcare. It is the exclusive forum for the nation's healthcare leaders to jointly develop policies, plans, and programs to achieve their vision of a 21st century healthcare system that makes affordable high-quality care accessible to all Americans. Members of HLC – hospitals, academic health centers, health plans, pharmaceutical companies, medical device manufacturers, laboratories, biotech firms, health product distributors, post-acute care providers, homecare providers, and information technology companies – advocate for measures to increase the quality and efficiency of healthcare through a patient-centered approach. We are uniquely positioned to address disaster preparedness comprehensively from all perspectives in the healthcare industry.

As you know, the COVID-19 pandemic has exacerbated the ongoing shortage of healthcare workers in America, leaving many healthcare facilities short staffed even as the number of COVID-19 cases decrease. In addition, the United States faces a physician shortage of up to nearly 124,000 physicians by 2034, including shortfalls in both primary and specialty care.[1] This shortfall could disproportionately affect rural and underserved communities. The 46 million Americans who live in rural areas often have trouble accessing care due to a shortage of healthcare workers and long distances to healthcare services that can be made more challenging by difficult terrain and severe weather. As a result, rural residents overall suffer poorer health outcomes and are at greater risk of dying from heart disease, cancer, unintentional injuries, chronic lower respiratory disease, and stroke than their urban counterparts. Without Congressional action, workforce shortages are likely to worsen and, consequently, the state of health for people across America may worsen as well.

Data has shown that due to the pandemic alone, 55 percent of the healthcare workforce is burned out, 60 percent say stress from the pandemic has harmed their mental health, and 75

[1] The Complexities of Physician Supply and Demand: Projections From 2019 to 2034, Association of American Medical Colleges (June 2021) https://www.aamc.org/media/54681/download?attachment

percent of nurses have reported exhaustion.[2,3,4] To combat this problem, HLC expresses support for legislation introduced in the last Congress, S. 1679/H.R. 3320, the "Allied Health Workforce Diversity Act," and urges Congress to reintroduce this legislation which would increase and strengthen the healthcare workforce while advancing diversity and inclusion. Specifically, this bill would provide scholarships and stipends to higher medical education programs and would increase the recruitment, enrollment, retention, and graduation of students from underrepresented and disadvantaged backgrounds which in return will reduce workforce shortages.

As Congress looks further into supporting the healthcare workforce, HLC also urges prioritization of the direct care workforce. The direct care workforce comprises about 4.5 million workers, including: nearly 2.3 million home care workers; over 700,000 workers in residential care homes; about 580,000 nursing assistants employed in nursing homes; and nearly 900,000 workers employed in other settings, such as hospitals. This workforce is the backbone of services and support in healthcare delivery. They play a critical role in supporting the lives of people who have functional limitations due to age or disability. The physical, emotional, and financial challenges direct care workers face cannot be overstated, and, for many, the challenges have increased over the last several years.

There is also a significant economic impact for family caregivers who provide about $470 billion annually in unpaid care to their loved ones. They face out-of-pocket expenses to assist their family members, as well as foregone potential income and retirement savings. An AARP report found that family caregivers spend, on average, nearly 20 percent of their income on caregiving expenses, or nearly $7,000 annually.[5] Their assistance helps save taxpayer dollars by delaying or preventing more costly nursing home care and unnecessary hospital stays. HLC urges Congress to reintroduce S. 1670/H.R. 3321, the "Credit for Caring Act" which would create a new, nonrefundable federal tax credit of up to $5,000 for eligible working family caregivers to help address the financial challenges of caregiving. Eligible working family caregivers caring for loved ones of all ages could receive the credit if the care recipient meets certain functional or cognitive limitations or other requirements. This tax credit would help family caregivers who care for non-dependents or who do not live with the person they are assisting.

In addition, HLC urges Congress to reintroduce S. 2210/H.R. 4131, the "Better Care Better Jobs Act." The bill would strengthen and expand the home and community-based services (HCBS) workforce. The bill enhances Medicaid funding for HCBS through increasing the Federal Medical Assistance Percentage (FMAP) by 10 percent permanently for states that expand access to HCBS and strengthen the HCBS workforce. To receive the enhanced FMAP, states would need to promote access and improve workforce recruitment and retention; update HCBS payment rates every two years with input from stakeholders; ensure increases in HCBS rates are passed through to workers to improve compensation; ensure rates are incorporated into managed care arrangements; and update, develop, and adopt qualification standards and training opportunities for workers and family caregivers.

---

[2] Medical burnout, Association of American Medical Colleges (June 4, 2021) https://www.aamc.org/newsinsights/medical-burnout-breaking-bad

[3] Stress in America 2020 Survey Signals a Growing National Mental Health Crisis, American Psychological Association (October 20, 2020) https://www.apa.org/news/press/releases/2020/10/stress-mental-healthcrisis

[4] The Mental Health of Healthcare Workers in COVID-19, Mental Health America (June, 2021) https://mhanational.org/mental-health-healthcare-workers-covid-19

[5] AARP: Family Caregivers Spend More Than $7,200 a Year on Out-of-Pocket Costs (June 29, 2021) https://www.aarp.org/caregiving/financial-legal/info-2021/high-out-of-pocket-costs/?cmp=RDRCT867fa361-20211014

To better address the national shortage of registered nurses, HLC believes Congress should reintroduce S. 4844/H.R. 8817, the "National Nursing Workforce Center Act." One of the major barriers to understanding this shortage is the lack of standardized information about the landscape of nursing in each state, making it difficult to develop informed interventions to recruit and retain nurses. Nursing workforce centers advance the profession through a data driven approach throughout 39 states in America. These centers conduct local research, publish reports on nursing supply, demand, and education, and share best practices. However, not every state has a center and those centers that exist do not always have the funding essential for their work. That is why we believe this legislation is an important step forward to support our nursing workforce.

HLC continues to work on multiple fronts in support of workforce expansion and flexibility in the short term. This includes support for immigration policies that enable the entry of qualified medical professionals into the United States; flexibility for healthcare professionals to practice across state lines; and enhanced funding, especially graduate medical education funding. Currently, there is a dire need to expand immigration rules that allow recruitment of nurses and other workers critical to the healthcare industry.

As well, HLC continues to support the need for more flexibility in state licensure. The COVID-19 pandemic highlighted the importance of having a mobile healthcare workforce that can address needs when and where they occur. However, current state licensure restrictions create barriers to workforce mobility. HLC believes Congress should enact legislation that would provide licensing reciprocity for healthcare professionals for any type of services provided to a patient located in another state during a public health emergency in communities where shortages exist.

Lastly, HLC believes Congress should further explore value-based care as a long-term way to better align the healthcare workforce and address shortages. A value-based care system will improve healthcare quality and outcomes for patients. The shift to value-based care will require numerous changes in the way our healthcare system is structured and operates. This shift will enable consistent and efficient data collection, and communication among healthcare providers which will allow for better utilization of the healthcare workforce. Additionally, value-based care will encourage greater use of appropriate telehealth services, leading to improved patient access to healthcare for millions of Americans in rural and underserved communities.

Thank you again for your efforts to address workforce shortages. HLC looks forward to continuing to collaborate with you on this important issue. If you have any questions, please do not hesitate to contact Debbie Witchey at (202) 449-3435 or dwitchey@hlc.org.

Sincerely,

Mary R. Grealy
President

QUESTIONS FOR THE RECORD

RESPONSE BY JAMES HERBERT TO QUESTIONS OF SENATOR PAUL AND SENATOR TUBERVILLE

SENATOR PAUL

Question 1. The American Nurses Association reports that the average age of a nurse is 52 years old and that at least a fifth of all U.S. nurses will be retiring in the next 5 years. The U.S. Department of Labor says that there are in excess of 200,000 open RN positions right now and that number is expected grow. Nurses are reporting record-high levels of stress because of severe workforce shortages. This data implies that the nursing shortage is about to get much worse. What is being done to combat these workforce shortages and alleviate the immense stress being suffered by nurses?

Answer 1. Nurse stress, burnout, and compassion fatigue are collectively contributing to the departure of nurses in the workforce. In order to combat this reality, healthcare systems need to analyze and address the root causes of nurse stress. At an organizational or micro level, these issues are varied and often co-occurring. It is vital for institutions to establish appropriate staffing levels reflective of patient complexity and acuity, the number of admissions or discharges within a given assignment, and the availability of support personnel. The work environment itself needs to be assessed and determined to be safe and free from harm. Nurses are encountering increasing acts of aggression, both verbal and/or physical, and health systems need to promote a 24-hour safe setting for nurses to execute their work. Compensation structures for nurses need to be reevaluated, along with ensuring that nurses are able to practice to the full extent of their academic preparation, experience, and professional licensure/credentialing.

At a macro-disciplinary level, a number of professional organizations are working to combat nurse stress and fatigue. For example, the American Nurses Association (ANA) launched the Healthy Nurse/ Healthy Nation initiative. This social action endeavor aims to enhance the health and well-being of the 4 Million registered nurses in the U.S., and in so doing, favorably impact the health of the Nation. The program offers ANA members health and wellness assessments, tool kits to improve focus areas such as sleep, activity, nutrition, stress management, and vehicles for establishing support/connections with others.

Finally, as I discussed in my testimony with respect to healthcare professionals more generally, we need to facilitate the training of more nurses, including both new, entry-level nurses as well as programs to upskill lower-level providers to become nurses. The primary bottlenecks in this regard are insufficient clinical training sites and the paucity of nurse educators. Many institutions (including my home university, the University of New England) are doing creative things to address both of these issues, but these could be facilitated with additional state and/or Federal support.

Question 2. For the last 15 years, nursing school enrollment has not kept up with hospital demand for nurses. The primary barriers to accepting all qualified students at nursing schools continue to be insufficient clinical placement sites, faculty, preceptors, and classroom space. How are we increasing nursing opportunities for U.S. students?

Answer 2. Increasing nursing school enrollment is a complex and multifaceted issue. The lack of appropriately prepared nurse faculty, limitations in expanding clinical placement sites, and modernizing nursing education infrastructure illustrate these vexing challenges. This can be best addressed by investing in nursing education. The re-authorization of the Title VIII Nursing Workforce Development Program as part of the CARES Act was an essential first step. Ongoing congressional funding is essential to continue to support opportunities to grow nursing education faculty, imagine innovative models for clinical education, and modernize nursing education facilities. The interest of the U.S. Department of Labor is also essential in solving this issue. Individual states play a role as well, providing funding opportunities to support the expansion of graduate medical education and creation of novel clinical rotational opportunities.

Embarking on new, innovative partnerships is also essential for addressing these challenges. This may involve creation of unique health system/academic institution alliances, or public/private educational institutions working in concert to co-create nursing education programs responsive to local or regional needs.

Question 3. Fifteen percent of U.S. nurses are foreign-trained, meaning that thousands of new U.S. nurses per year are foreign workers. Retrogression of visas is ex-

pected in 2024. If this pool of nurses were to run out, stress on nursing staff would be unsustainable, likely leading to even earlier retirements. Since visa retrogression will happen in 2024 and no foreign nurses will be able to enter the U.S., what steps are being taken to maintain foreign nurses' entry into the U.S.?

Answer 3. Entry into the United States and visa issuance is a legislative issue. Credentialing of foreign trained nurses and conferment of licensure is a nursing regulatory matter. The National Council of State Board of Nursing (NCSBN) is a not-for-profit organization through which nursing regulatory bodies (i.e., each of the 50 state boards of nursing) confer and act and together on issues impacting public health, safety, and welfare, including the licensure of nurses. The NCSBN is a member organization of the international center for regulatory scholarship, uniting nine member nursing organizations around the world to promoting research and data sharing to influence policy impacting the health, safety, and welfare of the public.

Foreign trained nurses applying for licensure in the United States need to be credentialed through the Commission on Graduates of Foreign Nursing Schools (CGFNS). This process verifies and authenticates the credentials for an internationally educated applicant. Foreign trained nurses may need to initially complete a qualifying examination and/or demonstrate English language proficiency. Foreign trained nurses may or may not be required to successfully pass the National Council Licensing Examination (NCLEX-RN). This is dependent upon their prior preparation. Each state board of nursing has its own requirements in determining educational and experiential comparability for individuals trained outside of the United States.

SENATOR TUBERVILLE

Question 1. In addition to doctors and nurses, the current health worker shortage includes technicians, assistants, pharmacy personnel, home health aides, nursing home staff, and more. America is experiencing shortages across every aspect of America's health care systems—not just the jobs requiring high-level and post-grad degrees. We need to train people throughout the care team, all across the industry. Not everyone desiring to pursue a career in health care wants to go to a full 4-year college or nursing or medical school.

Question 1(a). Please highlight what other opportunities outside traditional 4-year college settings are available to interested students?

Question 1(b). What training and incentive programs are out there?

Answer 1. There are an abundant number of essential health care roles that do not require 4-year baccalaureate education or graduate study. Certified nursing assistants (CNA's), home health aides (HHA's), medical assistants (MA's), licensed practical nurses (LPN's), X-ray technicians, and phlebotomists are examples of vital paraprofessional roles. Educational requirements differ depending upon the role, ranging from a few weeks to a year to complete training. Credentialing also varies, ranging from certification to licensure. Each state determines rules and regulations for these positions. Licensed practical nurses (LPN's) are governed by NSCBN (described above) and must successfully pass the NCLEX-PN to practice.

Public K–12 education is often also engaged in paraprofessional training, providing secondary students with health care "tracks" or "concentrations" leading to nursing assistant credentialing. Many community, technical, or vocational colleges offer this training in a post-secondary manner. Municipalities have become increasingly involved in this arena through adult education, offering nursing assistant training to community residents to enhance the regional workforce. Health care systems have also assumed an educational role, creating paid training programs in an effort to "grow their own" workforce. These models commonly pay an individual to complete the specified training, and once successfully completed, require future employment for a specified number of years. There are abundant opportunities for innovative higher education/health system partnerships to expand this essential workforce. Federal and state funding initiatives are critical to support the workforce growth needed in this arena.

Question 2. I have been contacted in particular by EMS professionals in Alabama who are sounding the alarm about their own individual shortages. Specifically, I recently heard from an EMS company in the state, NorthStar EMS. They are providing vital 911 emergency and interfacility ground ambulance services in both rural and urban counties in Alabama. Their organization, and every other ambulance service provider in Alabama, is facing an unprecedented workforce shortage. NorthStar noticed this issue several years prior to the pandemic and started their own training academy in order to make EMT education more accessible to people desiring to enter the field. When the pandemic started, interest in attending EMT

school dropped. Not many people wanted to put themselves into a front-line position, which made the problem worse. However, the ones who wanted to get into the profession at that time turned out to be some of the best students and workers they have had in years. They have finally started to see an uptick in interest from prospective students, but nowhere near where they need to be in order to get back to pre-pandemic levels, which leaves them far short of where they need to be.

According to NorthStar, a recent survey on the EMS workforce shortage—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 service providers face 100 percent turnover within a 4-year period. Staffing shortages compromise their ability to respond to health emergencies, especially in rural and underserved parts of the country. In several rural counties in Alabama, only one ambulance is staffed most days of the week—not because that is what the service wants to do, but because there are no staff to cover the open shifts.

The EMS workforce shortage has continually worsened over a period of several years with the pandemic exacerbating the current shortage and highlighting the need to better understand the drivers of workforce turnover.

Question 2(a). From your perspective, what can be done to correct the training and staffing pipeline of EMS workers, especially in rural areas?

Answer 2. Emergency management services (EMS) are part of the healthcare ecosystem and involve public safety (police and fire), public health, and regional healthcare delivery systems. EMS is generally organized around four (4) levels of care or responders to include: Emergency Medical Responder (EMR); Emergency Medicine Technician (EMT-B); Advanced Emergency Medical Technician (EMT-A); and paramedic (EMT-P). Each of these require different levels of education and preparation. The delivery of acute, complex, and life-threatening care optimally requires intervention at the EMT-A and paramedic level.

There are many drivers that threaten the current and future EMS workforce and pipeline. The impact of the pandemic on personal health and well-being has influenced the entire health care workforce, to include EMS. EMS compensation structures remain persistently low, rendering the role unattractive. According to the Bureau of Labor statistics, the 2021 median annual wage for emergency medical technicians was $35,470; and the 2021 median annual wage for paramedics was $46,770. The provision of EMS services requires 24-hour coverage, and staffing shortages commonly necessitate mandatory overtime to ensure appropriate community coverage. Career mobility is limited with few opportunities for professional growth and advancement.

The delivery of EMS services is complex and differs from region to region. A variety of entities including municipal fire departments, rescue squads, hospitals, and private companies all represent the numerous ways that EMS care is delivered. Rurality presents unique challenges to the EMS industry. The workforce itself, particularly at the higher levels of practice, is in scare supply. Response times in rural regions are significantly longer, and the public is more likely to survive a life-threatening event if care is rendered by an EMT-A or paramedic. In addition to longer response times, transport times are also lengthy, thus taking an ambulance out of service for another possible call. Ground ambulance costs have increased steadily over the past 5 years, and CMS reimbursement rates commonly do not cover the cost of services and transport. This results in a financial deficit for the EMS system, be it administered by a municipality, private company, and/or hospital.

Innovative educational programs to increase student interest and enrollment are needed to expand the pipeline of EMS provider. Federal and state funding should be allocated to support student scholarships and/or loan repayment once credentialed. CMS reimbursement rates must be re-examined to ensure the sustainability of the EMS system.

Question 3. In your testimony, you mention how critical is that we leverage the power of technology to reach underserved communities. In Alabama, we used Federal authority to make telehealth much more effective and feasible for patients and doctors during COVID. Providers in rural states were able to reach more patients with fewer health care workers using virtual visits and follow-ups. It was a lifeline in many rural areas and helped lift the burden placed on brick-and-mortar health care centers.

Question 3(a). What can we do to encourage further use and innovation in telehealth, especially in rural states and communities?

Question 3(b). How can it be best utilized to help address the current workforce shortage?

Answer 3. Telehealth is dependent upon the availability of appropriate tools and resources to achieve successful and sustainable telehealth practices. Reliable Internet, inclusive of broadband, is essential to support video chat capability, visual imaging, and two-way exchange. Federal and state funding is critical to ensure such infrastructure is regionally in place.

As noted, telehealth can provide vital patient care services, thereby improving access to care and health outcomes. Telehealth can also include telemonitoring, as with home care services which monitor and collect patient status data (e.g., self-care for heart failure programs). Telemonitoring can also be employed with respect to hospital inpatient unit oversight, such as an offsite clinician observing real time patient data and alerting facility-based staff regarding changes (e.g., virtual telemetry monitoring). Telehealth has additionally been impactful in creating virtual learning communities of health professionals and subject matter experts to inform best practices in care delivery (e.g., Project ECHO). Telehealth can also be employed with tele-precepting, uniting expert faculty with rural-based learners in supervising specialized patient care.

Academic preparation of today's health profession student needs to include didactic exposure and clinical experience with telehealth. Students need to be oriented to telehealth practices, examination strategies, approaches for building positive relationships with patients, appropriate documentation, and legal and policy implications. Faculty development is often needed, as telehealth is a new and evolving field. The integration of telehealth into health care curricula promotes graduate workforce readiness in this growing arena.

Question 4. Dental practices across the country are experiencing a significant shortage of hygienists and dental assistants.

Question 4(a). Are dental schools working with community colleges and career and technical training programs to come up with ways they can collectively encourage increased interest in those careers?

Question 4(b). What can we do at the Federal level to support those efforts?

Answer 4. Dental medicine and dental hygiene programs are actively partnering with community colleges to create educational pathways and promote student interest in the field of oral health. Community college graduates who earn an Associate Degree in health science are well qualified for entry into baccalaureate level dental hygiene education. For example, the University of New England has robust articulation agreements with regional community colleges for this very purpose. Each year, the dental hygiene program admits approximately 12 new community college graduates who will then study four additional semesters to earn the Bachelor of Science Dental Hygiene and eligibility for licensure. Innovative, accelerated pathways also exist for students seeking to attain dental medicine degrees (DDS, DMD).

Federal and state funding level can support these initiatives by enhancing scholarship opportunities to incentivize students into these careers. Additionally, loan repayment programs are another effective approach, especially for retaining graduates in documented regions with few oral health providers.

Response by Sarah Szanton to questions of Senator Paul and Senator Tuberville

SENATOR PAUL

Question 1. The American Nurses Association reports that the average age of a nurse is 52 years old and that at least a fifth of all U.S. nurses will be retiring in the next 5 years. The U.S. Department of Labor says that there are in excess of 200,000 open RN positions right now and that number is expected grow. Nurses are reporting record-high levels of stress because of severe workforce shortages. This data implies that the nursing shortage is about to get much worse. What is being done to combat these workforce shortages and alleviate the immense stress being suffered by nurses?

Answer 1. Thank you for the question. We are agree that the stress and shortages are a major problem. The FAAN act (Senate bill 246 from 117th Congress) which has not yet been re-introduced in this Congress would go a long way to solving many of the shortages, including addressing shortage of preceptors, financial aid for students and increasing the number of faculty members in nursing schools.

Question 2. For the last 15 years, nursing school enrollment has not kept up with hospital demand for nurses. The primary barriers to accepting all qualified students at nursing schools continue to be insufficient clinical placement sites, faculty, preceptors, and classroom space. How are we increasing nursing opportunities for U.S. students?

Answer 2. Thank you. The FAAN act described above would address each of these issues.

Question 3. Fifteen percent of U.S. nurses are foreign-trained, meaning that thousands of new U.S. nurses per year are foreign workers. Retrogression of visas is expected in 2024. If this pool of nurses were to run out, stress on nursing staff would be unsustainable, likely leading to even earlier retirements. Since visa retrogression will happen in 2024 and no foreign nurses will be able to enter the U.S., what steps are being taken to maintain foreign nurses' entry into the U.S.?

Answer 3. That's a great question. It is outside of my area of expertise as a Nursing School Dean so I do not have the technical expertise to provide the Senator the answer his important question deserves.

SENATOR TUBERVILLE

Question 1. In addition to doctors and nurses, the current health worker shortage includes technicians, assistants, pharmacy personnel, home health aides, nursing home staff, and more. America is experiencing shortages across every aspect of America's health care systems—not just the jobs requiring high-level and post-grad degrees. We need to train people throughout the care team, all across the industry. Not everyone desiring to pursue a career in health care wants to go to a full 4-year college or nursing or medical school.

Question 1(a). Please highlight what other opportunities outside traditional 4-year college settings are available to interested students?

Question 1(b). What training and incentive programs are out there?

Answer 1. Thank you for the question. I completely agree that not everyone wants to go to a full 4-year collage or nursing or medical school. One of the wonderful things about the health professions is that there are many rungs to jump onto to be able to serve patients, their families and communities. These include many community college programs for 2 year degrees and shorter than that for some fields. I am less aware of what incentive programs there are for other professions because I am a nursing school Dean and don't have technical expertise in the other professions.

Question 2. I have been contacted in particular by EMS professionals in Alabama who are sounding the alarm about their own individual shortages. Specifically, I recently heard from an EMS company in the state, NorthStar EMS. They are providing vital 911 emergency and interfacility ground ambulance services in both rural and urban counties in Alabama. Their organization, and every other ambulance service provider in Alabama, is facing an unprecedented workforce shortage. NorthStar noticed this issue several years prior to the pandemic and started their own training academy in order to make EMT education more accessible to people desiring to enter the field. When the pandemic started, interest in attending EMT school dropped. Not many people wanted to put themselves into a front-line position, which made the problem worse. However, the ones who wanted to get into the profession at that time turned out to be some of the best students and workers they have had in years. They have finally started to see an uptick in interest from prospective students, but nowhere near where they need to be in order to get back to pre-pandemic levels, which leaves them far short of where they need to be.

According to NorthStar, a recent survey on the EMS workforce shortage—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 service providers face 100 percent turnover within a 4-year period. Staffing shortages compromise their ability to respond to health emergencies, especially in rural and underserved parts of the country. In several rural counties in Alabama, only one ambulance is staffed most days of the week—not because that is what the service wants to do, but because there are no staff to cover the open shifts.

The EMS workforce shortage has continually worsened over a period of several years with the pandemic exacerbating the current shortage and highlighting the need to better understand the drivers of workforce turnover.

Question 2(a). From your perspective, what can be done to correct the training and staffing pipeline of EMS workers, especially in rural areas?

Answer 2. Thank you for the question. EMS workers are essential to providing Americans with emergency care. With new models, some are also providing important community based care such as check-ins for loneliness and whether people have enough food. As a nursing school dean, however, I do not have the technical expertise to provide the Senator the answer his important question deserves.

RESPONSE BY LEONARDO SEOANE TO QUESTIONS OF SENATOR PAUL, SENATOR TUBERVILLE, AND SENATOR BUDD

SENATOR PAUL

Question 1. The American Nurses Association reports that the average age of a nurse is 52 years old and that at least a fifth of all U.S. nurses will be retiring in the next 5 years. The U.S. Department of Labor says that there are in excess of 200,000 open RN positions right now and that number is expected grow. Nurses are reporting record-high levels of stress because of severe workforce shortages. This data implies that the nursing shortage is about to get much worse. What is being done to combat these workforce shortages and alleviate the immense stress being suffered by nurses?

Answer 1. The nursing shortage—and its strain on our existing workforce—is a significant concern to Ochsner Health. With over 1,200 open nursing positions across our system, and the cost of contract nursing having increased more than 800 percent since 2019, steps must be taken to grow the number of nurses in the health care workforce. At Ochsner, we have committed significant resources to the training and retention of nurses and implemented numerous programs to alleviate provider stress and prevent burnout.

Ochsner and our partners have developed nursing workforce programs that are accessible to individuals at all stages of their nursing career. We offer nursing preapprenticeship programs to high school and community college students, tuition reimbursement programs to full time community college and university nursing students, as well as "earn as you learn" apprenticeship programs for individuals already working as a Medical Assistant who want to become and LPN. We also offer scholarships and other financial assistance to employees who want to advance their careers by way of our career pathway programs. Finally, we have provided significant capital funds to build a new nursing program at a local community college, as well as providing Ochsner clinical nurses to serve in faculty positions at various nursing schools at no cost to the school.

At Ochsner, the mental health and well-being of our employees is of utmost importance, and we understand the strain and pressure the PHE put on our employees, but particularly bedside providers. We are particularly concerned that our clinicians are facing a more violent working environment; there has been more verbal and physical assaults on health care providers, including in our system. To help reduce the strain on our workforce and address burnout, we have undertaken a number of steps and launched new efforts in the clinical setting. We have a wellness office for our nurses and physicians. Other efforts include expanding the bedside care team to include more nursing assistants and LPNs in addition to RNs, all practicing within the scope of their licensure, to spread the workload and reduce pressure on the care team more evenly. Ochsner is also leveraging its long history of digital innovation to address provider stress through the implementation of the Virtual Nurse Program. This program, which provides 24-hour virtual nursing support to the patient care team, is an innovative staffing model focused on patient-centered care and safe distribution of workload across an integrated team of virtual and bedside nursing personnel. This approach allows bedside nurses to focus on direct care and leverages the bunker nurses—via technology hook-ups—to manage non-direct care matters—resulting in more efficient care delivery, a better patient discharge experience, and less strain on the bedside nurse. We worked with the Louisiana state legislature to make violence against health care workers a crime and we urge Congress to take similar action to provide the same safeguards to health care workers as are afforded airline employees.

Question 2. For the last 15 years, nursing school enrollment has not kept up with hospital demand for nurses. The primary barriers to accepting all qualified students at nursing schools continue to be insufficient clinical placement sites, faculty, preceptors, and classroom space. How are we increasing nursing opportunities for U.S. students?

Answer 2. Ochsner has made significant investments in educational opportunities for health care students. As the largest health care provider in Louisiana, Ochsner

is proud to serve as a clinical training site for numerous programs in the region. Additionally, Ochsner's $20 million investment in the Ochsner Center for Nursing and Allied Health at Delgado Community College provides matching funds for a new state-of-the-art facility on its campus in New Orleans, and covers full-time tuition for Ochsner employees pursuing a nursing or allied health certificate or degree at Delgado. Finally, we recognize that our nursing schools have limited capacity due to insufficient numbers of teaching faculty, and we are supporting several of our full-time employed Ochsner nurses in stepping out of their clinical roles 2 days a week to serve as clinical adjunct faculty at colleges of nursing. Ochsner continues to pay their salaries in full, which provides schools of nursing with faculty at no cost.

Question 3. Fifteen percent of U.S. nurses are foreign-trained, meaning that thousands of new U.S. nurses per year are foreign workers. Retrogression of visas is expected in 2024. If this pool of nurses were to run out, stress on nursing staff would be unsustainable, likely leading to even earlier retirements. Since visa retrogression will happen in 2024 and no foreign nurses will be able to enter the U.S., what steps are being taken to maintain foreign nurses' entry into the U.S.?

Answer 3. Ochsner agrees that maintaining a supply of well trained nurses who have a legal pathway to work in the U.S. is essential to helping us address workplace shortages and critical to closing the gap between patient demand and nursing need. We would support efforts to increase the visas available through proposals like the bipartisan Health Care Workforce Resilience Act which allows for recapture from previous fiscal years unused immigrant visas for physicians (15,000) and nurses (25,000), exempts these visas from country caps, and directs State Department and Department of Homeland Security to expedite these processing of these recaptured visas.

SENATOR TUBERVILLE

Question 1. In addition to doctors and nurses, the current health worker shortage includes technicians, assistants, pharmacy personnel, home health aides, nursing home staff, and more. America is experiencing shortages across every aspect of America's health care systems—not just the jobs requiring high-level and post-grad degrees. We need to train people throughout the care team, all across the industry. Not everyone desiring to pursue a career in health care wants to go to a full 4-year college or nursing or medical school.

Question 1(a). Please highlight what other opportunities outside traditional 4-year college settings are available to interested students?

Question 1(b). What training and incentive programs are out there?

Answer 1. Ochsner is proud that last year we invested more than $5 million to operate more than 29 different workforce programs, serving over 1,200 individuals. We have worked hard to ensure that these programs are accessible to individuals in both traditional educational pathways and those who choose alternate routes. Most of these programs are provided free of charge or include tuition assistance. Employment opportunities also await individuals finishing these programs. Ochsner offers nursing pre-apprenticeship programs to high school and community college students, as well as "earn as you learn" apprenticeship programs for individuals already working as a Medical Assistant who want to become and LPN. We also offer scholarships and other financial assistance to employees who want to advance their careers by way of our career pathway programs. We also have programs focused on individuals who are either un-or underemployed or lack proper credentials but wish to pursue opportunities within the health care system. MA Now is our signature community-facing program that links unemployed and underemployed to a nursing pathway. Students earn several industry-aligned credentials including the certified clinical medical assistant, phlebotomy, ED Tech Monitor, and EEG pathways. More than 250 MA Now graduates have been trained and employed by Ochsner. Graduates regularly move into leadership, LPN, and RN positions as they advance their careers. We also offer non-clinical opportunities including In-Patient Bedside Coding. This program is a 2-year program to build the knowledge and capacity for an individual to serve as an in-patient coder. This highly sought-after talent is in short supply across our Nation. The complexity of in-patient coding requires advance training. Our apprenticeship allows students the opportunity to grow their knowledge, skills, and abilities to successfully compete in this high demand occupation.

Specifically, with respect to students attending 2-year community college we have a number of programs.

- In February 2021, Ochsner launched a partnership with Delgado Community College (Delgado) to train the next generation of nurses and allied health professionals, forming the **Ochsner Center for Nursing and Allied Health**. Delgado is the largest educator of nurses and allied health professionals in Louisiana. Together, Delgado and Ochsner will meet critical workforce demands, providing more opportunities for local graduates in high-wage careers, and proactively pursue the career development of minority and disadvantaged students. Ochsner's $20 million investment in the center covers full-time tuition for Ochsner employees pursuing a nursing or allied health certificate or degree at Delgado and matching funds for a new state-of-the-art facility on its City Park Campus. In addition to RN and LPN programs, the facility will host Radiologic Technologist, Respiratory Therapy, Physical Therapy Assistant, Occupational Therapy Assistant, Surgical Technologist, Medical Laboratory Technologist, and Pharmacy Technologist programs.
- **Ochsner Nursing Pre-Apprenticeship launched** in 2021 in partnership with Delgado Community College and the Louisiana Department of Education (LDOE). It provides high school sophomores and community college students an opportunity to apprentice as nurses. This LDOE-approved Fast Forward Pathway serves high school students across Jefferson, Orleans, St. Bernard and the River Parishes and also supports students in St. Bernard in partnership with Nunez Community College. The program will soon expand to students in Shreveport, Lafayette, Monroe and Baton Rouge. With more than 350 students currently, the program seeks serve more than 600 students over the next 2 years.
- **Ochsner Facilities Pathway Pre-Apprenticeship** launched in 2022 in partnership with Delgado Community College and includes a high school pathway for the skilled trades (plumbing, light electrical, etc.) as well as an incumbent apprenticeship pathway. While the high school pathway is new in 2023, in partnership with Jefferson Parish Public Schools, the incumbent pathway has seven apprentices who will graduate in May 2023 from Delgado. This pathway has been submitted for recognition as a registered apprenticeship.
- **Ochsner's Medical Assistant to Licensed Practical Nurse (LPN) Apprenticeship** recently celebrated the pinning of 31 LPNs. In partnership with LCTCS colleges, North Shore Technical Community College, and Delgado Community College, the registered apprenticeship offers tuition-free career growth to current Ochsner Medical Assistants. Plans are underway to scale the program into the Shreveport and Lafayette areas.
- **Patient Care Assistant (PCA) to Certified Nursing Assistant (CNA)** is a 8-week pathway program for those with a strong desire for bedside caregiving who lack a credential. New hires enter an "earn as you learn" pathway that includes didactic training at a local community college while students supplement the ancillary staff in the hospital as they build their skills. Students graduate as a Certified Nursing Assistant and enter a pathway to progress to LPN and then on to RN.

Question 2. I have been contacted in particular by EMS professionals in Alabama who are sounding the alarm about their own individual shortages. Specifically, I recently heard from an EMS company in the state, NorthStar EMS. They are providing vital 911 emergency and interfacility ground ambulance services in both rural and urban counties in Alabama. Their organization, and every other ambulance service provider in Alabama, is facing an unprecedented workforce shortage. NorthStar noticed this issue several years prior to the pandemic and started their own training academy in order to make EMT education more accessible to people desiring to enter the field. When the pandemic started, interest in attending EMT school dropped. Not many people wanted to put themselves into a front-line position, which made the problem worse. However, the ones who wanted to get into the profession at that time turned out to be some of the best students and workers they have had in years. They have finally started to see an uptick in interest from prospective students, but nowhere near where they need to be in order to get back to pre-pandemic levels, which leaves them far short of where they need to be.

According to NorthStar, a recent survey on the EMS workforce shortage—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 service providers face 100 percent turnover within a 4-year period. Staffing shortages compromise their ability to respond to health

emergencies, especially in rural and underserved parts of the country. In several rural counties in Alabama, only one ambulance is staffed most days of the week—not because that is what the service wants to do, but because there are no staff to cover the open shifts.

The EMS workforce shortage has continually worsened over a period of several years with the pandemic exacerbating the current shortage and highlighting the need to better understand the drivers of workforce turnover.

Question 2(a). From your perspective, what can be done to correct the training and staffing pipeline of EMS workers, especially in rural areas?

Answer 2. Ochsner Health cannot fulfill our vision and mission without our EMS partners. Whether they are delivering a 911 emergency patient to our emergency departments (ED) or emergently transporting our patients between facilities in order to provide them the level of care needed, EMS is an essential component of our health care system. We have definitely felt the significant impact of the shortage of EMS staffing. Because of delays in EMS response to 911 calls due to shortages, our patients are arriving to us sicker. Our patients are facing delays in care due to a lack of available resources to transport critically ill or injured patients from a smaller facility to one that has the available resources and expertise to manage their conditions.

We value and appreciate what our EMS colleagues bring to patient care. We recently implemented an "EMS Timeout" initiative where we provide EMS professionals with an opportunity to present their patients to us upon arrival in the ED in a respectful, attentive environment. When these health care professionals are seen as peers and counterparts, it leads to improved patient care.

We also recognize that being a field EMT is physically demanding, and many are forced to seek alternative jobs due to the physicality of the profession. Ochsner Health has provided an additional avenue for paramedics who might have otherwise left the profession completely, leading to retention of experienced paramedics to continue practicing in their chosen field, albeit in the hospital setting, where they have become an integral part of our on campus care team. We work closely with our EMS partners and state entities to ensure EMS interests are supported and maintained at the highest level of excellence to arrive at the best possible patient outcomes. We also have an elite helicopter EMS program, Ochsner Flight Care, with intense, ongoing advanced skills training as another avenue for paramedics to pursue. We have a parish-based 911 EMS Service, St. Charles Parish EMS, that operates from one of our facilities.

We believe that providing our EMS colleagues with additional opportunities for employment will help to bring more interest to the profession. We strive to promote EMS as a lifelong career, rather than simply as a stepping stone, while also supporting paramedics who wish to continue their education to become nurses, advanced practice providers, or physicians.

SENATOR TED BUDD

Question 1. Dr. Seoane, how can health systems better partner with high schools and community colleges to develop and credential students for in-demand health careers?

Answer 1. Community colleges play a critical role in Ochsner's efforts to grow the health care workforce in our region. We are fortunate to have developed partnerships with excellent community colleges across Louisiana who educate and train Ochsner's current and future employees and providers in high quality programs in high demand fields. In return, Ochsner is proud to support our partners through capital investments, assistance with curriculum development, financial support for clinical faculty, and tuition assistance for students.

Specifically, with respect to students attending 2-year community college we offer the following programs:

Answer 1(a). In February 2021, Ochsner launched a partnership with Delgado Community College (Delgado) to train the next generation of nurses and allied health professionals, forming the Ochsner Center for Nursing and Allied Health. Delgado is the largest educator of nurses and allied health professionals in Louisiana. Together, Delgado and Ochsner will meet critical workforce demands, providing more opportunities for local graduates in high-wage careers, and proactively pursue the career development of minority and disadvantaged students. Ochsner's $20 million investment in the center covers full-time tuition for Ochsner employees pursuing a nursing or allied health certificate or degree at Delgado and matching funds for a new state-of-the-art facility on its City Park Campus. In addition to RN

and LPN programs, the facility will host Radiologic Technologist, Respiratory Therapy, Physical Therapy Assistant, Occupational Therapy Assistant, Surgical Technologist, Medical Laboratory Technologist, and Pharmacy Technologist programs.

Ochsner Nursing Pre-Apprenticeship launched in 2021 in partnership with Delgado Community College and the Louisiana Department of Education (LDOE). It provides high school sophomores and community college students an opportunity to apprentice as nurses. This LDOE-approved Fast Forward Pathway serves high school students across Jefferson, Orleans, St. Bernard and the River Parishes and also supports students in St. Bernard in partnership with Nunez Community College. The program will soon expand to students in Shreveport, Lafayette, Monroe and Baton Rouge. With more than 350 students currently, the program seeks serve more than 600 students over the next 2 years.

Ochsner Facilities Pathway Pre-Apprenticeship launched in 2022 in partnership with Delgado Community College and includes a high school pathway for the skilled trades (plumbing, light electrical, etc.) as well as an incumbent apprenticeship pathway. While the high school pathway is new in 2023, in partnership with Jefferson Parish Public Schools, the incumbent pathway has seven apprentices who will graduate in May 2023 from Delgado. This pathway has been submitted for recognition as a registered apprenticeship.

Ochsner's Medical Assistant to Licensed Practical Nurse (LPN) Apprenticeship recently celebrated the pinning of 31 LPNs. In partnership with LCTCS colleges, North Shore Technical Community College, and Delgado Community College, the registered apprenticeship offers tuition-free career growth to current Ochsner Medical Assistants. Plans are underway to scale the program into the Shreveport and Lafayette areas.

Patient Care Assistant (PCA) to Certified Nursing Assistant (CNA) is a 8-week pathway program for those with a strong desire for bedside caregiving who lack a credential. New hires enter an "earn as you learn" pathway that includes didactic training at a local community college while students supplement the ancillary staff in the hospital as they build their skills. Students graduate as a Certified Nursing Assistant and enter a pathway to progress to LPN and then on to RN.

A newer addition to our workforce offerings, is Ochsner's partnership with school districts and high schools around the state to offer their students an opportunity to experience working in the health care system during a particularly important time in their educational career. These unique programs offer high school students the opportunity to start a paid job in a high demand career field while still in high school, with the promise of free college tuition and a job upon completion of the program.

Specifically, with regards to high school students, we offer the following programs:

Ochsner Nursing Pre-Apprenticeship launched in 2021 in partnership with Delgado Community College and the Louisiana Department of Education (LDOE). It provides high school sophomores and community college students an opportunity to apprentice as nurses. This LDOE-approved Fast Forward Pathway serves high school students across Jefferson, Orleans, St. Bernard and the River Parishes and also supports students in St. Bernard in partnership with Nunez Community College. The program will soon expand to students in Shreveport, Lafayette, Monroe and Baton Rouge. With more than 350 students currently, the program seeks serve more than 600 students over the next 2 years.

Ochsner Facilities Pathway Pre-Apprenticeship launched in 2022 in partnership with Delgado Community College and includes a high school pathway for the skilled trades (plumbing, light electrical, etc.) as well as an incumbent apprenticeship pathway. While the high school pathway is new in 2023, in partnership with Jefferson Parish Public Schools, the incumbent pathway has seven apprentices who will graduate in May 2023 from Delgado. This pathway has been submitted for recognition as a registered apprenticeship.

A key aspect of scaling these types of programs is the availability of funding. Ochsner spends significant resources on developing and operating these programs, which limits the size and scope of any self-funded program. To encourage the growth in coordination between the Nation's academic institutions and health-systems, we would urge Congress to provide funding to support entities working together to increase the pipeline of physicians, nurses, and allied health professionals. We would also encourage funding to be prioritized for efforts that demonstrate a commitment to addressing economic and health disparities in the health care workforce.

[Whereupon, at 12:30 p.m., the hearing was adjourned.]

○