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**AFT Nurses and
Health Professionals** ❤️

HEALTHCARE STAFFING SHORTAGE TASK FORCE REPORT



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Our Mission

The **American Federation of Teachers** is a union of professionals that champions fairness; democracy; economic opportunity; and high-quality public education, healthcare and public services for our students, their families and our communities. We are committed to advancing these principles through community engagement, organizing, collective bargaining and political activism, and especially through the work our members do.

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LETTER FROM

RANDI WEINGARTEN, AFT PRESIDENT

For nearly three years, our nation's health professionals have worked through unprecedented challenges. This has compounded the strain on an already exhausted workforce, leaving most emotionally drained and far too many in mental health distress. As a result, frontline healthcare workers have been leaving and are continuing to leave the health professions in record numbers.

This year, I convened a Healthcare Staffing Shortage Task Force comprised of AFT state and local union leaders, as well as frontline healthcare workers. The task force's charge was to examine the state of the healthcare workforce and to identify steps that policymakers, employers and unions can take to ensure that hospitals and healthcare facilities are appropriately staffed to provide high-quality care to all. I want to thank each member of the task force and our members who participated in listening sessions, responded to surveys and lent their perspective.

While the consequences of the chronic understaffing of our nation's healthcare facilities can be deadly, the problem is solvable. Our nation's healthcare employers must invest in the workforce, improve the working conditions, make healthcare facilities a safe place to work, and engage frontline workers in collaborative decision-making. Prioritizing patients over maximizing revenue means recruiting and retaining the workforce needed to deliver high-quality care.

The dedication of our frontline healthcare workers to their patients and to one another was a bright light during the darkest days of the pandemic. We, as a nation, owe our frontline health workers so much, and this report is intended to highlight ways we can do that and, in so doing, put patients over profits.

In unity,

A handwritten signature in black ink, appearing to read "Randi Weingarten". The signature is fluid and cursive, with a large initial "R" and "W".

AFT President

TASK FORCE MEMBERS

- Vicky Byrd, Montana Nurses Association, AFT vice president
- Debbie White, Health Professionals and Allied Employees, AFT vice president
- John Brady, AFT Connecticut, PPC chair
- Anne Goldman, United Federation of Teachers, PPC chair
- Julia Barcott, Washington State Nurses Association, PPC member
- Carolyn Cole, Public Employees Federation, PPC member
- Shannon Davenport, Alaska Nurses Association
- Rebecca Garrabrant, United Federation of Teachers
- Nora Higgins, Public Employees Federation, PPC member
- Joshua Holt, Oregon Federation of Nurses and Health Professionals
- David Keepnews, Washington State Nurses Association, PPC member
- Jamie Lucas, Wisconsin Federation of Nurses and Health Professionals, PPC member
- Sandra Nin, United Federation of Teachers
- Maria Paradiso, United Federation of Teachers
- Anne Tan Piazza, Oregon Nurses Association
- Howard Sandau, United Federation of Teachers
- Elvie Smith, United Federation of Teachers

Introduction

Any conversation over the last 24 months with a frontline healthcare worker quickly reveals the deep frustration and anger with their employers and sheer mental, physical and emotional exhaustion.

The stories from AFT members are heartbreaking: A nurse in Connecticut assigned to 11 patients, a healthcare worker in Oregon who spends 20 minutes before each shift in tears trying to muster the emotional strength to go to work, the nurse in Montana who sees a colleague walking away from bedside care, the healthcare worker in New Jersey grieving the death of a colleague who contracted COVID-19 at the hospital. These are dark days for the healthcare workforce.

The COVID-19 pandemic revealed a healthcare system woefully unprepared for the crisis, allowing the world to see a chronic understaffing of our nation's healthcare facilities that existed well before the pandemic. To be clear, this staffing crisis is not new, and it's a crisis of the healthcare employers' making. Their decisions to put revenue ahead of patients and frontline caregivers left the workforce without appropriate personal protective equipment, exposed their employees to increasing levels of workplace violence, stretched patient loads to unprecedented and unsafe levels, and left a workforce exhausted and for far too many in mental health distress. As a result of these exploitative working conditions, it comes as no surprise that frontline caregivers are leaving their jobs in record numbers.

As U.S. Surgeon General Vivek H. Murthy recently wrote, "Today, when I visit a hospital, clinic or health department and ask staff how they're doing, many tell me they feel exhausted, helpless and heartbroken. They still draw strength from their colleagues and inspiration from their patients, but in quiet whispers they also confess they don't see how the health workforce can continue like this. Something has to change, they say."¹

There are profound long-term staffing consequences for our country's healthcare facilities. Frontline caregivers are experiencing unprecedented burnout and exhaustion from the trauma of working in perilous conditions. Now they are quitting in in record numbers. America's hospitals have failed to fulfill their most basic responsibility: providing a safe place for patients to receive medical care.

As one of our nation's largest unions representing healthcare workers, the AFT and our affiliates have been forced to reckon with dangerously inadequate staffing in our nation's hospitals and healthcare facilities, as well as colleagues who are planning to leave their jobs. Decades of understaffing has reached a crisis point, and it is a crisis of the healthcare industry's own making.

In response to the crisis of staff willing to endure the working conditions of our nation's healthcare facilities, delegates to the AFT's biennial national convention in July 2022, passed a pointed resolution "[Addressing Staffing Shortages in the Healthcare Workforce](#)"² adopting the recommendations made by the Healthcare Staffing Shortage Task Force and, among other things, specifically calling for:

- The passage of state and federal safe patient levels and securing staffing ratios in collective bargaining agreements;
- Banning mandatory overtime;
- Passage of federal and state workplace violence protection legislation, including the Workplace Violence Prevention for Health Care and Social Service Workers Act; and
- Adequate pandemic preparedness protections in the law through means such as an Occupational Safety and Health Administration infectious disease standard and updates to the Centers for Medicare & Medicaid Services emergency preparedness rule.

This report is the product of the AFT's Healthcare Staffing Shortage Task Force and the union's ongoing effort to improve our nation's healthcare system and the working conditions our members endure. It was informed by months of work by AFT's Healthcare Program and Policy Council, roundtable discussions between clinicians and policy experts, surveys of healthcare members, and anecdotal discussions and workgroups composed of healthcare union leaders.

This report examines various components of the staffing shortage crisis:

- 1.** Barriers to Successfully Recruit and Retain the Needed Workforce.
- 2.** Unsafe Working Conditions
- 3.** Unsustainable Staffing Practices and Workload
- 4.** Inadequate Compensation for Frontline Workers
- 5.** Corporate Trends to Maximize Revenue and Decrease Cost
- 6.** Insufficient Worker Voice and Trust

The staffing crisis in our nation's healthcare facilities is not some mysterious, intractable problem that we lack the tools to fix. Rather, given all that the nation's healthcare workforce endured through the pandemic and before, it is a completely understandable; and with a commitment from healthcare employers to put patients and their workforce above maximizing revenue, it is correctable. This report includes a menu of strategies that can be used to improve our nation's healthcare facilities and concrete examples of where they have been successfully used. It is intended to help frame the national discussion about the staffing crisis and to provide a road map to fixing the chronic problem.

Section 1: The Recruitment and Retention Problem

“So many nurses are shorthanded. It’s critical to resupply as people leave the profession.”

—a healthcare worker in Connecticut

“When we circulate people out of nursing, we lose a lot of brain power.”

—a healthcare worker in New York

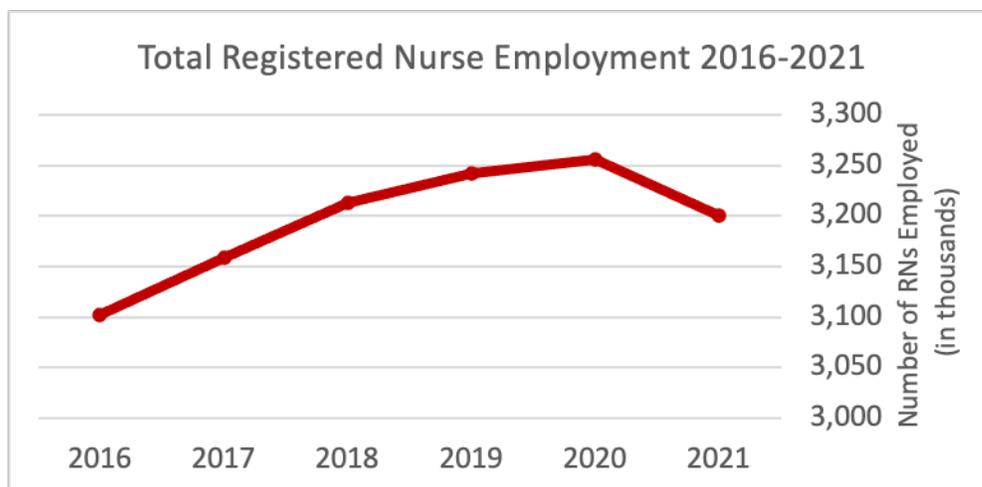
“We are critically short of nurses and ancillary staff”

—a healthcare worker in New Jersey

The Great Resignation: Healthcare Workers Are Leaving Their Jobs in Record Numbers

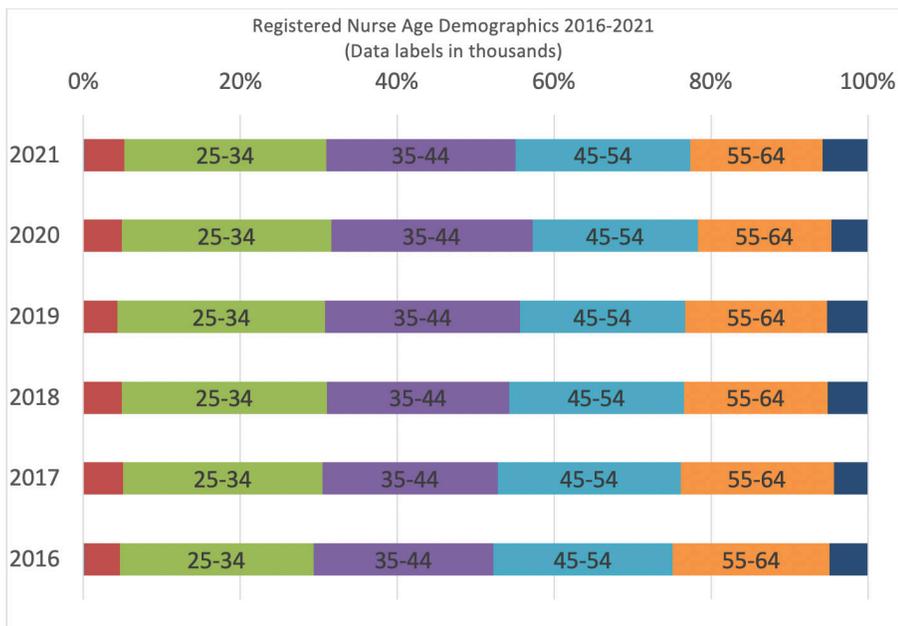
Almost universally, AFT leaders are hearing the same thing from frontline workers. Members working in already understaffed facilities are seeing their colleagues leave faster than they can be replaced.

These trends are not only anecdotal. In 2021, the U.S. Department of Labor Bureau of Labor Statistics (BLS) reported 55,000 fewer RNs employed than in 2020. This was the first decrease in total RN employment in more than five years.



Source: BLS 2016-2021

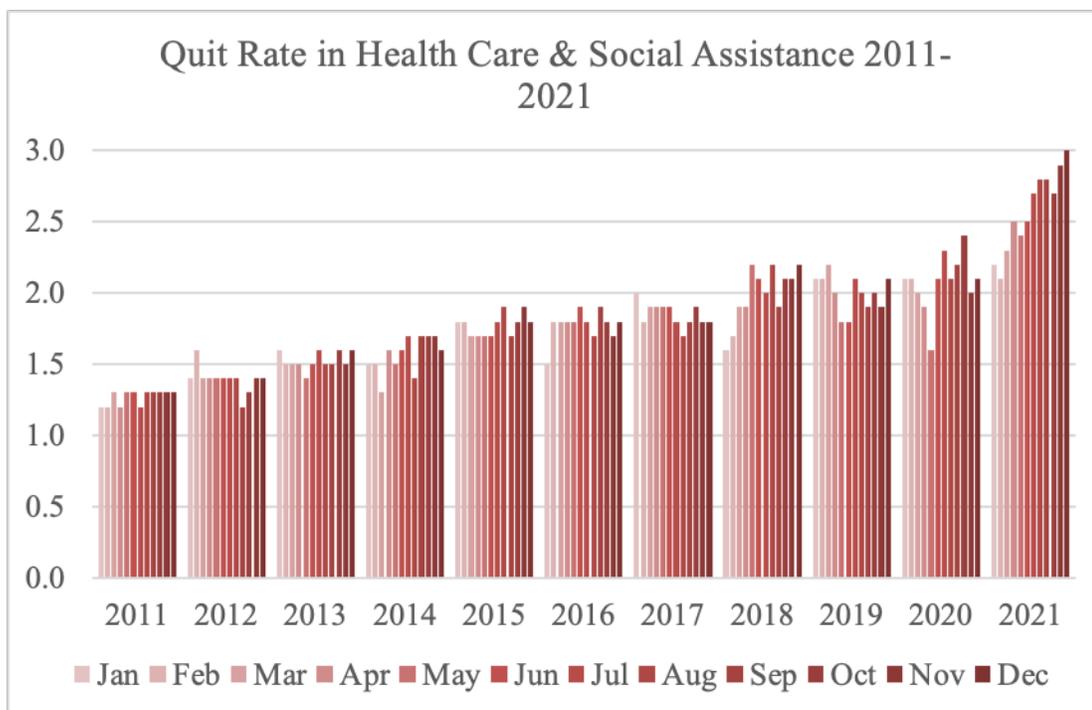
In this same year, the median age of RNs increased for the first time in more than five years, from 42.6 to 43.1. Looking more closely at the age demographics, we clearly see that this was driven by a reduction in total employment of RNs under the age of 44. Further, in 2021 there were 100,000 fewer RNs under the age of 44 than in 2020. This represents a significant reversal from the consistent trend of these workers making up a greater share of the RN workforce each year from 2016 to 2020.



Source: BLS 2016-2021

Looking at the rate of people quitting jobs in the healthcare and social assistance sector over time, we see just how historic this moment is.

In 2021, the healthcare and social assistance sector saw its highest quit rate in the last decade. In the graph below, we see the quit rate steadily increasing over the last decade until 2021 when it spikes to a record high at 3.0. In other words, a quit rate of 3.0 means that for every 100 workers in this sector, three quit their jobs in December 2021.



Source: BLS Job Openings and Labor Turnover Survey (JOLTS) data, 2011-2021

Workers represented by these numbers may have moved to a different employer in the healthcare industry, may have moved to a different segment of the industry, or may have left the industry altogether. BLS specifically excludes retirements from its calculation of the quit rate.

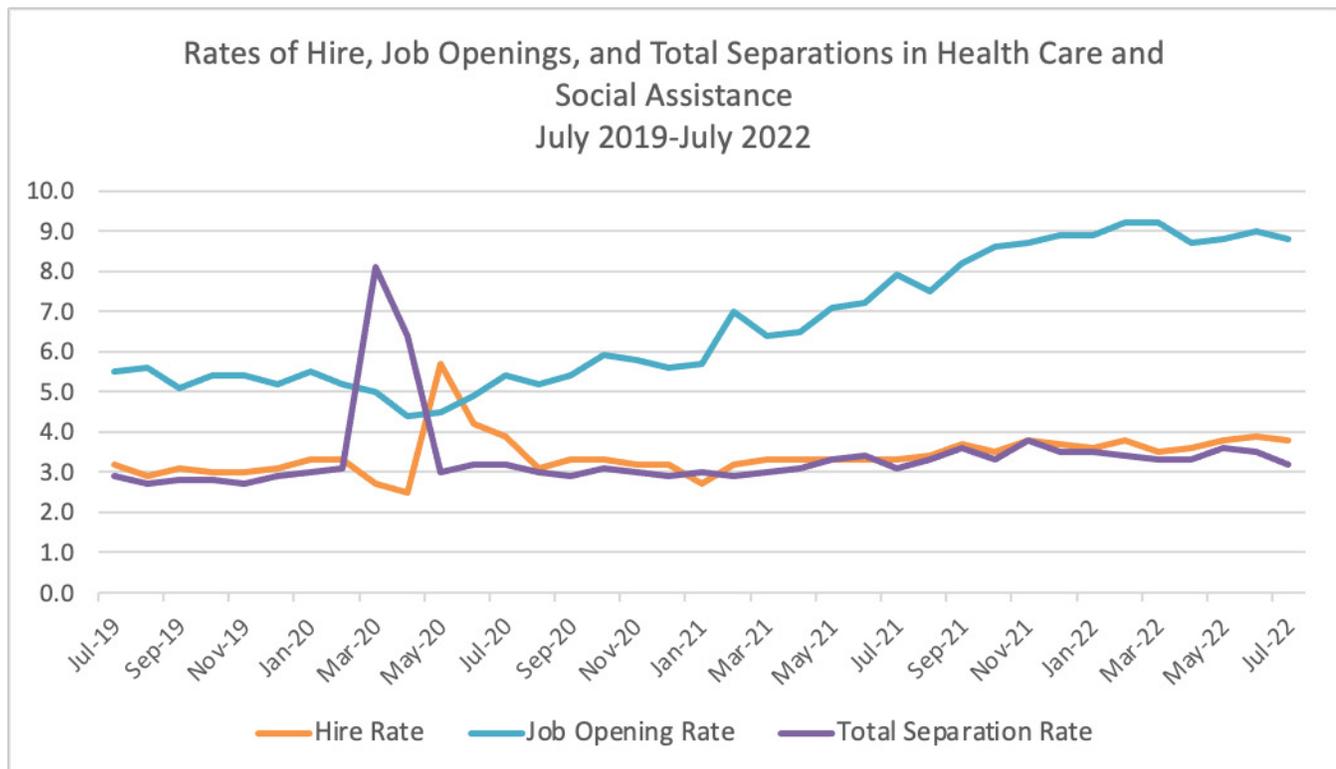
COVID-19 Has Exacerbated and Expedited the Staffing Crisis

In the wake of the COVID-19 pandemic, more and more healthcare workers have reported they were considering leaving their jobs or their professions altogether. A healthcare worker in Connecticut links this directly to short staffing, saying “You can only take care of so many people effectively. This is a recruitment/retention issue. Who’s going to want to go into work when it’s going to be horrible?”

In a February 2022 poll, 23 percent of healthcare workers—nearly 1 in 4—said they were likely to leave the healthcare field soon.

³ While many factors could influence an individual worker’s choice to leave, one cannot deny the overall impact of the pandemic on rates of workers leaving.

National data reflects the daily experience of our members too. Data from the Job Openings and Labor Turnover Survey (JOLTS) from the Bureau of Labor Statistics from March 2019 to October 2021 is demonstrative. The clearest inflection point happens in March 2020 when the World Health Organization declared COVID-19 a global pandemic. In this month, there is a drop in rates of job openings, hiring and people quitting their jobs. From this we know that the significant spike in the total separation rate in March was not driven by people quitting their jobs, but rather by layoffs and other factors.



There is also a critical second inflection point in the first months of 2021, when rates of job openings and quits begin to rise. Although it is impossible to attribute this increase to any single factor, the availability of vaccines and the loosening of pandemic restrictions present two logical explanations and ones that front-line stories support.

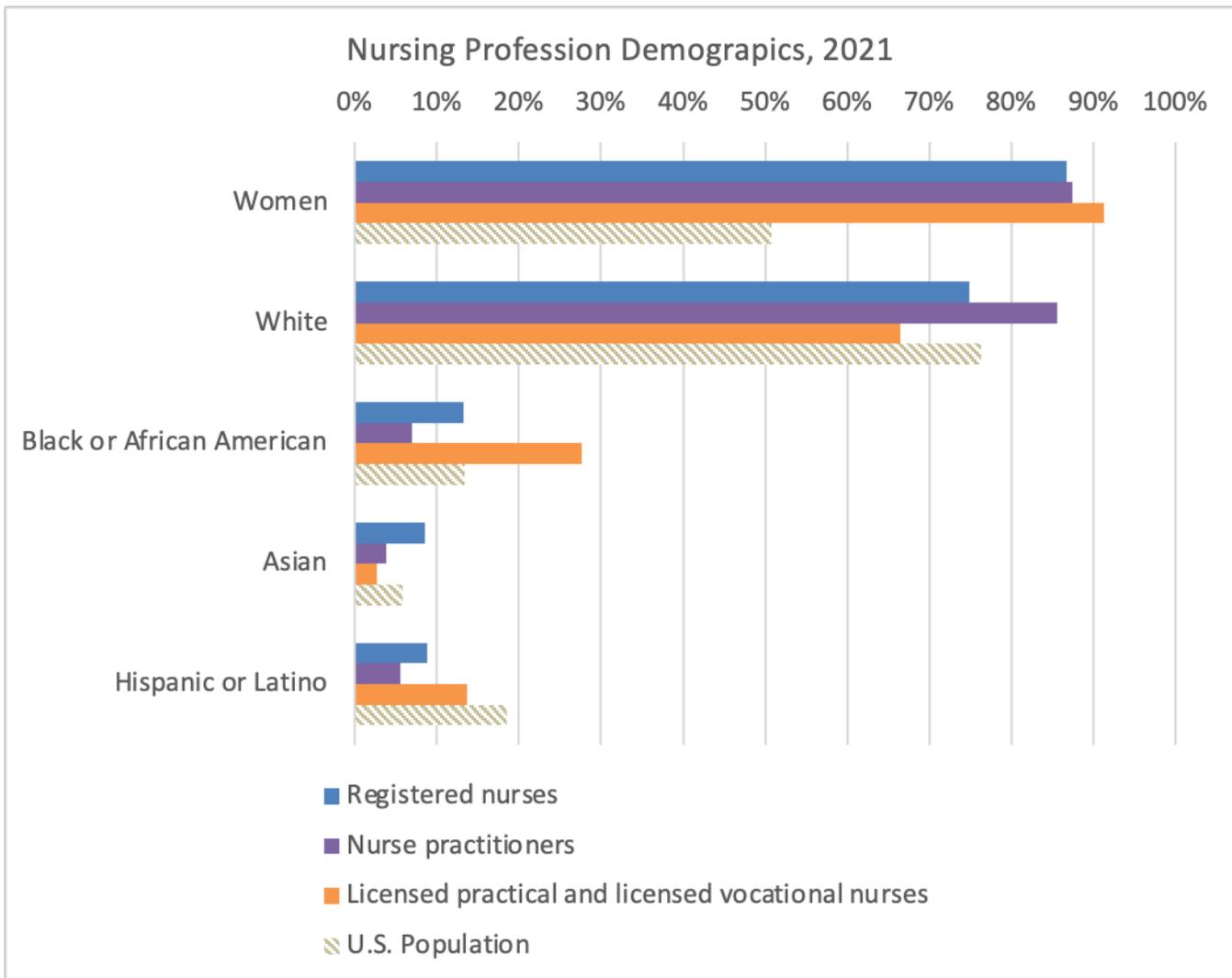
The “Great Resignation” comes as the nation’s population ages and grows more diverse, requiring more workers in the health sector. However, in 2021, we see that employers in this sector are only able to hire at about the same rate as workers leave. Yet, we see the rate of job openings continue to increase because of this growing need as the population expands and ages, leaving our healthcare facilities with projected staff shortages.

Of course, when healthcare workers leave their employers, they do not immediately lose the skills to be healthcare workers. Regardless of whether a person quits to pursue other, less-taxing professional opportunities requiring their qualifications, or they leave the sector altogether, the imperative for our healthcare facilities is to recruit and retain their workforce. Doing so requires deep industry reflection on why their facilities have become such undesirable places to work and how to fix the crisis they have created.

It Is Time to Improve Diversity, Equity and Inclusion in the Workforce Through Targeted Recruitment and Training

As our nation’s hospitals remain understaffed and the demand for healthcare professionals rises, there is an opportunity to make considerable progress toward greater workforce equity, which is a key component of truly centering health equity as the nation’s population continues to diversify. When the healthcare workforce reflects the populations it serves and operates with a deeper cultural sensitivity and understanding of their patients’ life situations, patient outcomes improve. This, in turn, increases the comfort level of patients seeking care. ⁴

As the graphs of BLS data show, minority healthcare workers are underrepresented; and as the complexity of the positions and the salaries increase, the diversity of the workforce decreases.



Source: BLS 2021

For instance, while people identifying as Black or African American make up 13% of the U.S. population, they make up only 7% of Nurse Practitioners, a higher paying role requiring more formal education than other nursing roles. This clearly demonstrates a lack of racial equity in the nursing profession, but it also demonstrates an opportunity to “right the ship.”

Examples of Strategic Approaches

Deploy new strategies to increase diversity in the local healthcare workforce, such as addressing racism in healthcare workplaces; developing program models that expand career outreach programs in communities of color that are underrepresented in healthcare jobs; and developing a workplace equity score that tracks healthcare facilities’ workforce diversity numbers, and how many workers from underrepresented communities successfully advance up the career pathway to higher paying positions; and regularly review equity in compensation differences based on gender, race, sexual orientation, disability and all other protected classes.

Strengthen the Pipeline By Coordinating and Expanding Model Programs

To “right the ship” and create a steady flow of new skilled workers to fill vacant positions, the healthcare pipeline and career pathways must be strengthened. The pathway should have multiple entry points to ensure that individuals have ample opportunity to join this workforce and to advance as high up the skill pathways as they desire.

To accomplish this, the sector must conduct targeted outreach, expand stackable credentials (professional credentials that can be lined up sequentially), provide affordable access to the required training programs and, where possible, accelerate the training process. To maximize the impact of currently uncoordinated healthcare education and training programs nationwide that serve people at various levels of education and training, a nationally coordinated strategy organized around specific projected shortages is required.

One cannot, however, simply pipeline their way out of the current staffing crisis. Until the healthcare sector addresses the deplorable working conditions, dangerous patient levels and inadequate compensation, it will be unable to attract and train new workers quickly enough to replace those who leave. New approaches must be implemented, and proven training models could be expanded.

Examples of proven training models that could be expanded include:

Union Negotiated Joint Labor-Management Training Programs—When labor and management work together to identify shortage areas and provide paid time off and financial support for workers to access the training they need, an individual healthcare facility can successfully grow its own workforce. The Ben Hudnall Memorial Trust is one example. Established in 2005 by Kaiser Permanente, the AFT-affiliated Oregon Federation of Nurses and Health Professionals, and a coalition of union bargaining partners, the trust creates “a culture that values and invests in lifelong learning and enhanced career development opportunities for represented employees.” The trust provides a diverse portfolio of programs and services to support its workers, ranging from career coaching and academic preparation to professional credentials and academic degrees that an individual worker needs to advance in their career to higher-paying positions.⁵

Healthcare Professions Career and Technical Education (CTE) High School Programs—CTE programs are an invaluable way for students to have a head start on two- and four- year college programs and, in some cases, prepare students for immediate employment in some healthcare jobs that do not require a college degree. These programs are built upon rigorous and integrated instruction of academic and industry-specific content as well as work-based learning experiences like internships. Students receive not only a high school diploma but also have an opportunity to pass an industry-recognized certification or licensing examination that can lead to employment. In the healthcare sector, there are successful CTE programs, such as the one at Clara Barton High School in Brooklyn, N.Y. , staffed by AFT members, which offer curriculum concentrations in nursing, including a nursing assistant and practical nursing programs. Students in the nursing assistant program provide direct patient care under the supervision of a registered nurse. Graduates of both programs will be prepared to take the certification exam and begin entry-level employment upon graduation. Students in the practical nursing program can also go on to two- or four-year college programs to become a registered nurse.⁶ Other programs around the county include dental assistant, dental lab technician, medical assistant, emergency medical technician and emergency medical responder, pharmacy technician and biotechnician assistant.

Healthcare Registered Apprenticeship Programs—A limited but growing number of healthcare apprenticeship programs have developed around the country for various healthcare job titles. These programs pair high-quality training with paid clinical experience to allow students to earn money while they gain the skills needed to be fully credentialed and hireable upon graduation.

Nursing Bridge Program—These programs allow current nurses to advance their careers by earning a higher-level nursing credential at an accelerated pace. The programs build on the candidate's existing nursing knowledge and allow them to work while enrolled. In select programs, there is also an option to test out of select courses. Bridge programs are available at all academic levels: associate, bachelor's, master's and doctoral degree programs. The programs require clinical experiences and placements, which are typically permitted to take place at the nurse's work site.

Accelerated Nursing Program: Non-Nursing Graduates—These program options have been gaining momentum. Baccalaureate program graduates with a non-nursing degree can enroll in an accelerated bachelor's or master's nursing program. These fast-track programs typically take 11 to 18 months to complete, including prerequisites (for the bachelor's program). The master's level program generally takes three years to complete. Participants receive the same number of clinical hours as their counterparts in traditional nursing programs, and they must meet rigorous admissions standards. Accelerated nursing programs are available in 49 states and the District of Columbia, the U.S. Virgin Islands and Guam.

RN Internships/RN Clinical Intern—Usually funded by a nursing program or healthcare facility, these programs give student nurses paid clinical experience while alleviating some of the work placed on RNs, nursing assistants and other healthcare positions. Working under a preceptor nurse, their duties can include evaluating patients' conditions; administering medication; and assisting patients with bathing, dressing and eating.

Nursing Residency Programs and Fellowships—These programs, collectively known as the ANCC Practice Transition Accreditation Program support RNs with less than 12-months of work experience (Nurse Residency) and experienced RNs (Nursing Fellowship) and newly certified advanced practice nurses transition into new practice areas. These programs are accredited by the American Nursing Credentialing Center (ANCC) and are recognized by the U.S. Department of Labor as industry-recognized apprenticeship programs.⁷

Remove Barriers to Entry by Expanding Student Loan and Repayment Programs That Incentivize Joining the Healthcare Sector

A 2019 analysis of data from the U.S. Department of Education found the average graduate of an associate degree in nursing (ADN) program held \$19,928 in student debt. For graduates with a Bachelor of Science in nursing (BSN), the average debt was \$23,711 and for graduates with a Master of Science in nursing (MSN), the average was \$47,321.⁸

No effort to recruit talent into the healthcare workforce can be complete until the cost barriers for accessing and completing higher education and training programs are addressed.

The proliferation of costly for-profit nursing programs that have lower NCLEX (National Council Licensure Examination) passage rates than nonprofit nursing programs exacerbates the problem.⁹ To obtain a nursing license, you must pass the NCLEX exam, which assesses the competency of nursing school graduates. Failure leaves the student in debt without the credential needed to obtain the employment to pay off the debt.

While there is no publicly available data on debt burdens or education costs for other healthcare titles, one can make some educated guesses based on the average cost of the level of education required for certain roles. For example, the average cost of an associate degree at a public institution is \$21,900 and \$57,254 at a private institution.¹⁰ Many healthcare roles, including lab technicians, surgical technologists, radiologic technologists, and respiratory therapists, require an associate degree.

Healthcare job titles that do not require a postsecondary degree are also not free of cost barriers because many require certification programs. For example, a program to become a licensed practical nurse can cost as much as \$15,000, and training to become a certified nurse assistant averages about \$2,000.

Education Barriers Disparately Impact Communities of Color

Sixty-two percent of 2019 college graduates were burdened by student loan debt,¹¹ disproportionately impacting women and people of color. In fact, 58 percent of outstanding federal student loan debt is owed by women.¹² Compared with their white peers, Black borrowers have higher total debt burdens and higher monthly payments. Four years after graduation, 48 percent of Black borrowers owe 12.5 percent more than their original balance, while 83 percent of white borrowers owe 12 percent less than their original balance in the same time period.¹³ This has a particularly large impact on racial equity in the healthcare workforce and is especially poignant for healthcare workers who have made unimaginable sacrifices during the COVID-19 pandemic.

The AFT Is Addressing Educational Barriers by Working to Improve the Public Service Loan Forgiveness Program (PSLF)—The AFT has been leading the effort to make PSLF available for more people working in public service roles. Employees who work full time (30 hours or more a week for eight or more months of the year) for a non-profit or government employer, can qualify for full forgiveness of their federal student loan balance after 120 qualifying payments. This includes most hospital and public health workers. During the Trump administration, this program was woefully mismanaged with workers' time credit not being applied correctly and their loan status wrongly placed into default. The AFT successfully sued the Trump administration. Through a year-long waiver, borrowers who did not previously qualify or who were denied were able to get credit for past payments and get on track for full forgiveness. When properly managed and promoted, and when healthcare professionals and other workers are given the necessary information, the program can be a powerful tool for recruiting and retaining healthcare professionals.

AFT Local Unions Are Working with State Legislatures to Strengthen the Pipeline and Lower Healthcare Workers' Student Debt

AFT-affiliated unions have been working with state legislatures around the country on targeted strategies that increase the pipeline. This includes the Oregon Nurses Association winning passage of the Nursing Workforce Omnibus Bill (H.B. 4003) earlier this year, which, among other provisions, creates a nurse internship license to augment the workforce and offers practical experiences for nursing students. AFT affiliates in New York have been working on the New York State Nurse Employment, Enhancement and Dignity Act (A. 7385/S. 6424) to provide hazard pay to nurses during a state disaster emergency, an annual tax credit for nurses, a student loan forgiveness program for nurses, and preferential school admission for nurses. The AFT-affiliated Alaska Nurses Association has been working on legislation (S.B. 10) to provide free or reduced tuition for essential workers who attend state-supported postsecondary educational institutions. The AFT-affiliated Washington State Nurses Association has been working with its Legislature on a bill (H.B. 1452) that expands scholarship programs for RNs' education.

Nurse Faculty Wages Need to Be Raised so That Master's-Level Nurses Can be Recruited, Allowing Nursing Programs to Accept More Qualified Students

All of the previously stated barriers to postsecondary education notwithstanding, the healthcare industry and policymakers must reckon with the reality that nursing education programs do not have the funding, facilities or faculty needed to address the workforce shortage. While similar dynamics may exist in other healthcare training programs, it is a particularly acute problem in the nursing profession. For instance, in 2019, nursing programs turned away more than 80,000 qualified applicants because the programs lacked the necessary resources to educate these individuals.¹⁴

According to 2020 data from the American Association of Colleges of Nursing, the average salary for a master's-prepared assistant professor of nursing is \$79,444. A nurse with a master's degree on the other hand, has many other career options, including nurse practitioner where the average salary across specialties is \$110,000, according to the American Association of Nurse Practitioners.¹⁵

One driving factor of the nurse faculty shortage is the student debt crisis. The average nurse with a master's degree who is carrying student debt has more than \$47,000 in debt, with monthly payments more than \$500.¹⁶ Nurses who want to teach the next generation of nurses may be unable to afford to do so. This is especially true for nurses of color who are more likely to have student loans and more likely to have higher loan balances, according to national debt statistics.¹⁷

Examples of Strategic Approaches

- The U.S. Department of Health and Human Services Department's Health Resources and Services Administration should convene an emergency task force to develop a national healthcare workforce strategy. The task force should include the U.S. Department of Education, Department of Labor, and both industry and labor representatives. The AFT is uniquely positioned to provide strategic input because our membership includes healthcare workers, career and technical education program teachers, nursing program and other healthcare professional program faculty.
- Targeted financial aid and loan repayment programs should be expanded, including the National Health Service Corps and the Nurse Faculty Loan program.

Section 2: Working Conditions Need to Be Improved to Recruit and Retain More Healthcare Workers

“I remember thinking during the first surge, ‘if we just make it through this with none of our members dying, we will be lucky.’ We made it until the third surge when we lost a beloved RN from the OR. We had over 75 percent of our members testing positive at one point during this pandemic. Many members were seriously ill, hospitalized, and some are still recovering with long COVID-19 symptoms. I watched my co-workers develop post-traumatic stress disorder in real time.”

—Sheryl Mount, Health Professionals and Allied Employees, New Jersey

Inadequate Staffing Leads to More Worker Injuries

The impact of inadequate staffing on the occupational safety and health of healthcare workers has not been adequately addressed. Although there is a growing body of evidence on the patient-safety risks associated with poor staffing, much more research is needed on workers’ injuries and illnesses. One of the few studies that looked at the relationship between occupational injuries and staffing found that shifts with fewer nursing care hours per shift, lower RN skill mix, and a lower percentage of experienced staff had higher rates of needlestick injury.¹⁸

The California nurse-to-patient staffing ratio law offers an opportunity to evaluate the impact of staffing on healthcare workers’ health and safety. One study found that registered nurses in California hospitals suffered 55.57 fewer illnesses and injuries per 10,000 RNs, a rate 31.6 percent lower than the rate in all other states. The reduction for licensed practical nurses was 38.2 percent.¹⁹

Workplace Violence Makes Hospitals One of the Most Dangerous Places in America to Work, and Enforceable Standards Are Needed to Protect Workers

“The amount of bullying and unprofessional treatment is pushing people out of the profession. The professionalism and respect we once had has gone to the wayside.”

—a healthcare worker in New Jersey

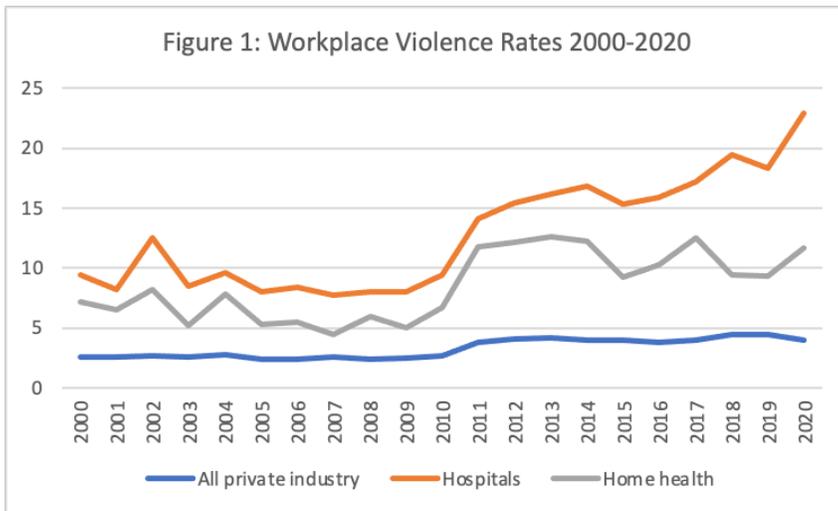
“I have experienced many assaults in my 17 years as an RN, including having a patient attempt to strangle me while his wife jumped on me and punched me. It is dangerous to work without enough staff in the psych unit. I developed PTSD when a patient held a gun to my chest in August 2020. I have taken care of many patients with PTSD, but I never realized how debilitating it is. I told management I was not OK—but they expected me to show up for my next shift.”

—Carol Grant, AFT Connecticut

Violence to healthcare workers is a serious and growing problem exacerbated by inadequate staffing. Healthcare and social services workers experience 76 percent of all reported workplace violence injuries in the American labor force, and the number of actual incidents of workplace violence is likely to be much higher.²⁰ One study of staff working in psychiatric hospitals found that 85 percent of the incidents of workplace violence were never reported.²¹

Workplace violence in healthcare continues to rise in tandem with the staffing crisis. The rate of reported assaults grew by 144 percent in hospitals and 63 percent in home health agencies from 2000 through 2020. The rate of reported assaults increased by 95 percent in private sector psychiatric hospitals and substance

use treatment facilities between 2006 and 2020.²² There were 87 workplace homicides from 2017 through 2019.^{23, 24} Pandemic-related pressures on healthcare accelerated this trend—the rate of violence in hospitals increased by 25 percent in one year alone, from 2019 to 2020.²⁵



Source: U.S. Bureau of Labor Statistics, Survey of Occupational Injury and Illness 2000-2020, Table R8

The Occupational Safety and Health Administration and National Institute for Occupational Safety and Health have both identified understaffing as a risk factor based on research from the 1990s.^{26, 27} Descriptive studies of workplace violence demonstrate that poor staffing increases the risk of violence.^{28, 29} Long wait times and inadequate attention can lead to escalating behavior in some patients and visitors. In some cases, workers are too busy to notice or respond. When there are too few workers available to safely restrain violent patients or when staff work in isolation, the risk of serious injury increases. More research is needed to investigate a causal relationship between understaffing and workplace violence. Two studies found that a higher staffing rate was associated with higher rates of assaults on staff and other patients in psychiatric units.^{30, 31} Critics of the studies argued that the researcher was comparing reported incidents of workplace violence, not the actual number of assaults, noting the high probability of underreporting in poorly staffed facilities.

OSHA, NIOSH and researchers have emphasized the critical importance of workplace violence prevention programs that train frontline staff and managers to report all incidents of workplace violence and “near misses” in order to develop evidence-based prevention strategies.³² Unfortunately, healthcare workers often do not report incidents of workplace violence because they find themselves blamed for their assault. More work is needed to identify the staffing issues at the root of workplace violence.

In 2016, the AFT led a coalition of unions petitioning OSHA for a workplace violence prevention standard for healthcare and social service workers. OSHA agreed to develop a standard, but the work stalled during the Trump administration. The Workplace Violence Prevention for Health Care and Social Service Workers Act was passed twice by the House of Representatives, requiring OSHA to develop an interim standard within one year and a final standard within 3.5 years. The bill was introduced in the Senate recently, but it has little chance of passing.

AFT Local Unions Have Been Working with State Legislatures to Make Their Workplaces Safer

AFT affiliates have been working with their state legislatures to create greater protections for healthcare workers. This includes the Montana Nurses Association; it has been working on A.B. 538, which requires reporting violence against healthcare workers. AFT affiliates in New York have been working on the Nurse Safety Work Act (A. 1639), which requires hospital staff to implement safety procedures when alone with a patient.

Examples of Strategic Approaches

Enact the federal Workplace Violence Prevention for Health Care and Social Service Workers Act

Fatigue Is Making Healthcare Jobs Unsustainable, and Healthcare Workers Need More Recovery Time

“Staffing was bad before, but now we have nine patients to a nurse, including patients being placed in hallways. We go 12 to 16 hours without a break to eat or drink. I have had nurses pass out because they haven’t had time to eat or drink. We had 72 mandated overtime shifts in January 2022. It’s particularly hard on night shift nurse; –we have had multiple cases of people working 36-hour shifts. People get so exhausted, they call out sick, which leads to more problems. At this point, financial incentives do not work, when people are this exhausted.”

—Sherri Dayton, AFT Connecticut

Research on nurse fatigue has focused on the effects of shift work, including extended shifts and overtime, night shifts and rotating shifts, and insufficient recovery time between shifts. Chronic sleep deprivation has been linked to these factors. Chronic sleep deprivation causes fatigue; reduced cognitive function; increased risk of errors, such as needlestick injuries; unsafe driving; and patient safety errors in the short term. Chronic sleep deprivation can cause cardiac, gastrointestinal, and metabolic illnesses in the long run. Chronic lack of sleep has also been shown to foster proinflammatory activity and immunodeficiency, putting workers at higher risk for infection.³³

More research on the relationship between understaffing and fatigue is needed. Nurses and other health-care workers are under pressure to work overtime and accept additional shifts without adequate rest when facilities are understaffed. According to one study of hospital nurses working successive 12-hour shifts, the majority slept for less than six hours between shifts.³⁴ Other studies have found that people who work rotating shifts sleep up to four hours less when they work at night.³⁵

In the past, research on the effects of mandatory overtime and extended work shifts aided in the passage of state laws prohibiting the practice. More research is needed to demonstrate how patterns of understaffing lead to increased demand for overtime. Additionally, research is needed to show the long-term mental health effects of fatigue and overwork.

Successfully Bargained Solutions

AFT local unions have been engaging in innovative bargaining to reduce fatigue among healthcare workers. This includes the Ohio Nurses Association, which secured “double back” language in its contract with Lima Memorial Hospital, requiring a certain number of hours between shifts. The ONA also achieved a ban on mandatory overtime at the hospital. The Oregon Nurses Association won double overtime for mandatory overtime at the Oregon Health & Sciences University, which puts financial pressure on the hospital to hire more nurses. Meanwhile, the Washington State Nurses Association secured an additional RN float position to ensure adequate coverage, allowing all staff to take meal and rest breaks. The Ohio Nurses Association won language in its contract with the Akron Medical Center allowing nurses to nap while on meal or rest break, showing how exhausted healthcare workers are.

AFT Local Unions Are Moving State Legislation to Reduce Fatigue at Work

AFT affiliates have been working with their state legislatures to reduce mandatory overtime. In New York, AFT affiliates have been working on A. 286A/S. 1997A, which imposes a civil penalty on an employer who requires a nurse to work more than their regularly scheduled work hours. The measure also provides the nurse with an additional 15 percent of the overtime payment from the employer for each violation. The Ohio Nurses Association was successful in passing legislation in 2021 that establishes a legislative study committee on RN staffing Issues to help legislators learn more about the issues and build support for better staffing.

Examples of Strategic Approaches

Ban mandatory overtime through federal and state legislation, regulation and collective bargaining agreements.

Inadequate Protections for Infectious Disease and Emergency Preparedness Risk the Lives of Healthcare Workers, and the Healthcare Industry Needs Greater Preparedness Requirements

“It was apparent that my hospital and others were not prepared. In April 2020, pregnant women started coming from New York into Connecticut hospitals to give birth. It was not until after we had COVID-positive moms and newborns that my hospital started testing these patients and giving N95s to labor and delivery staff. A psychiatric hospital in Connecticut was cited by OSHA for having no respiratory protection program at all after an outbreak among staff and patients.”

—*Sherri Dayton, healthcare worker, AFT Connecticut*

“It is hard to put into words how hard it has been working as a nurse through the pandemic. I get emotional talking about what has transpired over the last two-plus years. I equate it to being like what I imagine a war zone must be like. Never in my 37 years of nursing have I been so horrified to be a nurse and at the same time so proud to be a nurse.”

—*Sheryl Mount, Health Professionals and Allied Employees*

“COVID-19—you stole my life, wreaked havoc on my organ systems, wrecked my career, cost me thousands of dollars, made my sweet little boy cry in fear, almost shattered my soul, and took away something I can’t get back, which is time. Time with my family, friends, loved ones and community. You robbed me of memories. You robbed me of the life, I loved and valued. You stopped me in my tracks, but you will NOT win.”

—*Jessica, Alaska Nurses Association member, suffers from long COVID*

The healthcare industry’s lack of preparedness for infectious disease outbreaks has had disastrous implications for staffing and for healthcare workers. For example, early in the pandemic, hospitals elected to save money by not stockpiling enough personal protective equipment (PPE). The needless exposure to infections contributed to the death of 3,600 healthcare workers.³⁶ Others left the bedside because they got sick or worried about infecting themselves and their loved ones. They were joined later by those who couldn’t or wouldn’t work in intolerable staffing conditions. Healthcare workers were lauded as heroes but treated as disposable by the healthcare industry.

Prior to the COVID-19 pandemic, annual outbreaks of seasonal influenza regularly swamped hospitals and created short-term staffing crises. Analysis of the handling of the H1N1 influenza pandemic in 2009 and the Ebola epidemic should have alerted the hospital industry to the imperative need to develop stronger infectious disease outbreak preparedness plans, including improving ventilation systems and stockpiling respirators.

The Centers for Medicare & Medicaid Services issued an emergency preparedness rule in 2016 but failed to include requirements that employers maintain robust PPE stockpiles. The Office for the Assistant Secretary for Preparedness and Response within the Department of Health and Human Services maintained the Strategic National Stockpile, but Congress and two administrations failed to adequately fund it.

The labor community first petitioned OSHA for an infectious disease standard in 2005, but the agency did not begin work on the standard until 2010 in the aftermath of the H1N1 outbreak. Labor unions petitioned OSHA for an emergency temporary standard early in the pandemic, but the Trump-appointed secretary of labor refused. The Biden administration agreed to issue an emergency temporary standard on COVID-19 for healthcare workers, but it was delayed until June 2021 and allowed to sunset after six months. The agency has promised to issue the permanent standard within six to nine months. Our efforts to influence the content of the standard are underway.

Examples of Strategic Approaches

Secure adequate pandemic preparedness protections in the law through means such as an OSHA infectious disease standard and updates to the Centers for Medicare & Medicaid Services emergency preparedness rule.

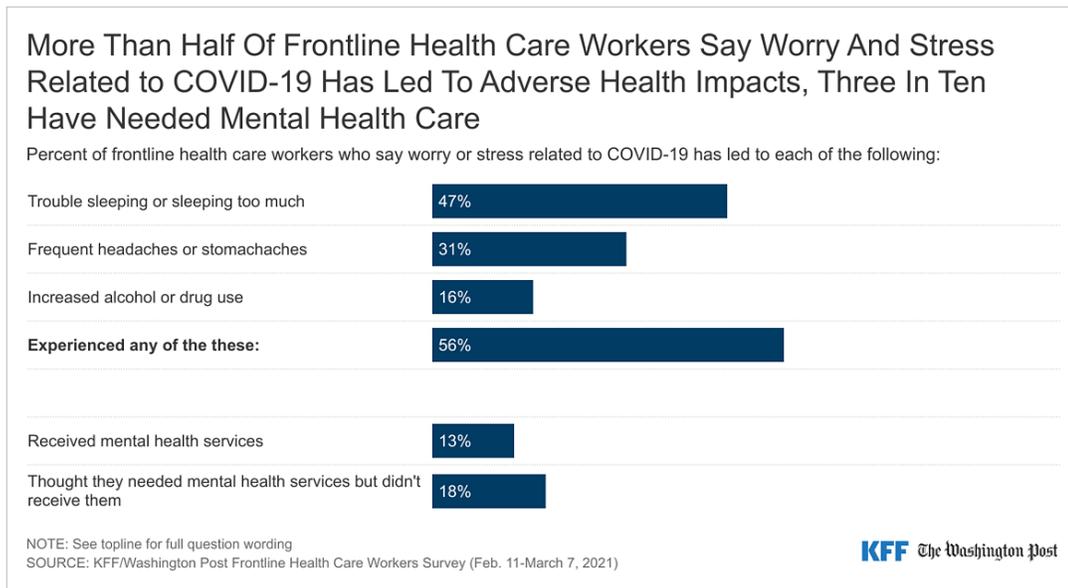
Addressing the Mental Health Crisis of Healthcare Workers Requires Funding for New Support Programs

Our nation's healthcare workforce's mental health is in shambles. For many years, healthcare workers, particularly those at the bedside, have been stressed and have suffered the moral injury of repeatedly being expected to make choices that transgress their long-standing, deeply held commitment to healing.³⁷ The scarcity of mental healthcare providers compounds the mental stress. Those who seek assistance are frequently unable to find providers or are placed on monthslong waiting lists.³⁸

According to the U.S. Department of Health and Human Service's Health Resources and Services Administration and the Kaiser Family Foundation, there are over 5,800 designated mental health professional shortage areas in the country. More than 6,300 mental health practitioners, including adult psychiatrists, psychologists, social workers and mental health counselors, would be needed to meet the needs in the shortage areas.^{39,40} The pandemic has changed the rolling boil of the mental health crisis into an overflowing pot characterized by depression, anxiety and suicide. This crisis is deeply shaped by the unsafe patient limits that cause frontline caregivers to quit their jobs, leading to even more understaffing.

A survey conducted in March 2021 by the Kaiser Family Foundation (KFF) and the Washington Post asked healthcare workers whether they felt the worry or stress related to COVID-19 had a negative impact on their mental health. According to the survey, 61 percent said yes. The stress of the pandemic had clearly taken hold of the country's caregivers just one year into the pandemic. Three out of 10 people polled either received or thought they needed mental health services because of the pandemic. At least 49 percent said the pandemic had negatively impacted their physical health, as well as their relationships with family members (42 percent) and co-workers (41 percent). Many people reported difficulty sleeping, frequent headaches, increased use of alcohol or drug use, all of which were attributed to pandemic stress and

worry. According to another recent study, almost 40 percent of emergency healthcare workers screened positive for burnout, and nurses were significantly more likely to be experiencing burnout compared with attending physicians.⁴¹



Another recent study found that more than 70 percent of healthcare workers have symptoms of anxiety and depression, 38 percent have symptoms of post-traumatic stress disorder, and 15 percent have had recent thoughts of suicide.⁴² As nurses and other healthcare professionals reach their breaking point, the deadly consequences of suicide have come to the forefront. This is what happened to Michael Odell, a 27-year-old travel nurse. Odell sought mental healthcare and medication after attempting suicide during the pandemic. For a time, Odell seemed to be fine but a year later, he left the hospital in the middle of his shift and committed suicide. Friends and colleagues in the nursing profession were shocked but understood how the pressures of seeing patients die every day, with little or no support and living with moral injury, drove him to do the unthinkable.

Although the height of the pandemic appears to have peaked, our healthcare workers continue to face mental health challenges. The staffing shortages put a tremendous amount of strain on tired and over-worked bedside caregivers, who work long hours wondering if another wave of the pandemic will bring in more cases than they can handle. The workforce urgently needs support.

Examples of Strategic Approaches

- Increase funding, programming, and other legal protections at the federal level to support health professionals in the areas of mental health, burnout, and stress Management, including addressing shortages in the mental health professions.
- Work in partnering with other organizations and mental health experts devoting resources and activities aimed at developing clear demands for improving healthcare workplaces, ensuring mental health needs of the workforce are addressed, and to develop resources and education programming that provide meaningful support to healthcare professionals.

Section 3: Safe Staffing Requirements Are Needed

“Staffing requirements are key to stabilizing the workforce, reducing burnout and turnover; we are in a vicious cycle where years of inadequate staffing, made worse by the pandemic, are now leading to more and more people leaving.”

—a healthcare worker, Washington State Nurses Association

One final question at the end of a Healthcare Staffing Shortage Task Force meeting: What do frontline healthcare workers need the most right now? The unanimous response was safe patient levels that put a limit on the number of patients that can be assigned to a single nurse. The appropriate limit varies depending on the department. For example, an ICU nurse can safely care for fewer patients than a med-surg nurse given the required level.

California is the only state that mandates safe patient levels for multiple hospital departments by law. Massachusetts mandates ratios only for ICUs by law and New Jersey mandates ratios for several departments through regulation of the hospital licensure process. A number of states also require healthcare facilities have staffing committees that include nurses. This is based on the idea that every hospital is different, and each should have the flexibility to develop staffing matrices that best fit their departments. Unfortunately, because they are often poorly enforced and lack a clear standard, staffing committees have not proven to be a successful strategy to achieve safe patient limits.

In contrast, safe staffing levels set by law in California have been shown to improve outcomes for patients and healthcare workers. (More on this in the “Unsafe Staffing Means Diminished Patient Outcomes” “Evidence of Patient Outcomes” section). Many experts argue that safe staffing levels are necessary because they provide hospital administrators and workers with a clear measurable standard. Setting the floor in law rather than collective bargaining agreements and staffing plans also allows for enforcement of these standards through state agencies rather than relying on hospitals to monitor their own compliance or on workers to file complaints after a plan has been violated.



Examples of Strategic Approaches

- Enact federal and state laws that mandate safe staffing levels and staffing ratios that include the whole care team and incorporate requirements into governmental regulations such as the Centers for Medicare & Medicaid Services Conditions of Participation.
- Include safe staffing levels in collective bargaining agreements.

Public Reporting Alone Is Not the Solution

The requirements for public reporting on hospital staffing levels vary greatly across the country, ranging from posting a daily staffing plan in plain view of patients at a hospital to public disclosure to a state agency. Public disclosure and other tools for transparency are important components of staffing solutions, but there is little evidence that reporting requirements alone directly improve staffing levels.⁴³ It is unrealistic and unfair to expect the public to possess sufficient industry knowledge to connect staffing levels to patient outcomes. Finally, while disclosure is an important part of enforcing safe staffing standards, it can't be the only way to keep patients safe.

Successful Collective Bargaining Strategies

AFT-affiliated unions around the country have been trying a variety of strategies at the bargaining table to reduce unsafe patient levels. For example, the Ohio Nurses Association at the Ohio State University Medical Center won safe patient staffing levels for its workers, including a nurse-patient ratio in the medical-surgical unit of 1:4, while the nurse-patient ratio for the critical care unit in the emergency department is 1:2. The nurses at OSUMC are now empowered to challenge patient care assignments that are unsafe because they exceed the established ratio. While nurses occasionally flex up to accommodate additional patients, it is rare and is only done when the nurse can safely care for all their patients. The Montana Nurses Association won important language at Deaconess Hospital that “recognizes the professional responsibility of nurses” and empowers nurses “to accept or decline overtime assignments based on their self-assessment of ability to provide safe care.”

AFT Local Unions Around the Country Have Been Working on State Staffing Legislation

AFT-affiliated unions nationwide have been working with their state legislatures to require increased staffing levels in their facilities. This includes the Health Professionals and Allied Employees in New Jersey, which has been working on S. 304 that would establish minimum RN staffing ratios for hospitals and ambulatory surgery facilities and certain Department of Health facilities. The Washington State Nurses Association worked on H.B. 1868 during the recently concluded state legislative session, which would create RN staffing ratios for acute care hospitals; it also would also address overtime, meal and rest break issues, and enforcement. AFT Connecticut worked with its state Legislature last year on S.B. 1, which includes safe staffing requirements. AFT-affiliated unions in New York have been working on S. 1032/A. 2954, which establishes minimum nurse-to-patient ratios.

AFT-affiliated unions have also been pursuing state legislation to require staffing committees. For instance, in New York, our unions won language in their 2019 state budget that requires the Department of Health to study how staffing enhancements and other initiatives can improve patient safety and care. AFT locals in New York have been working to curtail mandatory overtime with S. 6311, originally introduced in 2019.

Unsafe Staffing Means Diminished Patient Outcomes

Most critically, unsafe patient levels for healthcare workers have been linked to poorer patient outcomes, including higher likelihood of death. Decades of research have established a major consensus among healthcare and workforce researchers that staffing ratios address these issues.

When AFT leaders hear from members about unsafe staffing, the first concern is never, “This makes my job more difficult.” The biggest concern is always, “My patients aren’t safe.”

Every day, healthcare workers are forced to make impossible decisions due to unsafe staffing. Do they review the discharge instructions with a patient or respond to the flashing call button? Do they help a patient get to the bathroom safely or get another patient their medication on time? These are real decisions with real consequences for patient safety and having to face them every day all but guarantees workers will suffer moral injury.

Research reflects the impact of unsafe staffing on patient outcomes. Each additional patient added to the average nurse’s workload on a med-surg unit increased each patient’s chance of 30-day mortality by 16 percent.⁴⁴ In med-surg units, each additional patient per nurse was associated with a 5 percent lower likelihood of surviving in-hospital cardiac arrest.⁴⁵ Patients were 63 percent less likely to be readmitted within 30 days in hospitals where staffing in pediatric units was in line with the staffing limits (4:1) set in California state law.⁴⁶ Two-thirds of California staff nurses said the ratio law makes them more likely to stay at their jobs, and 74 percent say it has improved the quality of care in the state.⁴⁷

Outsized Use of Staffing Agencies: A Symptom of the Broken Labor Market That Needs Greater Oversight

“It’s difficult to depend on people when there are emergencies and crises when you don’t know the names of the traveling nurses because they are brought in and leave so quickly.”

—a nurse in New York state

“When you have a few travelers on a unit, they can definitely help augment staffing and help with an isolated crisis, but what we’re seeing are units that are really dominated with travelers. Then for those units that are short, we also have a float pool, so there aren’t regular staff; on specialty units, it’s a particular problem.”

—a nurse in Ohio

“When 70 percent of the staff are travelers and 30 percent are home staff, that is not good for continuity, for the history and the culture of the facility.”

—a nurse in Montana

With healthcare worker shortages and increasing patient levels during the COVID-19 pandemic, hospitals and health systems have begun turning more to healthcare staffing agencies. Though these agencies are not new to the healthcare landscape, rapidly escalating rates and accusations of price gouging have thrust them to the forefront of public debate over the cost of healthcare.

Many reports on staffing agencies sensationalize the amount paid to health professionals in these travel roles. While it is certainly true that these workers have been able to demand significantly higher pay during a public health emergency, the headlines frequently overlook the windfall for the staffing agencies that employ these workers.

A November 2021 analysis by Staffing Industry Analysts projected revenue for healthcare staffing agencies to grow to nearly \$25 billion—three times the level it was in 2011. But the study also notes this industry was experiencing rapid growth even before the pandemic. From 2009 to 2019, revenue tripled for the healthcare staffing industry, following larger economic trends toward gig work.⁴⁸

Traveling healthcare workers are a valuable addition to a hospital's care team in many situations, including bringing workers with specialized skill sets into rural and underserved areas. Staff nurses and health professionals work alongside them, often exchanging valuable insight. The problem arises when hospitals and health systems stop investing in recruiting and retaining staff nurses and health professionals and the use of temporary workers becomes a more expensive replacement rather than a supplement.

In a 2022 report, the American Hospital Association evaluated the cost of the pandemic for hospitals, including the increased money spent on temporary workers through staffing agencies. According to data cited in this report, travel nurses now account for a much larger portion of total hours worked by nurses in hospitals. In January 2019, travel nurses accounted for 3.9 percent of total hours worked by nurses in hospitals. In January 2022, they accounted for 23.4 percent.⁴⁹

As hospitals have relied more heavily on staffing agency workers, labor costs have skyrocketed. The AHA report also cites data showing a 213 percent increase in rates charged by staffing agencies between January 2019 and January 2022. As a result of increased prices from staffing agencies and hospitals' increased reliance on them, hospital labor expenses per patient at the end of 2021 were 36.9 percent higher than pre-pandemic levels.⁵⁰

Related to staffing agencies and efforts of the healthcare industry to surge nursing services as needed are efforts to enact the Nurse Licensure Compact. States that join the compact agree to recognize the nursing license issued by any other compact state. However, the multistate license scheme, while sacrificing state-specific nursing standards such as continuing education requirements, has not alleviated the staffing crisis in our nation's healthcare facilities.

The nurse labor market in our country has been broken. Hospitals have had to scramble to hire nurses in a time of public health emergency because they used lean staffing models prior to the pandemic. Every hospital competing for the same limited pool of nurses at the same time drove up wages. Coupled with years of deteriorating working conditions and lack of fair compensation, many nurses quit their staff nursing position to follow the money.

Some, frustrated with their working conditions, are undoubtedly trying to cash out before they leave the hospital industry. Many have been able to accept positions at nearby hospitals. This has resulted in staff nurses working side by side with travelers (when the department is not staffed entirely by travelers) who make two and three times as much as staff nurses do for the same work.

As a result, more staff nurses are quitting and taking traveler positions. This is clearly an unsustainable labor market. Instead of complaining of the high rates charged by staffing agencies, hospitals should accept responsibility for creating a labor market in which dedicated staff are undervalued and underpaid; hospitals should reduce pay disparities and improve working conditions.

Exploitation of International Workers

The dark underbelly of international staffing agencies, where some agencies engage in nothing short of international labor trafficking, is one of the most insidious components of the staffing agency market. Many of these agencies require nurses to sign exploitative employment "contracts" with provisions that are so restrictive they are akin to indentured servitude. These contracts limit the mobility of international nurses' labor.

Some international nurses have been denied the wages they have earned alongside hospital staff because they are unaware of American labor protections, such as overtime laws. These contracts often include exorbitant financial penalties for a “breach of contract,” including early termination. Workers who are trapped under these conditions are unable to report illegal labor practices and unsafe working conditions. Unfortunately, instead of these nurses being protected by labor law, staffing agencies have successfully sued for breach of contract and been able to garnish a nurse’s future wages. While increasing the number of international workers is only a small part of the solution to the labor crisis in healthcare, special care must be taken to identify bad actors who exploit these workers. We must also recruit ethically from other nations, taking care not to extract labor desperately needed in those nations.

Examples of Strategic Approaches

Enact state legislation requiring staffing agencies to be specifically licensed by each state they operate in, publicly disclose their contracts with healthcare facilities, their employment contracts, their spending, who is working where, as well as require that at least 80 percent of their spending goes to direct patient care, and that they will be disbarred if they have been shown to violate state or federal labor laws.

AFT Local Unions Have Been Winning Contract Language That Puts Guardrails on the Use of Travel Agency Nurses

Before the pandemic, AFT-affiliated unions had been successfully bargaining language that limited their employers’ use of travel nurses. The Washington State Nurses Association, for example, was successful in having the University of Washington Medical Center declare in their agreement that it “is the intent of the University of Washington Medical Center to minimize the employment of agency nurses.” The Ohio Nurses Association successfully bargained with the Cuyahoga County District Board of Health that any “substitute or temporary nurse will not be used to avoid filling any vacancies.” The Oregon Nurses Association successfully got the Sacred Heart Medical Center in Eugene, Ore., to jointly review the staffing pattern and use of per diem and other nurses in a unit and shift to determine whether additional regular positions/ hours should be posted.

Section 4: Compensation of Healthcare Workers Needs to Be Increased

The healthcare industry as a whole was worth a staggering \$8.45 trillion in 2018⁵¹ and accounted for more than 19.7 percent of total U.S. gross domestic product in 2020.⁵² Combined with the social services sector, in 2018 it was the largest employer in the country with over 20 million employees and more than \$1 trillion in annual payroll.⁵³

The compensation package for people at the top, including hospital executives, reflects this. However, the reality for the people who provide the direct care, provide food for patients, keep the facilities clean and hygienic, and otherwise support the operation of our nation’s healthcare facilities is far different; and they are increasingly discovering that their wages aren’t worth their working conditions.

While hospital CEOs earn an average \$600,000 annually, the true compensation differential at specific facilities can be much greater. For example, in 2018, the CEO of Kaiser Permanente, a large nonprofit health-

care system, made nearly \$18 million. In 2017, the top 10 highest-paid nonprofit health system executives earned \$7 million or more. Even the bottom 25 percent of nonprofit hospital CEOs enjoyed annual compensation of about \$185,000.⁵⁴

In contrast, other healthcare professionals make significantly less:

2021 National Average Salaries for Healthcare Workers

Pharmacists	\$ 125,690
Physician assistants	\$ 119,460
Nurse practitioners	\$ 118,040
Physical therapists	\$ 92,920
Occupational therapists	\$ 89,470
Registered nurses	\$ 82,750
Respiratory therapists	\$ 68,190
Clinical laboratory technologists and technicians	\$ 56,910
Licensed practical and licensed vocational nurses	\$ 51,850
Medical assistants	\$ 38,190

Source: U.S. Bureau of Labor Statistics

The gap is only wider for those hospital employees whose jobs do not require specialized degrees, such as janitorial and kitchen staff, and medical-records personnel. For instance, the Lown Institute found that the ratio of CEO wages to the wages of these workers ranges from 26:1 to 2:1.⁵⁵

	Hospital CEO Compensation per hour, on average (range)	Hourly Worker Wage on average (range)	Ratio of CEO wage to other workers on average (range)
Top 50 ranked hospitals for pay equity	\$65 (\$22 - \$104)	\$30 (\$17 - \$45)	2:1 (0.8 – 2.7)
Bottom 50 ranked hospitals for pay equity	\$923 (\$458 - \$3,289)	\$34 (\$21 - \$61)	26:1 (18.9 – 60.2)

Source: Lown Institute Hospitals Index

To successfully recruit and retain staff, the healthcare industry must fix its compensation gap.

Examples of Strategic Approaches

Conduct compensation surveys on a recurring basis and raise entry level salaries for all hard-to-fill positions, precepting, mentoring and clinical advancement; and develop meaningful steps increases and retention bonus targeting mid-career professionals who are leaving hospital employment in record numbers.

Section 5: Corporate Trends

“At the end of the day, maintaining the budget is a bigger priority for employers. They are willing to talk the talk and not walk the walk when push comes to shove. This is a huge problem.”

—a healthcare worker in Ohio

“Stop treating staff as something you can cut out to its lowest common denominator instead of treating staff as an asset.”

—a healthcare worker in New Jersey

Driven by an insatiable desire for income, hospitals and health systems have systematically undervalued and underinvested in the healthcare workforce. While executives enjoy multimillion-dollar compensation packages, healthcare workers have been forced to do more with less. Lean staffing models that rely upon on-call, mandatory overtime, and travel nurses to flex staffing at peak census levels have resulted in dangerous patient loads, which stretched many healthcare workers beyond their limits long before the pandemic.

Reconfiguring Care Models Should Be Driven By Patient Outcome Standards

Following the adage “never let a good crisis go to waste,” the healthcare industry has seized upon the COVID-19 pandemic to advance new cost saving strategies. One little-noticed provision of the CARES (Coronavirus Aid, Relief and Economic Security) Act gave the Centers for Medicare & Medicaid Services the authority to waive the requirement that hospitals provide 24-hour nursing services.

While this currently applies to only a limited total number of patients, the geographic footprint of these waivers is quite big with 206 hospitals run by 92 systems spanning 34 states have received temporary waivers to run what they call “hospital in the home” and “hospital without walls” programs. These models may foretell the future of care delivery, as evidenced by last year’s announcement by Kaiser Permanente and the Mayo Clinic of a \$100 million investment and joint partnership with at-home acute care company Medically Home.

Removing a patient from the hospital setting maximizes profit in the hospital industry by eliminating the need for ancillary services such as food services and environmental services and 24-hour nursing services. Instead, patients will care for themselves, and the hospitals will rely on occasional visits from other (typically lower-skilled and less-expensive) healthcare professionals, such as emergency medicine technicians or those employed by home health agencies. This does not address who is responsible for maintaining and monitoring the remote equipment, which is typically handled by a technician in the hospital.

Other “innovations” in healthcare include the “virtual ER,” which allows doctors from hundreds of miles away to visit a hospital emergency room through webcam and speaker; the application of artificial intelligence (for example, to diagnose illnesses); and task automation.

There is also increased pressure, often driven by the healthcare industry, on scope of practice—essentially who is allowed to do what. In some instances, expanding scope of practice for a given discipline makes sense, such as allowing a highly trained advanced practice registered nurse to work independently and provide much-needed clinician care in rural America. However, expanding the scope of practice for less-skilled healthcare practitioners only to save money for the employer can impair the quality of treatment provided to patients. These decisions should be driven by increasing access to high-quality healthcare, and not from cost considerations as the healthcare industry tries to find new ways to increase revenue.

By investing in and expanding such programs, the healthcare industry shows that rather than trying to solve the staffing crisis, it is instead looking for ways to deliver cheaper care. To put it bluntly, the industry is sacrificing patient care to save money. Instead of degrading the standard of care, we would all be better served by appropriately staffed healthcare facilities.

Examples of Strategic Approaches

Secure federal and state protections for scope of practice and develop new patient care quality metrics for care delivered remotely that guide deployment and reimbursement levels.

A System That Values Safety and Accountability and Protects Healthcare Workers' Professional Practice Is Needed

Healthcare is a high-stakes environment with incredibly complex systems on both the clinical and the business sides. Factors like the evolution of different models of nursing care, reimbursement-driven documentation systems, and advances in research and treatment mean incessant change for direct-care clinicians.

The criminal conviction of a Tennessee nurse in 2022 following a deadly medication error sent chills throughout the nation's healthcare workforce. At a time when healthcare professionals feel beaten down and abandoned by their employers, there is now a great deal of anxiety about their personal liability if they make mistakes, which are more likely when they operate in unsafe facilities and manage unsafe patient levels. A renewed focus on just culture and other approaches that ensure administrators are held accountable is crucial. Not only does such fear of punishment hinder system improvement that requires reporting of errors, but it is also a further deterioration of working conditions. Exhaustion, mental health stress, fear of punishment and inadequate compensation make it hard to recruit and retain a workforce.

Examples of Strategic Approaches

Enact state and federal laws and regulations that protect the licenses, jobs and livelihoods of health professionals from unfair civil, administrative and criminal penalties that are the responsibility of an employer.

Consolidation Lowers Wages and Does Not Increase Quality

Consolidation has been a growing trend in the healthcare sector throughout the 21st century,⁵⁶ and the pandemic has only widened the economic gap between the large, prestigious healthcare networks and the remaining community-based hospitals and critical access hospitals, many of which are in rural America.

This widening gap leaves the community-based hospitals ripe for acquisition. During the peak of the pandemic, the finances of these two types of hospitals were legitimately stretched to the breaking point as they struggled to provide more expensive care, lost revenue from higher-yielding procedures that had been suspended and couldn't afford personal protective equipment (there were insufficient stockpiles of PPE). In fact, some facilities were merely days away from not being able to make payroll.

Meanwhile, the larger healthcare chains that have more diversified revenue streams were able to better mitigate the loss of revenue from the suspension of elective surgeries and had greater financial reserves

they could tap into to cover the growing costs. Indeed, during the peak of the pandemic, for-profit institutions like HCA Healthcare made record profits. Meanwhile, small, independent hospitals are now financially strapped and ripe for acquisition by larger, prominent systems, which have evolved into regional, multimarket systems. While advocates of consolidation often claim that it will ultimately improve the quality of care, there is no evidence to that effect. In fact, Dr. N.D. Beaulieu and Dr. Dafny Beaulieu found that, “Hospital acquisition by another hospital or hospital system was associated with modestly worse patient experiences and no significant changes in readmission or mortality rates. Effects on process measures of quality were inconclusive.” Later, in 2020, E.S. Fisher and S.M. Shortell found that “greater financial integration was generally not associated with better quality.”⁵⁷

There is evidence however that consolidation imposes downward pressure on worker pay. Mergers that significantly reduce the number of hospitals in a local labor market have been found to lower wage growth for nurses and other skilled workers.⁵⁸ A recent study compared markets in which hospital mergers occurred between 2000 and 2010 to those that did not, and then looked at the effects on wages in the years afterward. According to the report “four years after these mergers greatly increased hospital concentration, nurses and pharmacy workers’ wages were 6.8 percent lower, and skilled worker wages were 4 percent lower than they would have been absent the merger.”

One possible explanation is that the hospital workforce has shifted toward lower-skilled, lower-wage workers within a category, for example from registered nurse to licensed practical nurse, following a merger.⁵⁹ This is consistent with “recent academic work has documented a negative relationship between labor market concentration and wages.”⁶⁰ As a result, healthcare positions in those hospitals became less attractive and harder to fill.

The Unique Challenge of Rural Healthcare

Many of the healthcare workforce shortage areas identified by the Health Resources and Services Administration before the pandemic are located in urban and rural settings with significant percentages of minority and underserved residents.⁶¹ This is particularly concerning because rural communities tend to have sicker, older and poorer residents than the country as a whole.⁶²

Complicating the challenge of ensuring that rural communities have access to the healthcare professionals they need is the high rate of rural hospital closures that predate the pandemic. Since 2010, more than 120 rural hospitals have closed, 39 since 2018.⁶³ An additional 453 rural facilities can be considered “vulnerable” to closure based on performance levels, nearly one-quarter of all rural hospitals in the U.S.⁶⁴ Rather than closing, rural hospitals acquired by larger systems often have their services hollowed out as they become feeder facilities for larger hospitals located farther away. In Ohio, for example a number of rural labor and delivery departments have closed, forcing expectant parents to travel greater distances to give birth.

The community impact of rural hospital closures has been profound. As Mark Holmes, Ph.D., of the University of North Carolina found, “Rural hospitals are often an anchor institution, providing not only needed healthcare, but also a significant portion of jobs and billions of revenues in purchasing goods and services from other businesses. As a major employer in rural areas, hospitals and their closures have tremendous impacts on the economies of already vulnerable communities.”⁶⁵

Examples of Strategic Approaches

Increase oversight of merger and acquisitions practices in the healthcare industry, including examining the impact on patient access to quality care through the U.S. Federal Trade Commission, U.S. Department of Justice and the Centers for Medicare & Medicaid Services, as well as greater state-level oversight.

AFT-Affiliated Unions Have Been Working on Aggressive Legislation to Curtail Corporate Practices in Healthcare

For example, the Oregon Nurses Association won legislation (H.B. 2362) in 2021 that requires approval from the Department of Consumer and Business Services or the Oregon Health Authority before any mergers, acquisitions, contracts or affiliations of healthcare entities and other entities if they are above a certain size in term of revenue or premiums. AFT Connecticut has been working on a variety of bills, including legislation to strengthen the state's Certificate of Need (CON) Program to prevent hospitals from unilaterally shutting down services like labor and delivery without going through the CON process. AFT Connecticut also has been working on legislation (H.B. 5575) that would establish community standards of health and hospital care for private for-profit hospital ownership in Connecticut as a means of prioritizing best-practice patient care over shareholder dividends and other unnecessary fee-for-service contracts. In New Jersey, the Health Professionals and Allied Employees is working on state legislation that would require contracts for sale of certain healthcare entities to preserve employee wages and benefits and honor collective bargaining agreements (NJ S. 315).

Section 6. Worker Voice and Trust

“It gives me hope that nurses haven’t given up yet. Having a union, at least we have a voice and this week, we can speak up and have at least some protections against retaliation.”

—a healthcare worker in New Jersey

Nurses ranked number one for the 20th year in a row in Gallup’s annual public opinion survey on honesty and ethics in various professions in 2021. Following the COVID-19 pandemic, this same poll in 2021 found that 89 percent of Americans rated nurses’ honesty and ethics as high or very high, a rating only surpassed by firefighters in 2001 following the terrorist attacks on 9/11.⁶⁶

As frontline care providers, nurses and health professionals have invaluable insight into how each decision made by hospital administration impacts patient care. This expertise coupled with the trusted position healthcare workers hold in their communities should make it obvious to healthcare employers that healthcare workers are their greatest asset. Yet, too often health systems treat healthcare workers only as an expense to be controlled. When employers treat healthcare workers like disposable parts and not dedicated professionals, it is no surprise that workers experience burnout, hospitals experience turnover and, ultimately, patient care suffers.

Impact on Patient Outcomes

Once again, extensive research supports our frontline members’ conclusions. Patients and staff both have better outcomes when healthcare workers have better work environments.

A 2019 meta-analysis of the association between nurse work environments and outcomes found that in hospitals with better nurse work environments, the odds of an adverse event or death were 8 percent

lower.⁶⁷ Additionally, a 2016 study found that in hospitals with poor nurse work environments, patients had a 16 percent lower likelihood of surviving an in-hospital cardiac arrest. The authors suggest that the link between safe staffing and in-hospital cardiac arrest survival might be especially strong because of the importance of quick intervention.⁶⁸

When a nurse has an unsafe patient load or an otherwise unsafe work environment, the extra time it may take to get to a patient experiencing cardiac arrest could be fatal. AFT leaders hear devastating examples of these incidents from members who bear the consequences of unsafe staffing.

Meaningful Shared Governance Leads to Better Patient Outcomes

For nurses and health professionals, knowledge about patient outcomes does not only come from analytical research, but also from their direct care experience. It is not surprising then that research has also linked nurse involvement in meaningful shared governance with patient satisfaction.

The percentage of patients reporting they would definitely recommend the hospital was 14 points higher in hospitals where nurses were categorized as “most engaged” in shared governance based on an assessment of three measures in the Practice Environment Scale of the Nursing Work Index, according to a 2016 study. The same study found that nurses in hospitals where staff were most engaged in shared governance were 44 percent less likely to report overall quality of care was fair or poor and 48 percent less likely to report a lack of confidence that hospital management will resolve problems related to patient care.⁶⁹

The best way to ensure a specific employer’s shared governance is to make it part of a collective bargaining process that holds management accountable for including the perspective of direct care providers. The most successful model is the national partnership between the Kaiser Permanente systems and the AFT’s Oregon Federation of Nurses and Healthcare Professionals and its other bargaining partners. Kaiser’s shared governance is far from a panacea for all that ails the healthcare system, but it has proven to shape management decisions in a positive way, albeit not with complete employee satisfaction.

Committees Work Best When There Is a Robust, Meaningful Worker Voice

Knowing that nursing is the most trusted profession, that better working conditions for nurses result in better outcomes for patients, and that specifically involving nurses in shared governance increases patient satisfaction, hospitals and health systems should see obvious benefits to partnership. Robust staffing committees and other labor-management partnerships can pave the way forward, yet many committee structures serve only to silence workers’ voices.

Union Contracts Are the Best Way to Ensure Workers' Voice

A collective bargaining agreement is the single most potent tool to ensure that healthcare professionals have a protected voice at their facility. CBAs create an accountable system where real discussion between labor and management takes place, giving workers more protection to speak up about difficulties. AFT-affiliated unions, like the Oregon Nurses Association, have successfully bargained for meaningful hospital committees. This includes Providence St. Vincent Medical Center where the ONA successfully bargained for clinical unit self-scheduling and the Oregon Health & Sciences University where ONA successfully bargained for unit-based nursing practices committees.

Examples of Strategic Approaches

The healthcare industry should respect the right of healthcare workers to form unions and immediately stop engaging in anti-union and union-busting tactics and, instead, develop labor-management partnerships that extend beyond the mandatory issues of bargaining.

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