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HOUSE OF REPRESENTATIVES
COMMONWEALTH *of* PENNSYLVANIA

House Democratic Policy Committee Hearing

Health Care Staffing
Thursday, January 26, 2023 | 11 a.m.
Representative Arvind Venkat

OPENING REMARKS

11 a.m. Chairman Ryan Bizzarro (D-Erie)

Rep. Arvind Venkat (D-Allegheny)

PANEL ONE

11:10 a.m. Chris Dell, Chief

McCandless-Franklin Park EMS

Eric Schmidt, Executive Director

Shaler Hampton EMS

Q & A with Legislators

PANEL TWO

11:40 a.m. Donald Yealy, M.D. Chief Medical Officer, Senior V.P.

UPMC

Susan Hoolahan, MSN, R.N., NEA-BC, President

UPMC Passavant McCandless and Cranberry

Q & A with Legislators

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PANEL THREE

12:10 p.m. Michelle Boyle, BSN, R.N.

Union Nurse SEIU Healthcare PA

Q & A with Legislators

PANEL FOUR

12:30 p.m. Margaret "Marge" DiCuccio, PhD, R.N., NEA-BC, Chief Nursing Officer

Allegheny General Hospital, Allegheny Health Network

Q & A with Legislators

Supporting Testimony – House Policy Hearing: Health Care Staffing

Thursday, January 26, 2023

Submitted by Chris Dell, Chief of McCandless-Franklin Park Ambulance Authority

Thank you for the opportunity to be here today for the purpose of discussing the staffing challenges facing Emergency Medical Services in Pennsylvania. My name is Chris Dell, and I am the Chief of McCandless-Franklin Park Ambulance Authority. Our agency serves 5 communities in the North Hills of Pittsburgh. I am the Immediate Past Chairman of the Allegheny County EMS Council, a Board Member for EMS West, an EMS educator, and an evaluator of students completing their EMS training. I have had the pleasure of being certified as an EMT since 1987, and a Paramedic since 1990.

The issue of EMS staffing is one that I have watched slowly evolve into what many are referring to as a crisis. To appreciate this it is necessary to reflect on the past when ambulance services were typically provided by volunteers either from a fire department or an independent ambulance service. History shows the "volunteer model" changed in the late 1980's when training requirements were increased and double working families became the norm. EMS agencies are now nearly staffed 100% by career personnel.

The issue of staffing is largely affected by training opportunities, or the lack thereof. Speaking from the perspective of Western PA, we have experienced a gradual decline of training opportunities to primarily just two per year (including CCAC who recently reinitiated their program). The lack of local training opportunities has forced many students to travel over an hour to attend classes. Combine that with the rising cost of programs from just $300 in the early 1990's to over $7,000 today and one can quickly appreciate the lack of desire to attend the training.

The lack of newly certified personnel entering the EMS system has very diverse effects on the industry as a whole. These include:

- EMS agencies needing to appeal to the State to lessen staffing requirements
- EMS agencies rendering themselves out of service during specified periods
- EMS agencies ceasing operations
- Short-staffed EMS agencies who are unable to cover their calls create burdens on neighboring EMS agencies to do so in their stead.

As with most things, money is always an issue. This comes into play in numerous ways, including:

- Pay rates for EMT and Paramedics are often lower than that of their public safety counterparts (Firefighters and Police).
- The cost of EMS operations has risen by the fact that personnel costs have risen, and equipment costs have risen. Sadly, revenue received per call has largely stayed flat.
- There are very few grants or scholarships available for interested individuals to attend EMT or Paramedic training.

In 1996, EMS was referred to as the Public Health Safety Net. This label was created in part because of the projected and now experienced reliance on EMS as one's entrance to the diverse healthcare system during an injury or illness. EMS has shown a gradual increase of calls year after year. This growing dependence on EMS now includes hospitals who depend on EMS agencies to transport patients who are discharged, or who need moved from one hospital to another. Naturally, we need more people to be able to meet that demand.

Suggested Solutions

As with nearly every challenge, funding is part of the solution. To that end, I suggest the following strategies be explored in greater detail:

- Subsidizing EMS training institutions; This will serve to keep the training institution open and to lessen the costs of the students.
- Create grant/scholarship opportunities for individuals seeking EMS training.
- Create a program of reimbursement for individuals who have completed an EMS training program following a period of exhibited commitment to EMS.

I welcome the opportunity to address my comments and suggestions. Please feel free to contact my via phone at 412-367-5883 ext. 304, or via email at chris.dell@mfpaa.org .

Supporting Testimony
PA House Democratic Policy Hearing - Health Care Staffing
Thursday, January 26th, 2023

Financial Roadblocks to adequate EMS Staffing

Eric Schmidt, Chief, Shaler Hampton EMS

Thank you for the opportunity to be here today and discuss the current challenges facing Emergency Medical Services staffing in Pennsylvania. My name is Eric Schmidt, and I for the past 4 years I have been the Chief of Shaler Hampton EMS, serving 3 suburbs north of Pittsburgh. I am also the current Chair of the Allegheny County EMS Chief's, a component of the Allegheny County EMS Council. I have been an EMS provider since 1982, first as an EMT, but now and for most of those years as a Paramedic. I am honored to sit with other health care providers from the region and collectively illustrate our challenges.

My colleague will illustrate the training challenges that are negatively impacting EMS, and I will focus on the financial perspective. Although much of the data that I present today will be specific to Allegheny County, I believe that it translates well to much of the Commonwealth, except for rural Pennsylvania EMS, who face the same challenges illustrated today, but to a much more significant degree. In total, the approximately 750 EMS agencies in Pennsylvania respond to more than 1.8 million emergencies each year, more than 4,900 per day.

In March of 2022 the Allegheny County EMS Chiefs conducted a survey of municipal funding to the 35 EMS agencies that then provided emergency response to the 130 municipalities in Allegheny County, with 32 agencies responding (91.4%), representing 128 of 130 municipalities in the county (98.4%). Of the 32 responding agencies, 9 agencies (29%) that serve 44 communities (33.8 of the municipalities in Allegheny County), receive zero funding whatsoever from the communities that they serve. Below are two additional tables looking at per capita and percent of operating budget municipal contributions for Allegheny County, these funds are provided in both cash and services in kind, using a variety of different formulas.

Per Capita Municipal Contribution		
Amount	# of Serv	%
0	9	29.0%
.01 - $2.00	7	22.6%
$2 - $5.00	7	22.6%
$5.01 - $10	5	16.1%
$10 - $20	2	6.5%
>$20	1	3.2%
	31	100.0%

% of Operating Budget Covered by Municipal Contribution		
Amount	# of Serv	%
0%	**9**	**29.0%**
.01-5%	**10**	**32.3%**
6-10%	**6**	**19.4%**
11-15%	**3**	**9.7%**
16-20%	**0**	**0.0%**
>20%	**3**	**9.7%**
	31	**100.0%**

Clearly illustrated is the wide disparity in EMS funding practices within the county. Although a recruitment and retention issue also, from a financial perspective we clearly lose EMS providers

to two significant areas, to become police officers and nurses, where the additional training is not that significant, but the increases in income are significant, and while they change careers, they still are able to take care of people. In the following examples I will use comparisons to our public safety partners in the police service, due to comparative data that is readily available. *I also want to be very clear that in no way is this meant to disparage police officers, they are valued partners in providing public safety and deserve what they earn*.

In our first example is a comparison between the starting and 5 year pay as an average for police from 3 communities, as compared to the pay for the EMS staff that serve the same three communities;

	Police Average	Medic Average	EMT Average
Starting	$45,667	$47,840	$37,440
Year 5	$86,174	$55,016	$43,056

As another means of comparison, the per capita contributions made by the 3 communities to their EMS agency is $4.18, while the average per capita contribution to their 3 police departments is $172.86, a multiple of more than 40. Bear in mind that by comparison this highlighted EMS agency receives a very high level of support from the 3 communities that they serve. Imagine the comparison to those municipalities that provide zero level funding to EMS, but almost universally have full time police departments that are 100% locally funded?

A common reason cited by municipal officials for not providing funding to EMS is because "EMS bills insurance and get paid." The table below, is one year of actual data from one EMS agency, I would encourage any of you to please inquire with the EMS agencies in your legislative district to see how their numbers compare;

A 1 Year Billing Analysis for a Suburban PA EMS Agency
Total Dispatched Calls (12 Months) = 5,707
Total Billable Calls (12 Months) = 4,312
Calls without any revenue = 1,395
Average Payment from Insurance = $343
Cost to put an ambulance out the door, per call = $530
NET Deficit per call = $187 or $806,344 annually based on insurance payment alone
80% of all payors, pay significantly less than the cost of operations ($530 per call) with the average NET from Medicare, Medicaid & Self Pay of $253.

Figure 1 - Out the door cost = annual budget divided by total calls

Detail for the above data is attached to this report. The highlighted agency has the benefit of providing emergency service only, due to strong community support, while many (24 of 32 in Allegheny County or 75%), actively provide non-emergency transports to supplement their bottom line. But what happens when that agency is on a non-emergency transport and an emergency occurs in their service area? The answer is that the patient waits longer for care, maybe a few minutes, often more. In the "best case" scenario this means that maybe they just suffer pain longer than needed, or a senior citizen lays on the floor longer – in the "worst case" maybe the effects from their stroke are more severe, or their heart more damaged, or they die. At our core we are all care providers, and these are the things that keep us awake at night.

Also of significant note are the 1,395 calls without any resulting revenue, these are fire standbys, community festivals, weather standbys, etc, that all create wear and tear on our equipment and staff, use gas, etc, with zero dollars returned. As one example. the #1 cause of firefighter deaths is cardiac arrest – we want to be there, we need to be there, but there is an underlying cost.

Certainly not to be forgotten is the expense side of the equation. We have just endured the 3 most extraordinary years in the 40 years that I have been in EMS due to the pandemic, and the expense increases have been substantial. Supplies previously used occasionally (masks, gowns, decon equipment, etc) we have used on every call and acquisition costs are many multiples of what they used to cost for already stretched budgets. Fuel costs per gallon have doubled for vehicles that get 10 miles per gallon or less. Capital costs have certainly grown as well with many unfunded mandates for expensive but necessary technology. Consider the pictures below, on the left is a fundraiser to buy a fully equipped advanced life support (ALS) ambulance (late 70's early 80's) for $35,000 including the vehicle and all equipment, and on the right is a current cardiac monitor and a stretcher system, just 2 components of a modern-day ALS ambulance, <u>each</u> valued at $40,000, total cost of acquisition including the vehicle and all required equipment can easily exceed $300,000 per ambulance.

<u>Solutions</u>

Most of the challenges discussed today can at least be partially tied to EMS finance, so the solutions are improved financial support. Focus in this area will not only improve the long-term viability of the system, but also positively help to address recruitment and retention issues. The fastest and most logical solution is for local elected officials to recognize the vital service provided by EMS, and their ability to help build a robust EMS system for their communities, as their constituents are the direct beneficiaries of a quality EMS system. If you look at municipal budgets and tax dollars you will see significant funding for parks, roads, trash pickup, police, code enforcement, etc, with most of these services funded at 100%.

Our needs are comparatively modest because we do derive significant income from insurance payments already. The days of EMS being provided at no cost to the communities that we serve must be behind us. There is also a need for state legislation to create a local funding mechanism or develop a state mechanism, but my concern is that this solution will take too long. All too often change comes only after a tragedy, and this has certainly already occurred in

the Commonwealth, but with your assistance we can prompt change now to avoid future tragedies.

In closing, what we do best is care for the sick and injured, and we are certainly adept at stretching a dollar. We ask for and welcome your assistance in addressing the real and growing crisis facing the EMS system in Pennsylvania. Thank you!

Submitted by;
Eric Schmidt, EMT-P, Chief
Shaler Hampton EMS
director@shalerhamptonems.org
(412) 670-8904 Cell

Comparisons of Municipal Support for Public Safety in Allegheny County PA

There are 130 municipalities in Allegheny County, and each receives EMS, Fire, and Police services in some manner. For Police and Fire this is almost exclusively at municipal expense. The data below represent 101 of 130 municipalities. Of the 130 municipalities, we were unable to get data from 28 municipalities. Of those, 8 provide municipal EMS funding and 20 do not, It is assumed that near 100% of the 28 do incur Fire and Police expense. The City of Pittsburgh was excluded from this analysis due to significant differences in spend and structure.

Total Annual Municipal Public Safety Spend

(this represents only 101 of 130 municipalities for Fire & Police spend)

$251,253,073

(excluding Pittsburgh)

Breakdown by Agency Type

FIRE	POLICE	EMS
$30,579,269	$217,019,974	$3,653,830
Average per Municipality		
$302,765	$2,148,713	$36,177

2022 Allegheny EMS Chief's Survey of Municipal Support (32 of 35 agencies responded, representing all but 2.5 municipalities in the county) WITHOUT Pittsburgh

#	Date Completed	Agency Name	2021 Municipal Emergency Responses	2021 Non-Emergency Transport Call Volume?	2021 Support Calls	2021 Total Call Volume	Contribution per Call	Total Population Served	Contribution Per Capita	Collective Square Miles Served?	Municipal Funding Amount	% of Ops Budget Covered	# of Municip Served
1	3/10/22 11:46:03	Baldwin EMS	11,000	0	600	11,600	$15.52	70,000	$2.57	25.0	$180,000	10.0	4
2	3/9/22 14:25:26	Brentwood Ems	1,600	200	100	1,800	$52.22	10,000	$9.40	1.5	$94,000	15.7	1
3	3/8/22 11:59:45	Citizens Hose Ambulance Service	120	120	48	2,928	$10.25	10,100	$2.97	8.0	$30,000	3.5	1
5	3/8/22 15:25:22	Collier Twp. EMS	1,953	4,211	520	7,116	$0.00	8,419	$0.00	14.6	$0	0.0	2
6	3/8/22 14:28:45	Eastern Area Prehospital Services	11,287	883	90	12,260	$0.08	37,814	$0.03	6.3	$1,000	0.0	6
7	3/12/22 16:55:17	Eureka Fire Rescue EMS	1,750	79	23	1,852	$0.40	10,166	$0.07	20.0	$750	0.0	5
8	3/14/22 12:39:06	Fire Department of North Versailles	2,406	0	467	2,873	$5.22	9,960	$1.51	8.2	$15,000		1
9	3/9/22 11:25:20	Foxwall EMS	854	533	125	1,512	$46.30	7,845	$8.92	8.3	$70,000	13.0	2
10	3/14/22 14:24:08	Lower Valley Ambulance Service	4,933	208	928	4,933	$0.00	18,667	$0.00	30.0	$0	0.0	6.5
11	3/14/22 17:50:47	McCandless Franklin Park AA	4,903	2,079	1,376	8,358	$3.59	70,881	$0.42	64.0	$30,000	2.8	5
12	3/14/22 7:11:26	McKeesport Ambulance Authority	9,036	329	439	9,804	$10.20	35,000	$2.86	11.3	$100,000	5.0	5
13	3/14/22 12:56:07	Medical Rescue Team South Authority	10,846	0	0	10,846	$110.64	75,000	$16.00	14.0	$1,200,000	22.0	6
14	3/15/22 7:23:42	Monroeville EMS Inc.	8,819	488	0	9,307	$14.51	31,405	$4.30	20.2	$135,000	13.5	2
15	3/8/22 13:56:40	Munhall Area Prehospital Services	4,760	865	223	5,848	$0.44	22,000	$0.12	4.0	$2,580	0.0	3
16	3/8/22 14:44:01	NorthWest EMS	15,000	3,900	1,200	20,100	$0.00	70,000	$0.00	92.0	$0	0.0	14
17	3/10/22 10:30:28	Parkview EMS	2,640	260	200	3,100	$17.10	14,000	$3.79	9.0	$53,000	6.0	3
18	3/15/22 10:26:04	Plum EMS	2,947	9	495	3,451	$144.89	27,200	$18.38	29.0	$500,000	31.0	1
19	3/8/22 11:52:56	Priority One EMS	3,200	4,300	400	7,900	$0.00	10,221	$0.00	3.3	$0	0.0	4
20	3/15/22 7:02:15	Quaker Valley Ambulance Authority	1,443	421	230	2,094	$65.66	14,450	$9.52	28.1	$137,500	9.0	11
21	3/8/22 11:44:19	Richland EMS	1,231	44	380	1,655	$0.00	11,373	$0.00	14.6	$0	0.0	1
22	3/9/22 17:14:35	Robinson EMS Inc.	4,254	457	154	4,865	$6.17	14,236	$2.11	13.0	$30,000	0.04	3
23	3/8/22 10:50:52	Ross/West View EMSA	7,500	500	3,500	11,500	$26.09	56,000	$5.36	36	$300,000	9.0	5
24	3/10/22 12:37:24	Scott Township EMS	5,625	0	5	5,630	$0.00	26,781	$0.00	6.0	$0	0.0	3
25	3/8/22 12:30:10	Shaler Hampton EMS	4,790	39	961	5,790	$36.27	50,231	$4.18	27.4	$210,000	9.0	3
26	3/8/22 17:20:04	SouthBridge EMS	4,500	0	342	4,842	$11.98	32,000	$1.81	48.0	$58,000	4.0	2
27	3/8/22 12:21:14	Southeast Regional EMS	7,500	4,000	500	12,000	$30.00	54,000	$6.67	95.0	$360,000	10.0	9
28	3/9/22 10:52:06	Tri-Community South EMS	6,672	0	496	6,953	$0.00	65,309	$0.00	30.6	$0	0.0	3
29	3/9/22 11:53:45	Valley Ambulance Authority	5,693	1,179	863	7,735	$0.00	52,674	$0.00	89.3	$0	0.0	4
30	3/14/22 15:26:52	West Deer EMS	1,400	64	300	1,769	$18.65	13,000	$2.54	28.5	$33,000	4.0	1
31	3/9/22 8:56:40	White Oak EMS	3,231	1,857	279	5,088	$13.17	9,728	$6.89	8.6	$67,000	7.0	3
32	3/8/22 13:40:01	Woodland Hills EMS	3,011	125	200	3,336	$0.00	18,300	$0.00	5.1		30.0	5
		TOTALS	**154,904**	**27,150**	**15,444**	**198,845**	**$19.98**	**956,760**	**$3.45**	**799.0**	**$3,606,830**	**204.5**	**125**
							Average		*Average*				

Health Care Staffing in Pennsylvania

House Democratic Policy Committee

January 26, 2023

Testimony Submitted by Donald M. Yealy, MD

Senior Vice President and Chief Medical Officer,

University of Pittsburgh Medical Center

and

Susan Hoolahan, MSN, R.N., NEA-BC

President,

UPMC Passavant McCandless and Cranberry

UPMC
LIFE CHANGING MEDICINE

Throughout the COVID-19 pandemic and still today, UPMC and other health care organizations throughout the Commonwealth and across the country have faced evolving challenges, including patient capacity concerns and clinical staffing shortages. Through it all, our health care teams have remained dedicated to meeting the needs of the patients we serve, but that commitment to caring is taxed today.

Despite hiring 34,000 new employees last year, UPMC has more than 12,000 open positions across the system, including more than 3,000 nursing posts, and we have more than 500 employees in various stages of quarantine or isolation at any given time- meaning they are home and not at the bedside.

When neighboring hospitals closed their doors and deferred patient care in the height of COVID-19, UPMC kept our lights on and continued providing care, safely doing so by addressing the fears of patients and providers with the right tools and training. We never eliminated jobs, cut pay, or reduced benefits. Even when financial strain made things difficult, we provided merit-based increases in 2020-2022. We have steadfastly listened to the needs of our patients and employees, learned from our experiences, and created innovative solutions to overwhelming problems, all while providing world-class care.

Just two weeks ago, UPMC took another step in supporting our employees by announcing that minimum starting salaries for all non-union, entry-level positions will increase to $18 an hour by 2025 for the Pittsburgh region and Central/North Central Pennsylvania hospitals and facilities. Other sites within our footprint will reach $18 an hour by early 2026. For those who take advantage of our full benefits package, including retirement match, comprehensive health insurance, and generous paid time off, UPMC's minimum wage will amount to $27 an hour. We also offer paid tuition and loan forgiveness for our nurses, and we have started to provide subsidized emergency and backup child and senior care services.

Why all of these actions at UPMC? It is because we value our employees and know they are the essence of our organization, the people who deliver the life changing *care*. We believe the best way to recruit new employees, retain the employees we have, and continue being the employer of choice in the regions we serve is to act in these ways. We're investing in our employees so that they ultimately invest in us and those we serve.

One group with the most workforce challenges is nurses, which is why UPMC has consistently adapted and responded by investing in pipeline, recruitment, and retention efforts. Other groups in the health care workforce are also critically understaffed, and we focus on those people in similar ways.

UPMC
LIFE CHANGING MEDICINE

In December 2021, UPMC launched our own staffing agency for registered nurses, echocardiography sonographers, and surgical technologists with one year of experience or more; the program reduced our reliance on external staffing agencies and allowed us to better align our resources with the highest levels of vacancies and most pressing clinical needs.

In addition, any new graduate nurse who agrees to a 2-year commitment receives a $10,000 sign on bonus and may qualify for a monthly loan repayment program if working in inpatient/procedural, surgical services, and emergency departments. We have also created a tuition loan forgiveness program for nursing students who enroll and successfully complete their first semester at a UPMC School of Nursing, of which we have six throughout the state.

While many take advantage of this program, Pennsylvania hospitals, including UPMC, continue to face one of the worst nursing shortages in the country. By 2026, it is estimated that the Commonwealth will face a deficit of more than 20,000 registered nurses, the largest gap of any state. The shortage is due in part to an aging workforce, not enough nurse educators, and an increase in patients seeking care. For our situation to improve, more must be done to encourage middle and high school students to get in the pipeline and pursue careers in public service, including nursing.

Recently, UPMC signed onto a budget request from the Pennsylvania Commission for Community Colleges that would support the health care workforce. Investments outlined in the request to the governor and legislature include providing secondary school students with early opportunities to explore different disciplines in high-demand health care fields, implementing a scholarship program for students seeking a credential in health care at a community college, and expanding opportunities for Pennsylvanians to earn their Bachelor of Science in Nursing at a community college. UPMC strongly supports this effort and any others that will increase the sustainability of our state's health care workforce.

UPMC also is engaging another source of dedicated professionals to join our team - military veterans. In November of last year, UPMC became a partner in the U.S. Army's PaYS program, which guarantees soldiers an interview and possible employment after military service. The program allows us to actively recruit highly trained servicepeople who are transitioning back to civilian life and looking for careers in health care.

These men and women have already shown their dedication through serving our country, and many have leadership, organizational, and interpersonal skills in addition to medical training and experiences that translate well into the health care sector. This is why UPMC has supported, and will continue to support, any legislative efforts that will streamline the process of getting veterans into the health care workforce faster.

For example, in the last legislative session, Representative Tim O'Neal introduced a bill that would have ensured a military member's education and training be taken into further consideration. If passed and signed into law, it would have allowed veterans who wished to continue their medic specialty and obtain the necessary certification needed to become EMTs with fewer hurdles in place.

At UPMC and UPMC Health Plan, we also know how critical early care is and the role of first responders, like EMTs. It is why we launched Freedom House 2.0 in late 2020. The program recruits, trains, and employs first responders from economically disadvantaged communities, many of which were significantly impacted by the pandemic. Freedom House 2.0 builds on the original Freedom House, which operated in Pittsburgh from 1967-1975 and is widely recognized as the country's first paramedic program. Today's participants receive mentorship and financial support, and they get state approved EMT certification and community paramedic training. Graduates of the program are guaranteed an interview with UPMC and receive other job placement support.

At a time when volunteers are losing interest and first responders are difficult to recruit, these are the kinds of solutions we should be supporting and expanding. The positions are open and available; it's time we evaluate current laws and regulations and understand what is keeping potentially qualified candidates from filling them.

If there is one thing I want you take away from this testimony, it is that more must be done to support the health care workforce in Pennsylvania. We should be expanding programs that work, dismantling policies and programs that do not, and supporting legislative efforts that strengthen our workforce, not undermine it.

To that end, I wish to comment on mandated staffing ratios. While well intended, these ratios do not create more nurses, nor do they create more medical assistants, patient care technicians, phlebotomists, etc. They do not account for today's care team composition and the changes in tasks that allow safe, effective care. Mandated ratios create more administrative work by forcing hospitals and nurse leaders to manage rigid state-determined ratios within dynamic patient care teams in ever-changing environments, even when patient needs and volumes do not support the ratios required.

At UPMC, we are not alone in believing that every hospital and health care facility is unique and should be able to appropriately staff their care units based on a variety of factors. Without this ability, the safety and well-being of patients may be compromised. We embrace being accountable for delivering quality, compassionate care – but we do not think ratios are the answer. They were not the answer to safe staffing before the COVID-19 pandemic, and they are certainly not the answer now.

Thank you again for allowing UPMC to provide testimony on this critical topic. We welcome the opportunity to act as your resource and partner.

Michelle Boyle, BSN, RN, SEIU

House Democratic Policy Committee Hearing: HealthCare Staffing Crisis
Chairman: State Rep. Ryan Bizzarro (District 3)
Host: State Rep. Arvind Venkat (District 30)
When: 11 a.m. to 1 p.m., Thursday, January 26th, 2023
Where: McCandless Town Hall

- Thank you Mr. Chairman Bizzarro, State Representative Venkat, and all the members of this committee for this policy hearing about the short-staffing crisis in health care.

- My name is Michelle Boyle, I'm a registered nurse for 28 years. I returned to a medical surgical floor last year after 6 years in case management. Also I worked as a nurse member coordinator for the Nurse Alliance SEIU and have spoken to nurses across the state for the past 3 years.

The Short-Staffing Crisis

- Pennsylvania is facing a **catastrophic staffing crisis** in our hospitals that must be urgently addressed by the healthcare industry, individual hospitals who take in massive revenues, and by the state legislature by passing the Patient Safety Act.

- Unsafe staffing puts all our lives at risk - patients and staff alike.

- The short staffing crisis is THE issue forcing nurses and frontline healthcare out of the profession. No blood team, exsanguination of pt, bathroom break post surg pt in 50's died.

- **To be clear: we have a nurse and frontline worker crisis – NOT an administrators crisis. Nonsupervisory frontline nurses and healthcare workers must have a say in protecting patients. We are trusted with patient's lives, we were trusted when we put our lives on the line during the pandemic, trust us to provide solutions to protect those we most care about, our patients.**

    - The massive loss of highly-skilled, experienced nurses is a threat to our healthcare system and the ability to provide quality care to our patients.

    - According to an American Economic Liberties Project report that was released just last week – and received widespread media attention – cited a survey that **93 percent of Pittsburgh hospital workers** said they think about leaving their jobs at least once a month.

    - 90 percent reported that their units don't have the staff to keep up with quality patient care. Anymore we are relieved when a patient survives their hospital stay

- In addition to to the Patient Safety Act, in order to address this crisis the legislature **must support the retention of nurses through increased compensation, tuition reimbursement and loan forgiveness, and other direct financial support.**

    - The legislature has appropriated money, nearly $60M over the last few years towards the nurse loan forgiveness program. But the legislature must go further and allow any nurse who is committed to work in Pennsylvania for a set time to be able to go to college, or get the training and certification they need, for free.

- To really solve this crisis, we must **demand accountability and transparency from hospitals**. The only way to do that is to **enact the Patient Safety Act** that will improve patient care standards.

- **The hospital industry wants to move past the Patient Safety Act and talk about every other issue. But to really address our hospital staffing crisis, it begins and ends with passing the Patient Safety Act to bring real accountability and protect our patients and essential workers.**

- That's why I am **asking every single member of this committee, who hasn't already done so, to immediately sign onto the Patient Safety Act as a co-sponsor** and make a firm commitment to move this bill.

    - Yes, frontline healthcare workers are certainly not paid enough for the stress, trauma, exhaustion, and workload we are put through - despite our service and dedication to our patients.

    - But no amount of compensation is going to take away the anxiety, stress, and trauma that nurses feel when we might lose a patient, or negatively affect their health, BECAUSE we're short staffed. This is the stark reality that nurses face.

- Nurses, through the power of our Union, can and do make a huge difference by advocating for better staffing within our collective bargaining contracts. This is an improvement for workers and patients alike.

  But we can't do it alone, going clinic by clinic, unit by unit, hospital by hospital. We need systemic change by passing laws and policy.

- We're **fighting against the Hospital Association and their well-paid lobbyists on top of multi-billion dollar health systems and conglomerates with their corporate lawyers. Never has there been so much money in healthcare with such poor and devastating outcomes.**

- That's why we simply **have to address the elephant in the room**, and that is the **monopoly-power of UPMC**. Yes, the short-staffing is a national, and even an international issue.

    - But the truth is that UPMC, which has an **estimated 75% of all hospital nurses in the Pittsburgh region** - and is forcefully anti-union – and will spare no expense denying nurses a voice on the job.

    - Even when nurses do try to form a union and/or negotiate a contract, they still hit a wage ceiling and "industry standard" that holds down wages and pushes skilled nurses away.

- Last year, our **nursing home workers** through our union sat down with the industry to enact improved staffing regulations and achieved incredible results for residents, families, and caregivers that also **won more investments into the long term system that yes improved bedside care - AND strengthened the overall system.** There is no reason why we couldn't achieve the same results with the short staffing crisis in hospitals.

- We do believe that nurses, and the hospital industry, along with a bipartisan approach of the legislature, can focus our energy into solving this short-staffing crisis and pass the Patient Safety Act that will improve quality patient care, bring back skilled nurses to the workforce, and also benefit the industry.

- The legislature simply cannot let this crisis persist - it must take action. We urge the House to bring the Patient Safety Act, as bipartisan legislation to the floor for a vote this year.

Conclusion:

- This is the year to finally resolve the short staffing crisis and we look forward to being partners in that effort.

- Thank you for the opportunity to address this committee. I am eager to answer any questions you may have for me.

House Democratic Policy Committee Hearing

Health Care Staffing Crisis
McCandless Town Hall, Wexford, PA

Margaret (Marge) DiCuccio, PhD, RN, NEA-BC, Chief Nursing Officer,
Allegheny General Hospital -- Allegheny Health Network

January 26, 2023

Chairman Bizzarro, Representative Venkat, and members of the House of Representatives the Allegheny Health Network (AHN) appreciates the Committee's efforts to examine the challenge of healthcare workforce shortages in Pennsylvania. There have been concerns for years about looming supply and demand imbalances in the healthcare workforce. The shortage is no longer looming. It's here now, and it's a crisis.

AHN, a Highmark Health company, is an integrated healthcare delivery system with a service area spanning western Pennsylvania and portions of New York, Ohio, and West Virginia. As a non-profit health network, we aim to extend our reach to as many people as possible to offer them a broad spectrum of care and services. We have 14 hospitals and more than 200 primary- and specialty-care practices. And we have approximately 2,400-employed and affiliated physicians in every clinical specialty, 19,000 employees and 2,000 volunteers. Together, we provide world-class medicine to patients in our communities, across the country and around the world.

Nurses traditionally have been the main support of the healthcare system; thus, the current and future shortage of nurses is potentially an existential crisis for hospitals and health systems.

The nursing shortage facing America began long before the pandemic propelled it into the headlines once again. The United States has experienced nursing shortages periodically since the early 1900s. Multiple factors led to each shortage, from world wars to economic recessions. But the magnitude of the current nursing shortage, announced in 2012, is greater than ever before in this country. Specifically, a shortage of nurses practicing in acute care, at the bedside.

While these remarks are from my perspective as the Chief Nursing Officer at Allegheny General Hospital, the greater Pittsburgh region is a microcosm of the country, and the Commonwealth.

In our nursing organization, registered nurses (RNs) provide direct patient care 24 hours a day, 7 days a week. In early 2020, of the budgeted 3,100 nursing positions, we had approximately 300 open positions to fill. That is a vacancy rate of 9%. Fast forward to today, 2022, and we now have approximately 767 open bedside RN positions to fill. That is a vacancy rate of 42%. Retention of nurses has also shown dramatic changes. In 2020, turnover of nurses at the bedside averaged 12%, 2021 increased to 22%, an increase that was sustained through 2022.

The healthcare workforce challenges facing the country are more extreme and broader this time around and have many causes. The nursing shortage in Pennsylvania mirrors a national shortfall, including overworked, burned out and dissatisfied nurses, decrease in nursing recruitment and retention, faculty shortages, insufficient funding for nursing programs and advancing age of nurses. All of this was intensified by COVID.

We are living in a world where RNs are leaving hospital employment at far greater rates than we have ever seen. It is important you hear about the effects and consequences of not having adequate numbers of nurses to care for the patients of our communities. In our most recent Clinician Wellness Survey, our fourth annual, AHN bedside nurses reported a 54% incidence of burnout, at AGH 72%.

Access to healthcare due to staffing shortages is even more dire. Every day we read about hospitals throughout the country losing millions if not billions of dollars per year. Hospitals are closing urgent care centers, obstetric, pediatric, and other services to try to survive. Hospitals have had to also close operating rooms due to staffing thus delaying both elective and emergent services. Critically ill patients boarded in the emergency department have also spent long hours or days waiting for inpatient beds due to lack of trained staff even when beds become available.

Hospital patients waiting to be discharged have long waits to find rehabilitation and skilled nursing facilities because they have also been affected by short staffing. This inability to transfer patients to appropriate facilities only adds to the short fall of inpatient beds.

Nurses are leaving the bedside for many reasons, with the main reason being the workload from lack of staffing. The staffing crisis has left a major imbalance in the workloads for remaining nursing staff. This has been especially true during the pandemic. Many hospital employees were asked to move from their usual departments and roles to assist with the intensive care of COVID-19 patients.

Overwhelmed frontline-working RNs have been running a constant risk of developing nurse burnout. The phrase struggles to encompass the depth of the physical and emotional exhaustion nurses experience as the result of heavy workloads, long hours, and the stress of treating critically ill patients.

Other reasons are the emotional and physical toll of the job and family needs. The heightened stress levels of today's nurses are due to more than just the pandemic, more than just the need to make urgent life-altering decisions, and more than just working long hours. It is all these things and more, combined, that weigh on the shoulders of many RNs.

Another reason nurses are leaving their current organizations – not the bedside – is to work for a nursing agency who is paying out of market wages by price gouging hospitals and health

systems. These nursing/travel agencies offer unprecedented compensation to individuals along with the opportunity to visit new places and the ability to have extended time off between assignments.

For such a complex, multifaceted problem, there is no simple solution, no silver bullet. But there are strategies and practices that we can examine and put into play today. However, the fundamental issue that must be addressed, for all nurses across the Commonwealth, is how to attract them to stay at the bedside or come to the bedside in the first place. The shortage of skilled nurses entering and staying in the workforce affects both patient care and other healthcare workers on the team. Nurses are so important to healthcare delivery that any challenge they face impacts us all.

As a health system, we are addressing the basic needs of the bedside nurse – wage and benefit equity and competitiveness, safety and security, flexible scheduling to fit lifestyles, and reducing the workload as best we can. But as a health system, we can only do so much. We cannot compete with the nursing agencies who are paying exorbitant amounts of money. In fact, we are feeding that beast ourselves. Because we don't have the staff, we too are paying those excessive nurse agency rates to reduce the workload of our current staff and to ensure we can take care of the patients who seek our services.

There are many times when we, as a large health system with advanced services, cannot take patients who need to transfer from hospitals outside our network because we don't have the staff to take care of them. This compromises the health and safety of those patients who require tertiary and quaternary levels of care.

This vicious cycle must be addressed. By the end of 2021, our health network paid $57 million in agency fees and incentive pay. That is 3 times what we normally pay in a year. In 2022 our health network paid $151 million in agency and incentive pay which is 9 times the historic rates. And like other financially stressed hospitals, its money we don't have. Our losses will have a significant impact on our ability to provide the services our communities need.

As legislators, you can help.

Actions legislators can take include making a long-term commitment to funding health care workforce education – (1) fund scholarships/programs to entice job seekers in health fields and expand student loan forgiveness for health care providers in exchange for a commitment to working at the bedside; and (2) create/fund a program to compensate practicing health care professionals who are also willing to work as educators/preceptors.

There is one thing that won't work to solve nursing and other workforce shortages – legislatively mandated staff-to-patient ratios. Supporters argue that hospitals are shortchanging their nurse staffing to save a buck — in the process, burning out their nurses, and putting patients in danger. Opponents say ratio laws would exacerbate nursing shortages across the country, limiting access to care, and take important staffing decisions out of the hands of nurses.

Mandated staffing ratios is a deeply flawed, inflexible, rigid approach to setting staffing levels that does not improve quality, safety, or outcomes, but in fact would adversely affect patients. A law might sound good in theory, but in practice could lead to undesirable consequences – at the top of the list is access to healthcare. As stated previously, hospitals across the state, in every area of the state, are either losing money or barely surviving. Mandated staffing ratios would result in longer wait times for patients to get care in the emergency department and other units

of the hospital. Hospitals will be forced to turn away patients because they'll have to go on emergency bypass and shut down some of their units because they don't have enough nurses to meet the ratios. An unexpected influx of patients, caused by anything ranging from a flu outbreak to a mass shooting, could mean there won't be enough nurses on hand to meet the ratios. The worst-case scenario is that a mandate could force safety-net hospitals out of business. These aren't theories or threats of dire consequences of what will happen with staffing shortages – *this is what is happening today.* Ratios will further exacerbate this grim reality.

Imposing ratios would add additional costs to the health care system -- many hospitals cannot absorb those costs. And a lot of those costs would be passed on to patients and families in the form of higher health care costs.

But one of the biggest arguments against mandated ratios is that there's simply no proof that they work to improve care for patients. The evidence is not conclusive that ratios improved quality, safety, or outcomes. Mandated ratios don't even improve job satisfaction in the workplace.

Putting staffing ratios into law robs nurses of the flexibility — and the independence — they need when it comes to staffing. The best staffing model is a fluid approach, one that's able to adjust to changing conditions from day to day, patient to patient, unit to unit. For instance, some patients require lots of time and care, others, much less. Likewise, nurses differ in their skill and experience levels. All of this and more should be considered when determining staffing.

One way to do that is using acuity, which is a way of measuring and scoring the amount of care different patients need. For instance, more complicated or challenging patients would likely be deemed high acuity; less time-consuming patients would be low acuity. Ideally, that would be considered when assigning patients, so that no one ends up being overwhelmed with multiple high-acuity patients or caring for just a few low-acuity patients.

Hospitals use different tools to calculate acuity, ranging from custom-made to commercial software, but the common thread is that the approach is flexible. So instead of a fixed number of patients, nurses' assignments shift from day to day.

Until recently, Allegheny General Hospital (AGH) was the only facility in the state with mandated staffing ratios in our union contract. Unfortunately, our experience with ratios has not been workforce stabilization, but the opposite. The turnover and vacancy rates over the last two years were higher at AGH than they were in any of the other AHN facilities without fixed ratios.

Nurses left to take high paying travel positions with no guarantee of reasonable ratios and often the knowledge they would have much higher patient caseloads. As nurses left, it became more difficult to meet the contracted ratios 100% of the time. When AGH could not meet the ratio expectation, nurses became more dissatisfied and viewed the workload more negatively than at other AHN hospitals and more nurses left.

Today, we have an agreement to maintain ratios at a time in healthcare when doing so results in limiting access to life saving medical care to patients that require a higher level of care. Patients are forced to wait in community hospitals for hours when they should be receiving care at a tertiary or quaternary facility. If legislation goes into effect mandating ratio adherence significant delays of care will occur throughout the Commonwealth. If you mandate ratios, it will not bring nurses back to the bedside in mass but instead it will place timely access to healthcare for the

citizens of Pennsylvania at risk. Enacting a mandated ratio into law will falsely raise expectations for nurses and when hospitals cannot realistically meet them, nurses will become even more disgruntled. Any way you look at it, mandates put hospitals in an untenable position.

Thank you again for the opportunity to share our thoughts on this issue. AHN welcomes the opportunity to continue discussions with this Committee as well as others on ways to improve healthcare workforce shortages.

House Democratic Policy Committee
Workforce Crisis in Personal Care and Assisted Living
Written Testimony
January 26, 2023

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Thank you for this opportunity to submit written testimony to the Democratic Policy Committee on the workforce crisis affecting Personal Care and Assisted Living communities. The Pennsylvania Assisted Living Association otherwise known as PALA is the statewide association dedicated to supporting Personal Care and Assisted Living communities in the Commonwealth.

The 1,076 Personal Care Homes (PCH) and 68 Assisted Living Residents (ALR) serving over 45,000 seniors provide care to the aging population of the Commonwealth. Argentum, our national association, reports the senior living industry in Pennsylvania has a $6.2 billion economic impact. Our communities employ nurses, direct care workers, administrative, maintenance, environmental services and dietary employees to provide for the residents of PCH and ALR. Senior Living in Pennsylvania experienced losses of $2 billion during COVID-19. A large portion of these losses can be attributed to the workforce crisis. For example, one of our members paid $1,318,154.00 for staffing agencies from March 2020 to April 2022 for their 4 communities to supplement their workforce.

Yes, there was a workforce crisis prior to COVID-19, but it has been exacerbated by this virus. There were several contributing factors to the lack of workers because of COVID. Our workforce is overwhelmingly women, many of them with children. COVID-19 closed schools and required virtual learning. Our workforce had to make a choice on coming to work or staying home with their children for virtual learning. Since the childcare facilities were closed, there were no options for our workforce to find a place for their children while at work. The uncertainty of school schedules and childcare access prevented many from re-entering the workforce including the escalating cost of childcare. Communities had workers leave because they were afraid of bringing home COVID-19 to their families. The direct care workforce is also an aging workforce with health issues themselves. Their fear of contracting COVID-19 led many to retirement.

PCH and ALR are now in competition with other industries that are struggling to hire workers. It is difficult to compete with the local Sheetz, Wawa or Rutters when they are offering $16.00 to $20.00 an hour for applicants for a less stressful job of care giving. Drive down any street and you will see signs looking to hire employees. Nurses and direct care workers can leave our communities and work for staffing agencies and earn 2 to 4 times the amount we can pay. Since PCH/ALR is a private pay for the residents, the need to increase pay rates for staff would fall to the consumers, the residents, with increased rates.

Older Adults will outnumber children by the year 2034 in this country. The statistics are staggering:

- 10,000 Americans turning 65 every day in the United States
- 70% of seniors will need long-term care
- Senior living has lost 380,000 caregivers since March 2020
- 96% of assisted living communities are facing staffing shortages

Personal Care Homes are closing in Pennsylvania. Many of these PCH served the low income and SSI residents. These homes could not continue to operate because of the increased costs for operation and workforce. Several closed because they were unable to employ staff to provide the care or the owners were exhausted from working 24/7.

We all know there is a crisis, but we need to develop solutions to stop the drain of workers from long-term care (LTC). There have been several studies, workgroups and reports on the workforce crisis in Pennsylvania LTC prior to COVID-19:

- 2019 Who Will Care for Mom & Date? – PA Auditor General Eugene DePasquale
- 2019 A Blueprint for Strengthening Pennsylvania's Direct Care Workforce – PA Long-Term Care Council
- 2007 Addressing PA Direct Care Workforce Capacity - Governor's office of Health Care Reform
- 2003; Finding Solutions to the Direct-Care Workforce Crisis. PHI and PA Intra-Governmental Council on LTC

What good is a report if it sits on a bookshelf and is not activated?

At the meetings of the Long-Term Care Council, I continually ask for an update on the recommendations in the Blueprint. The committee members worked hard to develop this report and it is frustrating that there has been no action since 2019. One of the recommendations is to raise the public awareness of the important role direct care workers provide in caring for older adults. The general public only hears the horror stories and not the fantastic stories that happen daily in our communities because of the dedicated staff and amazing residents.

It's time to stop talking about the workforce crisis and start implementing solutions. Here are suggestions from PALA to help ease the crisis:

Review regulatory requirements for PCH/ALR direct care staff that require a HS diploma or a non-US diploma that is equivalent to a US diploma.

- Currently all Direct Care Workers in PCH/ALR require a HS diploma or GED.
- This regulation eliminates an opportunity to hire those who have been caregivers for children or elderly family members but do not meet the education requirement.
- Providers must apply for a waiver to hire a caregiver without a US diploma. The non-US must be equivalent or exceed US educational requirements. The document must also be translated into English by a certified translation service prior to submission.

Review regulatory education requirements for PCH/ALR administrators.

- The need for administrators is increasing because of many factors including retirements and exhaustion from COVID.
- Education requirements eliminate potential administrators with the skills and experience from obtaining certification as an administrator.

- Governor Shapiro's executive order that reviews skills and experience rather than education requirement's should be adopted by the Department of Human Services to alleviate the lack of administrators for communities.

Embrace immigrants and refugees to help with the direct care workforce shortage by eliminating barriers to employment.

- Immigrants and refugees are a source for providers for caregivers.
- Barriers include the US HS diploma requirement. This especially can be difficult if they fled their county with minimal belongings.

Technology advances in long-term care are not aligning with current regulations. Review the options to adapt technology to assist with the workforce crisis.

- Technology continues to advance, and regulations are not keeping up.
- Regulations in Flintstone era and we are in the Jetson era.
- Alexa/Google were essential to residents during the pandemic to communicate with families.
- Call Bell systems, Fall Prevention, Health monitoring can assist caregivers in responding to resident needs quickly.

Provide childcare funding to all employees, not only low-income employees who choose to work in LTC.

- Childcare is a barrier for many to return to work.
- A caregiver may want to pick up an extra shift or work more hours but if they do, they will lose childcare subsidies or insurance.

Promote and increase the apprenticeship programs for direct care workers.

- PALA's Apprenticeship initiative with Argentum increases the opportunities to showcase the careers that are in senior living. This program can assist in retaining and recruiting direct care.

Implement the public awareness campaign as recommended in the LTC Council Blueprint.

- You can do this in your own district. Support direct care workers in your newsletter and social media.
- Visit a PCH/ALR in your community.
- Walk in their shoes – "Bring a legislator to work" day.
- Introduce a House Resolution for Direct Care Worker Day

Provide funding for student loan forgiveness not only for nurses but for direct care workers that commit to working in LTC.

- **Support Rep. Kosierowski's HCO 926 – Student Loan Forgiveness.** This legislation specifically helps the workforce in Personal Care and Assisted Living communities.

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- There are direct care workers strapped with loans that could benefit from a grant if they give a commitment to work in LTC**.**

Support Rep. Kosierowski's HCO 918 Retention Bonuses for LTC employees. Legislation last session did not move in the House Aging and Older Adults Committee.

- Support this legislation that provides workforce retention and bonuses for Personal Care and Assisted Living communities.

PCH/ALR are not nursing homes. PCH/ALR do not receive home and community-based funds. PCH/ALR are our residents' homes, but they have been left behind by legislators in Harrisburg and Washington, DC. Federal funds did assist other health care entities with the workforce crisis but there is no Medicaid for PCH and ALR. In fact, Pennsylvania is one of only three states that does not allow ALR to qualify for Medicaid.

PALA appreciates your understanding the financial crisis and appropriating funding to help provide for the seniors in our communities, but the battle is not over. The crisis now is with the workforce and recruiting and retaining caring, compassionate, and qualified employee to care for the vulnerable residents in our communities.

Thank you again for this opportunity to discuss the workforce struggles of Personal Care and Assisted Living communities in the Commonwealth.

Please do not hesitate to contact me for further information.

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A Roadmap for Growing Pennsylvania's Health Care Talent

January 2023

The Hospital + Healthsystem Association of Pennsylvania

A Roadmap for Growing Pennsylvania's Health Care Talent

A mutual commitment to strengthen Pennsylvania's health care workforce

January 2023

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The Hospital + Healthsystem Association of Pennsylvania

HAP thanks Jefferson Health for providing photos used throughout this report. All photos on the cover and on pages 9, 13, and 19 are courtesy of Jefferson Health.

Acknowledgments

This report was developed by The Hospital and Healthsystem Association of Pennsylvania's (HAP) Health Care Talent Task Force, which was convened to help HAP explore workforce needs, new models of care, and strategies to help Pennsylvania hospitals attract and retain the necessary health care talent to serve their communities. Task force members include:

CHAIR: Hugh Lavery, Senior Vice President, Government/External Affairs, Jefferson Health

Robert J. Batory, Senior Vice President/Chief Human Resources Officer, WellSpan Health

Joseph Cassidy, Former Vice President/Chief Human Resources Officer, Holy Redeemer Health System (Retired)

Kate FitzPatrick, Executive Vice President, Connelly Foundation Chief Nurse Executive Officer, Jefferson Health

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HAP appreciates their efforts to provide guidance and direction to the following HAP staff in the development of this recommendation report:

Jeff Bechtel, Senior Vice President, Health Economics and Policy

Mary Marshall, Senior Director, Workforce and Professional Development

HAP retained consulting assistance to support this effort. HAP appreciates the expertise that Carrie Amann—who has an extensive background in local and statewide policy issues centered in workforce development and education—provided to this report's development.

A Roadmap for Growing Pennsylvania's Health Care Talent

Pennsylvania's health care workforce is in crisis. The state's health care workforce shortages—intensified by the COVID-19 pandemic—are some of the most severe and persistent in the country. State government intervention and strategic policy are necessary to support the needs of health care professionals and their employers, and to ensure high-quality care remains available in Pennsylvania, regardless of ZIP code.

The Hospital and Healthsystem Association of Pennsylvania (HAP), led by its Health Care Talent Task Force, calls for a mutual commitment among the governor, legislature, and Pennsylvania hospitals to:

- **Prioritize health care talent infrastructure**
- **Support health care workers**
- **Strengthen the health care community**

Despite economic and workforce disruptions, Pennsylvania's health care sector remains a national innovator, economic driver, and quality employer for hundreds of thousands of Pennsylvanians. Commitment and action to overcome workforce shortages will only strengthen Pennsylvania's health and communities.

HAP has built upon its initial recommendations from 2020, providing this stakeholder roadmap for closing gaps in Pennsylvania's health care workforce. Working together, we can arrive at a destination that benefits patients, providers, hospitals, communities, and the commonwealth's economy.

Prioritize Health Care Talent Infrastructure

The **governor** can	**Lead on health care talent priorities** • Create a Health Care Workforce Council and hire chief health care talent officer within the governor's office • Direct state agencies to conduct research and collect data on evolving health care workforce needs **Help clinicians get to work caring for patients** • Modernize and streamline licensing, enrollment, and credentialing processes • Fully operationalize interstate licensure compacts
The **legislature** can	**Make a long-term commitment to the health care workforce** • Authorize and fund a Health Care Workforce Council and chief health care talent officer • Implement the council's recommendations as they are developed
Pa. **hospitals** can	**Inform health care talent growth** • Provide timely data and expert assistance to the council • Inform discussions about health care workforce shortages and in-demand competencies

Support Health Care Workers

The **governor** can	**Promote health care careers** • Work across state agencies to build interest among students and mid-career job seekers **Develop health care career pathways** • Help interested candidates connect with entry points like mentoring, training, and education
The **legislature** can	**Prepare the next generation of providers** • Create stipend program for health care professionals willing to also work as educators/preceptors **Make health care education accessible** • Fund scholarships to entice Pennsylvanians into health fields • Expand student loan forgiveness for health care providers
Pa. **hospitals** can	**Enable educators** • Provide incentives and flexibility for health care professionals willing to work as educators/preceptors **Support employees** • Emphasize diversity, equity, inclusion, and accessibility • Offer flexible scheduling and benefits that foster work/life balance • Support employees who want to advance in health careers • Invest in and support workplace safety efforts to deter violence

Strengthen the Health Care Community

The **governor** can	**Cut through red tape** • Create a one-stop shop for health care employers and educators to meet the requirements of multiple state agencies
The **legislature** can	**Advance telehealth** • Expand providers abilities' and ensure adequate reimbursement for telehealth services **Encourage innovation** • Support pilot programs that explore collaboration • Enable professionals to practice to fullest extent of their training
Pa. **hospitals** can	**Empower providers to focus on patients** • Invest in technology so providers spend less time on administrative tasks and more on patient care • Adopt models for collaboration and patient-centered care

A Healthy Pennsylvania Supports Communities

Pennsylvania is the sixth largest economy in the United States and the health care and social services industry leads as the commonwealth's top employer. In the aftermath of a national pandemic, hospitals specifically remain among the top job creators. For example:

- In 59 of 67 counties, at least one hospital is among the top ten largest employers
- In 18 counties, a hospitals is the largest employer

Pennsylvania's hospitals and health systems are rooted in the communities they serve and provide unwavering support to Pennsylvanians in need of life-saving and preventative care.

Health care careers are growing steadily in Pennsylvania. The Pennsylvania Department of Labor & Industry projects that the health care and social services industry will continue to be the largest in Pennsylvania until at least 2030, with average estimated gains of 13,000 jobs per year. Despite projections of growth, Pennsylvania lacks the necessary supply of workers to fill those career opportunities. The commonwealth has nearly twice as many medically underserved areas (MUA) and 62 percent more medically underserved populations (MUP) as the average state.

Pennsylvania also has twice the number of primary care health professional shortage areas (HPSAs) than the region's average and one third more than the national average, according to data released

Pennsylvania hospitals **support communities**

$168b economic impact

590k jobs for PA

Source: Beyond Patient Care: HAP, "Economic Impact of Pennsylvania Hospitals, Fiscal Year 2021"

Pennsylvania's workforce shortages are among the **most severe in the nation**.

#1 for registered nurses
20,345 shortfall

#3 for mental health professionals
6,330 shortfall

#3 for nursing support staff
277,711 shortfall

Based on projected needs by 2026.
Source: Mercer, "2021 U.S. Healthcare Labor Market"

Defining Health Care Workforce

For the purposes of this report, the health care workforce is defined as all physical and behavioral health care providers with direct patient care and support responsibilities, such as physicians, physician assistants, nurses, nurse practitioners, primary care providers, allied health professionals, and all support professionals.

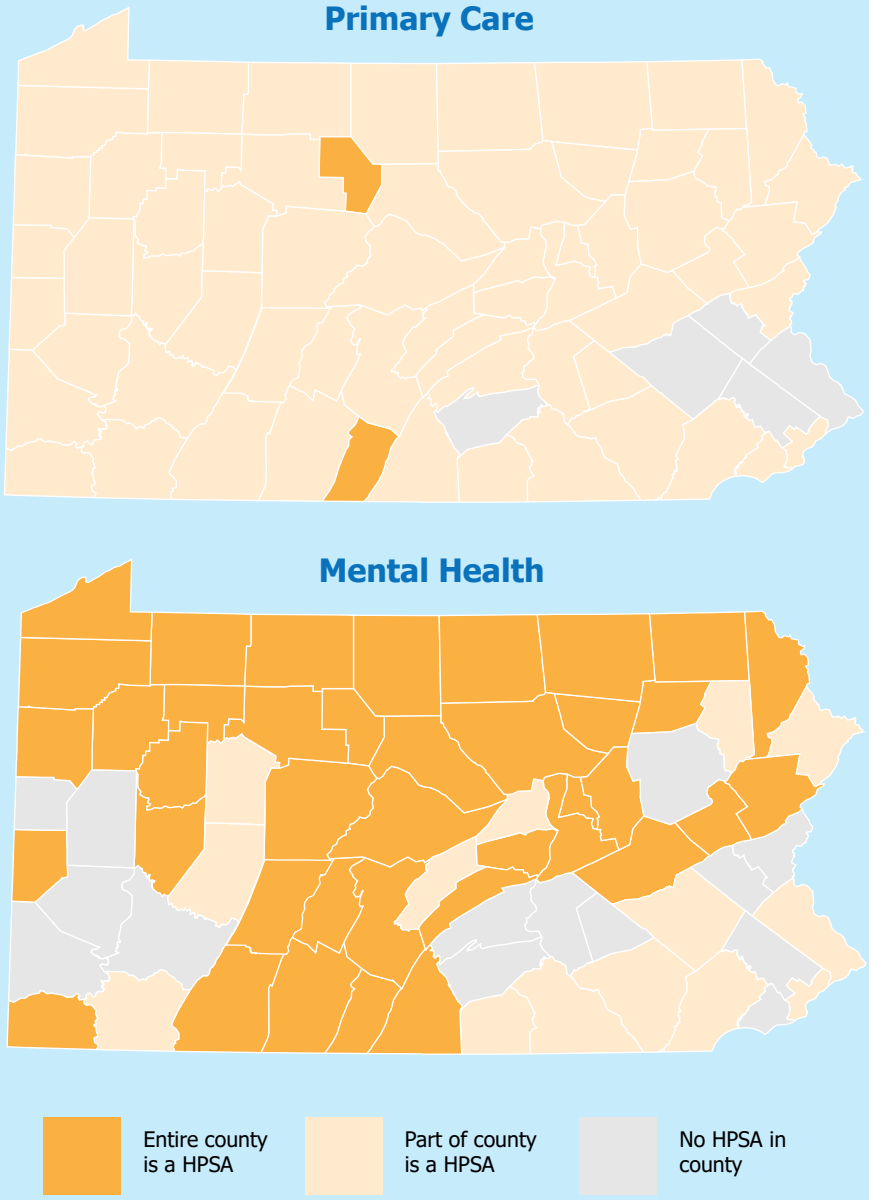
during June 2019 by the U.S. Department of Health and Human Services, Human Resources and Services Administration (HRSA). Data also suggests that primary care practitioner (PCP) shortages will continue to be a problem in Pennsylvania and around the nation. By 2030, the commonwealth will fall short by 1,000 of the additional PCPs who will be needed to care for Pennsylvanians.

Mercer's 2021 U.S. Healthcare Labor Market report examined the health care labor market over the next five to 10 years and found Pennsylvania to be among the states that will experience the greatest shortages of registered nurses, mental health workers, and nursing support staff. Specifically, Pennsylvania is projected to have a deficit of more than 277,711 health care workers, such as medical assistants, home health aides, and nursing assistants by 2026. Pennsylvania also is projected to have a shortfall of 20,345 registered nurses by 2026, the largest in the nation.

If there is a shortage of health care workers, how will Pennsylvania provide care for patients in need?

State government, the health care industry, economic leaders, community activists, and others share a vested interest in ensuring we have the health care workforce needed to care for Pennsylvanians. Together, we can commit to public policy and operational initiatives that improve the supply of health care workers, protect patient care, and improve Pennsylvania's economic outlook.

Health Professional Shortage Areas



MUA: Geographic areas with a shortage of primary care health services for residents.

MUP: Specific subgroups of people living in a defined geographic area with a shortage of primary care health services. These groups may face economic, cultural, or linguistic barriers to health care.

HPSA: Defined service areas with a critical shortage of primary care physicians, dentists, or mental health providers. Can be a geographic area, a population group, or a specific public or non-profit facility.

Source: Health Resources and Services Administration

Prioritize Health Care Talent Infrastructure

Pennsylvania must demonstrate focus and strategic action, partnered with hospitals and health systems, to address the health care workforce shortage. A key first step is establishing a chief health care talent officer and **Health Care Workforce Council** in the governor's office.

The commonwealth's chief health care talent officer would lead the efforts of the Health Care Workforce Council, which would reflect diverse representatives from hospitals and health systems (including health care workers), industry, labor representatives, education and training providers, workforce development organizations, community-based organizations and other government and non-government stakeholders invested in the current and future health care workforce.

The council would be assigned to strengthen Pennsylvania's health care workforce by assessing current and projected workforce needs; coordinating workforce-related policies, programs, and initiatives across agencies; and facilitating the talent pipeline of a diverse and culturally competent workforce. This work should not be limited to health-oriented agencies. Instead, the council should engage the state Workforce Development Board as well as the departments of Labor & Industry and Community & Economic Development to drive employment vitality.

The council would implement the recommendations made throughout this report and other key priorities. HAP's recommendations include:

Embed Customer-Centered Design into State Licensing and Provider Enrollment

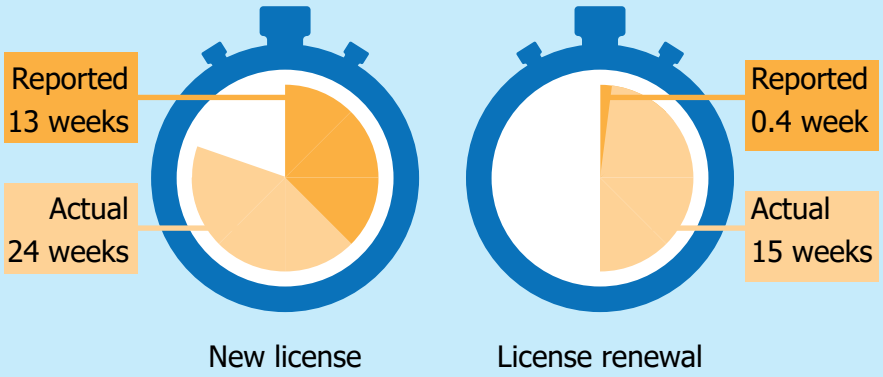
Licensing, credentialing verification, and enrollment in the Medicaid program are required before providers can bill for services. Any delays in the commonwealth's processes have direct and negative ripple effects on efforts to fill open positions to ensure access to care for patients.

To become a nurse in Pennsylvania, the State Board of Nursing must first review and approve a license following successful completion of education and testing requirements. In its April 2022 report, the Joint State Government Commission reported that the board averaged issuing 15,000 nursing-related licenses annually, that actual processing times were significantly under-reported, and that processing times were considered to be some of the longest processing times across the United States.

Likewise, during August 2022, the Department of Human Services (DHS) was managing more than 29,000 active Medicaid provider

Nurse License Processing Times

Joint State Government Commission Findings



Source: Joint State Government Commission, "License Processing Times of the Pennsylvania State Board of Nursing," 2022

enrollment applications. DHS has been understaffed for some time, which further exacerbates processing backlogs. In Pennsylvania, enrollment in the Medicaid fee-for-service program is required for providers to participate in Medicaid managed care program. Managed care organizations routinely require the Pennsylvania Medicaid ID number before they begin their own provider credentialing process.

It is counterproductive for new hires to wait months before they are licensed while their Medicaid enrollment applications (when required) are processed.

HAP commits to continuing its collaboration with the departments of State and Human Services and other stakeholders to promote a customer-centered design into board and agency operations that foster effective and timely reviews. Establishing accountability by publicly posting up-to-date licensing and enrollment backlogs should be a key component of this effort.

The use of COVID-19 waivers demonstrated the ability to safely provide quality services under conditional approvals until backlogs are resolved. As licensing and credentialing delays continue to impede health care occupations such as nurses and physicians, HAP encourages the establishment of license and program review timeline requirements and provisional approvals.

Fix Information Technology

Pennsylvania invested at least $10 million into the Pennsylvania Licensing System (PALS) since its launch in 2016. However, the system has been riddled with persistent issues. Bureau of Processional and Occupational Affairs (BPOA) staff are to be commended for their public service and resiliency to improve processes since the PALS launch. Yet, the bureau remains understaffed and under-resourced with temporary fixes instead of long-term solutions.

PALS is ineffective and unnecessarily exacerbates health care workforce shortages. HAP strongly encourages the administration to modernize its approach to information technology solutions, recognize its own shortcomings, increase staff capacity, and implement effective third-party solutions to process licenses and program reviews for dedicated professionals who want to study and work.

Address Interstate Compact Delays

Interstate compacts maximize Pennsylvania's opportunities to increase its labor force by enabling out-of-state licensed professionals to relocate and work in the commonwealth. Compacts have been enacted legislatively but are facing administrative delays in practice. This creates missed opportunities and employment barriers for health care workers.

The Health Care Workforce Council should assess and identify barriers in the interstate compact implementation; the role of state agencies, including the Office of Administration, Department of State, and Pennsylvania State Police; and provide recommendations that prioritize timely enactment of existing and future compacts. For future legislative efforts, HAP recommends the establishment of critical timelines and provisional interstate/licensure approval processes when there is a failure to meet deadlines.

Develop Routine Health Care Talent Reports

The Health Care Workforce Council should establish a research agenda to best inform its actions. That research agenda should require the health care workforce licensing boards and state agencies including, but not limited to, the departments of Health, Human Services, Education, Drug & Alcohol Programs, and State to collect and report health care workforce data to the state's Center for Workforce Information & Analysis. Data sharing will also be necessary from hospitals and health systems and education programs.

Fund Demonstration Projects

To develop a strong talent pipeline of health care workers, the council must have informed decision making and the ability to seed and fund demonstration projects with Pennsylvania's hospitals and health systems in at least the following focus areas:

- Defining and targeting health care talent recruitment and retention gaps
- Mapping the credential pathways and talent pipeline in Pennsylvania education and training institutions
- Assessing the talent pipeline for critical occupations including allied health professionals, advance practice professionals, behavioral health providers, nurses, physicians, and primary care providers
- Defining the in-demand competencies and skills that education, training, and continuing education programs should be prioritizing and assessing if programs are meeting these needs

Health Care Staffing Agency Challenges

Hospitals often must supplement their own workforce with temporary agency staffing in order to sufficiently staff beds and use the capacity of their facilities.

Health care workers—both those employed by hospitals and by staffing agencies—are entitled to fair compensation for the incredible care they provide. However, the American Hospital Association (AHA) and others have shared reports from hospitals where third-party staffing agencies are misleading workers, providers, and others while increasing costs to hospitals by three to four times the standard rates.

HAP encourages Pennsylvania to use its authority to review the market conduct of third-party staffing agencies to eliminate false and misleading advertising and prevent price-gouging. Policy makers should also explore an offset for some or all of hospitals' costs associated with unforeseeable health care staffing expenses.

Member Perspective: Why Prompt Licensing Matters

Gina Marone, DNP, RN, NEA-BC

Chief Nursing Officer and
Vice President of Healthcare Services

Einstein Healthcare Network –
Jefferson Health

At Einstein, now part of Jefferson Health, hiring new graduates is our lifeline to ensure a pipeline of nursing staff needed to care for patients.

Once hired, getting the newly licensed nurses to the bedside quickly is critical, especially if you have hundreds of nursing positions vacant. Unfortunately, licensure has not been an easy feat for graduates because of delays with processing and posting for initial licenses. Typical licensure delays are averaging about more than six weeks from nursing graduates passing the National Council Licensure Examination to being able to start in their new role.

Our nursing staff is stressed as they meet commitments to patients and serve our community through workforce shortages. To ease that strain, we need to get new nurses to bedsides faster. Delays mean nursing graduates must wait to use and apply the clinical skills they have learned in the professional environment. At the same time, we must wait to get nurses started and oriented in positions that are critical to maintaining high-quality patient care.

The licensure delays further compound our challenges maintaining day-to-day operations on patient care units and ensuring patient care needs are met and quality remains high. Staffing shortages negatively affect patient care and quality, patient satisfaction, workflow efficiency, and certainly, worker retention. All of these factors lead to higher health care costs and may contribute to a reduced service.

Helping nursing graduates get to work caring for patients as soon as possible is critical.

Support Health Care Workers

Many factors contribute to the mismatch between health care needs and the number of workers available. Pennsylvania is aging, the birth rate is decreasing, communities are diversifying, retirements are increasing, and the supply of workers across all sectors is shrinking. Workplace violence is rising, putting greater strain on health care workers.

HAP is well positioned to partner with policymakers and elected officials to prioritize support for all Pennsylvania health care workers.

To attract more workers to health care careers, we must strategically address each intercept point along the talent pipeline: education and training, recruitment, retention, and succession planning.

Movement across this pipeline is not always sequential and career mobility is not always continuous. We must explore modern ways of workforce development that address employer and worker needs alike. We must embrace able worker populations of all ages leading with inclusion and equity. And we must continue industry efforts to improve and advocate for the safety of health care workers.

Diversify the Talent and Education Pathways

Addressing the workforce shortage requires strengthening existing career pathways and tapping into new opportunities. HAP is committed to fostering new collaboration and partnership models among health care organizations and education institutions across Pennsylvania. Approaches should include a

Pennsylvania Hospital Staff Vacancy Rates

42% medical assistants

33% respiratory therapists

32% nurse practitioners

32% nursing support staff

31% registered nurses

Source: HAP, "Addressing Member Hospital Workforce Needs," 2023

targeted focus on retooling adult workers who are in search of new career opportunities and incorporating digital skills, technology, and automation into existing training and education for in-demand health care occupations.

Policy and legislative efforts should leverage partnerships and investment among industry, education, and workforce development priorities. This includes models that center employer and occupational demands with worker interests, including pre- and registered apprenticeships, dual enrollment, micro-credentialing and badging, educational technology, and adult career and technical education programs of study.

We must not overlook existing worker skills, experiences, and abilities that align with health care occupation demands. The Health Care Workforce Council should minimize administrative operations and policies that delay career entry and maximize existing skilled workers engaging in education, training, and recruitment activities. Recognizing prior learning, licensure, and work experiences for working adults—including transitioning military service members and veterans and professionals looking to re-enter the industry after prior exits—should be maximized as credit and advanced standing for future health care workers.

Worker migration into Pennsylvania can help alleviate workforce shortages. Approximately 7 percent of Pennsylvania residents are immigrants, according to the American Immigration Council, and more than 40 percent of adult immigrants have a college degree or more education. Pennsylvania should explore administrative and legislative action that establishes and/or improves credentialing and licensure for immigrants. Devoting additional staff to applicant assistance in the Department of Health's J-1 VISA programs could improve processing delays and ease workforce shortages.

Make Affordable Education and Training Accessible

Most health care careers are accessible with some education and training beyond high school, with routes that lead to four-year degrees and higher. However, the rising costs of post-secondary education restricts new workers from entering health care. Pennsylvania must sustain and expand funding supports for students entering health care fields and existing workers. This includes continuing the Student Loan Relief for Nurses Program enacted in

Advancing Health Equity

During 2022, HAP launched its Racial Health Equity Learning Action Network to help hospitals and health systems identify and confront systemic inequality and structural racism in health care and address racial, cultural, and ethnic health disparities in our communities.

The program takes a collaborative and data-driven approach and is designed to help hospitals and health systems apply a quality improvement lens to their equity efforts—improving health outcomes for people of color.

response to the pandemic, which directed $50 million in loan relief to Pennsylvania nurses.

Additional effort should be made to enhance subsidies, matching funds, and recruitment and retention supports available within financial assistance and economic development programs for health care employers and educators, such as the Pennsylvania Targeted Industry Program and WedNetPA.

Promote Health Careers

Projections show the health care and social services industry remaining the top employer in Pennsylvania for the near future. The Health Care Workforce Council could create a statewide program that helps people interested in health care careers connect with professionals in the field and access education and career pathways.

In HAP's 2022 workforce survey, hospital members noted they are experiencing increasing vacancy and turnover rates for most clinical positions and increasing workplace violence that threatens worker safety.

HAP members are not standing idly by. They are re-designing recruitment and retention strategies to address worker needs, including recruitment incentives, flexible schedules, compensation increases, and supporting workers in holistic ways.

Ensure Safe Workplaces

Increases in violence and verbal abuse against health care workers have contributed to challenges. Violence and abuse is not part of a health care worker's job and is unacceptable.

Hospitals are making renewed efforts to improve workplace safety by investing in safety assessments, training, safety infrastructure and technology, and other improvements. These efforts must be continued and enhanced.

The commonwealth can bolster this important work by supporting safety investments and creating shared resources. Centered on retaining quality workers in safe working environments, the Health Care Workforce Council should bring together stakeholders, including HAP and its members, to create shared resources and curriculum supporting the health care workforce well-being, retention, and cultural competency. This includes developing materials to support safety and risk assessments and staff training for prevention and de-escalation.

Roadblock: Health Faculty Shortage

The pathway to health care careers faces its own roadblock: a shortage of faculty and preceptors who provide necessary education and required clinical supervision to future health care workers.

The Health Care Workforce Council should invest in demonstration projects that increase the supply and funding of educators and preceptors, who provide students with well-rounded experiences to transition into employment with 21st century skills.

Member Perspective: Finding Talent

Penn Medicine finds talent for some critical, entry-level positions through a collaboration with a community program, the West Philadelphia Skills Initiative (WPSI).

WPSI provides unemployed Philadelphians who are seeking opportunities with the skills necessary to succeed in jobs that may not otherwise have not been available to them. WPSI has not only provided us with a pipeline of individuals who are well-trained to fill these crucial roles but it also supports our commitment to invest in our community and foster a more diverse workforce.

Barbara Todd, DNP, CRNP, FAANP, FAAN
Director, Practice & Education – Advanced Practice
Hospital of the University of Pennsylvania

Pennsylvania is home to:

1,773

Health care training programs

401

Nursing programs

9

Medical schools

Member Perspective: Connecting High School Students with Health Careers

Mary Grace Simcox, Ed.D
President
Pennsylvania College of Health Sciences

Pennsylvania College of Health Sciences partnered with our local intermediate unit, Harrisburg Area Community College's Lancaster campus, and the Lancaster County Stem Alliance to establish a Health Care Careers Academy (HCCA) for Lancaster County high school students. The students were chosen from three local school districts to learn about health care careers through a two-week summer camp and enrichment opportunities during the school year. At the end of the program, students had the opportunity to earn a micro-scholarship.

Out of 108 enrolled HCCA students, almost all attended at least one day of the summer camp throughout their three years in the program. In addition, students were engaged in the program during the COVID-19 pandemic and completed micro-scholarships, college courses, internships, and job shadowing experiences. The program was made possible by generous funding from BB&T Financial (now Truist Bank).

We also worked with Penn Medicine Lancaster General Health to provide more than 300 high school students with an immersive, two-day experience highlighting health careers. Students rotated through health care professions and learned about the education required for the field. Guidance counselors were informed about admission requirements for health care-related academic programs. This empowers them to direct students into more purposeful course selection while still in high school.

Strengthen the Health Care Community

Pennsylvania's hospitals and health systems care for all Pennsylvanians.

HAP stands ready with the administration and legislature to strengthen the health care community by ensuring that all Pennsylvanians have access to quality, equitable, and affordable health care services.

Advance Telehealth Services

Workforces shortages stress traditional methods of delivering health care. The COVID-19 pandemic fostered solid testing grounds for safe, effective telehealth services in Pennsylvania. HAP members were able to effectively pivot to virtual services and meet patient needs. Sustaining telehealth in Pennsylvania means making lifesaving and life-improving services more accessible to patients.

Leveraging investments in broadband infrastructure, telehealth services can grow and serve more communities across Pennsylvania. HAP urges policymakers to evaluate the nearly $1 billion influx of federal broadband funding and invest in the commonwealth's telehealth needs as this funding is deployed. Communities, especially in rural areas, where patients face challenges accessing health care are often also those with shortages of health care professionals.

HAP calls on the administration and General Assembly to advance telehealth services in Pennsylvania by codifying now-expired regulatory waivers in effect during COVID, including expanding authority of telehealth providers and ensuring adequate reimbursement for telehealth services.

Align Clinical Experiences and Workforce Shortage Areas

Pennsylvania should also enact and invest in physician retention initiatives in rural and suburban communities. One beneficial model is the Homegrown Health Care Initiative, which shows medical students the benefits of personalized learning environments in smaller health systems and incentivizes them to remain in those areas when they become doctors. The initiative provides third- and fourth-year clinical

Add Pennsylvania to the List

Pennsylvania is one of only nine states that does not have telehealth services established in state law. HAP supports telehealth legislation that include clear definitions, guidelines, and payment structures.

experiences to medical students in targeted health care workforce shortage areas, predominantly central and western Pennsylvania.

Another model, the Physician Shortage Area Program at Thomas Jefferson University, recruits, trains and supports medical students who grew up or spent significant time in rural communities or small towns and who plan to practice in a similar setting following their residencies. Graduates of the program are eight times more likely than their peers to become rural family physicians.

Adopt a One-Stop Shop for Health Care Employers and Educators

Pennsylvania health care employers and education programs interact with at least five different state agencies and boards to meet licensing, credentialing, and program review requirements.

A lack of interoperability and information-sharing coupled with recognized under-staffing across agencies creates unnecessary burdens, duplicative efforts, and significant delays that prevent educators from graduating students and employers from hiring work-ready Pennsylvanians.

A one-stop shop approach promotes systemic collaboration across state agencies that eliminates redundancies, establishes data-sharing agreements, eases the burden on limited agency staff, and reduces unnecessary steps that burden industry employers.

Searching for Behavioral Health Care

Pennsylvanians struggle to access behavioral health care. Simply put, there are not enough services to meet the need. As a result, patients navigate multiple service points with significant delays before finding the care they need. Increased funding for county behavioral health services would increase access to services and reduce strain on health care workers.

Who Does What?

A one-stop shop for health care-related licensing, credentialing, and program review would increase collaboration and reduce administrative burdens for health care providers.

Now, five different state agencies oversee health care tasks. Here's a look at some of what each agency does.

Education: Nurse aid credentialing

Human Services: Provider credentialing including for physicians and behavior health professionals; and facility licensing for mental health, personal care, and assisted living

State: Licensing for nurses, nursing home administrators, dentists, physicians, certified nurse midwives, behavioral health providers, select allied health professionals; psychologists, osteopaths, podiatrists; physical therapists, and occupational therapist

Drug and Alcohol Programs: Facility licensing

Health: Facility licensing

HAP stands ready with the administration and General Assembly to adopt a one-stop shop approach for health care employers and education programs.

Streamline Patient Access with Innovative Care Models and Expanded Practice

Patient-centered care promotes improved quality of life with easier access, improved patient satisfaction, and reduced readmissions.

The Health Care Workforce Council's engagement with HAP could explore ways to scale and sustain new models of care for patients. These include evaluating other states' scope of practice for professional health care licenses, redesigning rural health care, encouraging collaborative care, expanding models like EmPATH units to more effectively care for people experiencing behavioral health emergencies, and adopting other innovations. Expanding such opportunities could better help Pennsylvania health care professionals provide quality care amid a workforce shortage.

These modern care models improve coordination and alignment across health care services that results in greater access to behavioral health, as well as primary, acute, and oral care. Building upon the regulatory flexibilities extended during the public health crisis would help Pennsylvania health care practitioners practice to the full extent of their education, training, and license.

Venue Shopping Adds Barriers

During August 2022, the Pennsylvania Supreme Court made an abrupt public policy change by eliminating a rule that has stabilized the state's medical liability system and protected Pennsylvanians' health care for nearly two decades.

The decision reverts to a pre-2003 legal framework that allows personal injury lawyers to move medical liability claims from the counties in which the alleged event occurred to counties that have histories of higher payouts. This practice is called "venue shopping."

We've been here before, with bad outcomes. Venue shopping makes it harder to attract and keep health care providers in Pennsylvania, reduces patient care services, creates unaffordable provider premiums, and causes insurers leave the market.

HAP urges the state policymakers to take action to protect Pennsylvania health care.

Pennsylvania's Next Generation of Health Care

The health care workforce is changing.

Pennsylvania's hospitals and health systems must evaluate and redesign how they attract and keep talented health care professionals, prioritizing workplace culture, diversity, and employees' preferences, values, safety and wellness.

The commonwealth must modernize operations and public policy to help current and future health care professionals get to work caring for Pennsylvanians. Pennsylvania must intentionally act to address the worker shortage before it threatens communities across the commonwealth. We must capitalize on the economic strength of the health care sector and commit to improving care for all Pennsylvanians and their communities.

Together, HAP and Pennsylvania's leaders, policymakers, and elected officials can transform the next generation of health care.

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The Coming Collapse of the U.S. Health Care System

BY **ROBERT GLATTER AND PETER PAPADAKOS**

JANUARY 10, 2023 3:16 PM EST

Dr. Glatter is Editor at Large for Medscape Emergency Medicine, and Assistant Professor of Emergency Medicine at Zucker School of Medicine at Hofstra/Northwell; Dr. Papadakos is Professor, Department of Anesthesiology and Surgery, University of Rochester Medical Center

It's four in the morning and you awaken with crushing chest pain. Your family calls 911 and paramedics arrive and diagnose a cardiac event. They inform you that they need to transport you forty-five minutes away because your two local hospitals have closed over the last several months. Even when you arrive at the hospital, there is massive overcrowding and they inform you that there are no ICU beds open for you in that fifty percent of the beds in the cardiac unit are "browned out" due to lack of staff. This nightmare is an all too familiar post pandemic reality about the delivery of health care in our country. This is not the expectation that the public expects in the delivery of health care in one of the richest nations in the world that has been at the cutting edge of health care innovation of the last century.

What has led to this post-pandemic nightmare is multifactored. The pandemic changed how health care professionals are both valued and how they see themselves. During the height of the pandemic they were heroes that were endangering their lives to help the community. But now things look different.

https://time.com/6246045/collapse-us-health-care-system/

Around 7,000 nurses on strike in New York City nursing strike is emblematic of the dire situation. Nurses, who are essential to the critical functioning of all hospitals, are entitled not only to more equitable compensation and benefits, but ultimately safer staffing ratios in all patient care settings. What's ironic is that the strike will force these very health care systems to replace employed nurses with temporary nurses from staffing agencies, further compounding their financial woes, and ultimately, their bottom lines. Until we invest in people and their value in healthcare, we won't be able to see light at the end of the tunnel.

Everyday we read about hospitals throughout the country losing millions if not billions of dollars per year. Hospitals are closing urgent care centers, obstetric, pediatric and other services to try to survive. One of the major factors that has triggered this crisis is the lack of staff. Post-pandemic hospital staffing has massively decreased with a rise in temporary locum staffing dependency. Hospitals and clinicians no longer have regular staff that can build professional and patient relationships; instead, they are dependent on locum staff with short term contracts to provide such services. Those locum providers are at all levels of the professional ladder from physicians, mid-level providers, nurse, respiratory therapists, and radiology technologists. This staffing model has led to many issues both professionally and financially.

On the professional level this massive short fall of staff and dependency on temporary staff has created a critical issue in the realm of patient care. Hospitals and clinics have shut down services in all vital patient services. It is not uncommon to hear that health care systems have shut down Pediatrics, Psychiatry, Obstetrics, and ICU. Other healthcare systems have gone to the point of closing down entire hospitals because of staffing issues. Another important factor is the crisis is that outpatient services have reduced hours and days. It is obvious that this reduction of services has greatly affected access to health care. Individuals have lost the ability to get timely appointments, x-rays, and tests. In many communities, it is the underserved that have payed the greatest price in terms of getting timely care.

https://time.com/6246045/collapse-us-health-care-system/

Hospitals have had to also close down operating rooms due to staffing thus delaying both elective and emergent services. Critically ill patients boarded in the emergency department have also spent long hours or days waiting for inpatient beds due to lack of trained staff even when bed become available. Even when they may be ready for hospital discharge patients have long waits to find rehab and skilled nursing facilities because they have also been affected by short staffing. This inability to transfer patients to appropriate facilities only adds to the short fall of inpatient beds.

During the pandemic, it was not uncommon for older providers with health issues to retire than to go into work. Individuals that did go to work worked long hours and had increased levels of stress. Post pandemic, many of these individuals were not financially rewarded: they saw COVID-19 relief money go to upgrade facilities, build new buildings, and other non-employee rewards. This obviously changed the relationship between the bedside providers and hospital leadership.

Adding to this breakdown for many were the city and state vaccine mandates. Many believed that they had worked hard with limited resources and experience against COVID-19 and now the appreciation is losing your job over your own ability to make health care decisions. Another major issue is the shortfall of individuals who wish to be health care providers. Many individuals and families observed how hard healthcare workers were required to work and to work while other professions and jobs could work from home.

One of the most important aspects in the shift was the introduction of massive numbers of temporary workers during the pandemic which continues today. Temporary workers (typically known as Locums) are a major contribution to staffing issues. As regular hospital staff learn about the financial rewards that locum providers receive, it only leads to more individuals questioning, “why do I still work here?”.

https://time.com/6246045/collapse-us-health-care-system/

Locum providers may be receiving two to three times the hourly rate of pay, and in some cases, free housing, rental cars and meal allowances. This is not a good model for worker satisfaction where an individual works through the pandemic with all its stress and is now training an individual who will make many folds their salary with additional perks who has no loyalty to the facility. In some areas of the country locum health workers may be from the hospital down to the street. Employees from hospital A go to hospital B then hospital C without having to travel.

Also integral to this discussion is the high pre-pandemic levels of burnout and attrition among providers that further devastated the supply of available healthcare providers leading into the pandemic. Addressing this issue is integral for the ongoing supply of providers throughout the U.S.

The widespread use of locums also affects the way and quality of the care provided. In the complex environment of health care delivery over the last few decades, we have learned that the best care is provided by individuals who work as teams caring for specific issues or problems. Prime examples of this are operating rooms and ICUs. Here, providers know the individual expertise and skills of each provider and protocols and guidelines needed to care for specific conditions. You can easily see how this would generate the best care. With short term locum providers, use of this system collapses into a world where individuals do not know the guidelines, location of supplies, the needs of individual providers and what each individual brings to the table. What also suffers is the ability to run through simulations and learning scenarios because staff is temporary. Many of us will see a rise in complications and poor outcomes in the next few years because of the breakdown in the healthcare team.

The massive financial drain imposed by staff shortages and use of locums has led to many health care facilities reaching the point of financial instability. Daily reports of massive quarterly losses by both internationally known and local hospitals where billions of dollars are being lost in an industry which was already working on a slim margin will

lead to many additional facility closure. This has affected not only rural hospitals with slim operating margins, but larger urban healthcare facilities as well. The loss of such important services in hospitals and associated outpatient facilities will impact care for our communities for future generations.

So, if all of the hospital and healthcare facility close, where will we get our care? The answer is bleak. If we are hit with another pandemic where will the care be delivered, where will the beds be? This critical financial issue is also going to affect other industries. Medical technology companies cannot sell cutting edge ventilators, monitors and imaging devices to facilities that have no cash flow. Aging medical infrastructure cannot be repaired, upgraded or replaced in this financial environment.

As a backdrop to this evolving crisis, we wonder why is this not a major news story. Why are our local and national leaders addressing this issue?

https://time.com/6246045/collapse-us-health-care-system/

https://www.mcall.com/news/pennsylvania/capitol-ideas/mc-nws-pa-hap-workers-shortages-20230124-3btdndzxx5grphiqeas2c6wfey-story.html

CAPITOL IDEAS

Pa. hospitals call on Gov. Josh Shapiro to address state's health care worker shortage, said to be among worst in nation

By **Ford Turner**
The Morning Call
•
Jan 24, 2023 at 7:38 pm

HARRISBURG — Citing Pennsylvania's dubious distinction of having some of the most severe shortages of health care professionals in the nation, hospitals want Gov. Josh Shapiro and lawmakers to act.

The Hospital and Healthsystem Association of Pennsylvania on Monday called for a health care workforce council to be established, led by a chief health care talent officer.

Ongoing shortages include a 32% vacancy rate for nursing support staff, a 32% vacancy rate for respiratory therapists, and a 31% vacancy rate for registered nurses, according to HAP. It said Pennsylvania has a worst-in-the-nation shortfall of 20,345 registered nurses.

"Government leaders, educators, and the health care community must work together to support, attract, educate, and train the health care professionals needed to care for Pennsylvanians," HAP President and CEO Andy Carter said in a statement.

The call from HAP came less than a week after Shapiro was sworn into office, but after years of growing recognition that Pennsylvania's shortages are dire.

HAP's data showed:

- The shortfall of 277,711 nursing support staff in Pennsylvania is the third most severe in the nation, and the shortfall of 6,330 mental health professionals also is third worst.
- From 2019 to 2022, vacancy rates for nursing support staff — certified nurse assistants, personal care assistants and nurse aides — increased from 31.5% to 32.3%.
- Certified registered nurse practitioners' vacancy rates increased about 10% in the same time period, respiratory therapists' vacancy rates went from about 20% to 32%, and medical assistants' vacancy rates increased from 30% to 42%.

HAP said it wanted a “mutual commitment” from Shapiro, the Legislature and hospitals to prioritize health care talent infrastructure, support workers and strengthen the health care community.

Shapiro’s spokesperson, Manuel Bonder, said the governor is aware of the health care worker shortages and “knows the critical importance of bringing people together to tackle our workforce development challenges.”

Bonder said Shapiro “will be taking direct, proactive action toward addressing this crisis.”

In an unrelated move Tuesday, Shapiro said he signed an executive order to establish the Pennsylvania Office of Transformation and Opportunity, as well as the Economic Development Strategy Group.

In a news release, Shapiro said the office would be “a one-stop-shop for businesses looking to grow and will work to aggressively reignite Pennsylvania’s economy — fostering innovation, supporting transformational economic development, and creating real opportunity for businesses and workers alike in our Commonwealth, particularly in communities that have too often been left behind.”

Sen. Lisa Boscola, a Northampton County Democrat, said the pandemic made it clear hospitals and nursing homes are short-staffed and “we needed to do more to help recruit and retain talent.”

In 2021, former Gov. Tom Wolf signed into law a Boscola bill intended to qualify more nurses for licensure by letting Pennsylvania join a multistate nurse licensure compact.

“There are a host of other compact bills I am advocating for the state to join,” Boscola said.

She and Washington County Republican Sen. Camera Bartolotta are pushing fellow lawmakers to approve a bill to let certified registered nurse practitioners work independently, jettisoning the requirement for collaboration agreements with physicians.

Wayne Reich Jr., president of the Pennsylvania State Nurses Association, said the main focus should be on reasons nurses leave their jobs.

“They come out of nursing school, they see what the conditions are like, and they leave the profession,” Reich said.

Hospitals, Reich said, could have mitigated the worsening staffing crisis during the pandemic by offering a “pandemic stipend” to staff nurses, who many times quit hospital jobs to take better-paying positions as travel nurses.

Nonetheless, Reich said, “This was happening before the pandemic started. The pandemic made everything worse.”

Cheryl Schlamb, president of the Pennsylvania Coalition of Nurse Practitioners, said the Boscola-Bartolotta bill would help.

“People are going to drive across the state line and work where they can apply their skills with limited restrictions,” Schlamb said.

She spoke in positive terms of HAP’s proposal.

“If we can stop the bleeding and get young people to stay in this state and do the work that is needed, that is great,” she said.

Asked about HAP’s proposal, Dr. F. Wilson Jackson, president of the Pennsylvania Medical Society, said it supports any effort to develop the health care workforce, adding the society is particularly concerned about the mental health of health care workers who toiled through the pandemic.

The Lehigh Valley’s two major health care systems, Lehigh Valley Health Network and St. Luke’s University Health Network, could not immediately provide data on vacancies in particular staff areas.

LVHN spokesperson Brian Downs said, “LVHN is experiencing staffing challenges similar to other health care and non-health care organizations in the region. This data shows why it is so important throughout the industry to recruit and hire qualified candidates.”

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