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The Health Wonk Shop: The Health Care Workforce Under Pressure – Strikes, Shortages, and Staffing Requirements

Larry Levitt:

Hello, I'm Larry Levitt from KFF. Welcome to the latest episode of The Health Wonk Shop. About once a month we delve into timely and complex health policy topics with experts from a variety of perspectives. Today we're looking at the healthcare workforce, focusing in particular on nurses and allied health professionals. Notwithstanding recent reports of an AI powered automated diagnostic pod, healthcare is at least for now, primarily a labor intensive service. For patients to access care, we need the right healthcare workers in the right place available to provide it. Historically, the healthcare workforce has been fairly recession proof, but that wasn't entirely true in this last pandemic fueled downturn. And while healthcare employment has largely recovered, that's not the case for all segments of the healthcare workforce or in all parts of the country. There are clear signs of stress within the healthcare workforce with shortages, strikes, and burnout.

Today we're joined by a smart panel of experts to dissect what's happening and what's behind it. Gretchen Berlin is a senior partner at McKinsey and a registered nurse by background. Bianca Frogner is a health economist, director of the University of Washington's Center for Health Workforce Studies and professor in the Department of Family Medicine. And Alice Burns is associate director of KFF's program on Medicaid and the uninsured. If you have questions, submit them at any time through the Q&A button in Zoom and we'll get to as many of them as we can. Also note that this session is being recorded and an archived version should be available later today. Bianca, let's start with you with a pretty basic question. Do we have a shortage of healthcare workers or is that even the right question to ask?

Bianca K. Frogner:

Well, thank you so much for having me here today, Larry, and for having this conversation. So as my good friend Erin Frayer at UNC would say, asking the question of do we have a health workforce shortage is just a starting point in a conversation. And I'm glad that this is where we're starting today. It is not a simple yes or no answer. I think generally there is a broad perception among employers that we have a shortage, but we really have to ask where, for whom, for what purpose are we having a health workforce shortage? I think we certainly feel a lot of stress in the primary care space.

I think we're feeling a lot of stress in the behavioral health space as well as the long-term care space. So we have many sectors of the healthcare industry that are certainly feeling a crunch of trying to find workers to fill the slots as well as then we have a maldistribution problem of different areas of the country also struggling to find workers to fill the slots that they need, particularly in rural areas and underserved communities. So I would say it is a good question to ask of whether or not we have a shortage or not, but it's not a simple yes or no question.

Larry Levitt: And this is a complicated question which we'll come back to, but what's behind it? I mean, in most parts of the economy, you reach kind of an equilibrium. That pay rises, attracts more people to the profession. What's going on here?

Bianca K. Frogner: Well, I certainly think we're still struggling with the aftermath of Covid, or maybe aftermath isn't even the right comment to say. I mean, where we are with Covid, we're in a new world relative to where we were a few years ago, where there's a combination of just the lingering effects of bad feelings among healthcare workers where initially they were kind of promoted as heroes and then as time has gone on, they're feeling a lot of workplace violence, really take a hit... they're really feeling that in their workplace right now. And so as a result, our workers are feeling tired and burned out and they're saying, "I've had enough." So that's kind of coming from Covid, but that's certainly what's fueled a little bit before Covid. You add to that that many of our workers are facing low wages and as the economy recovers in this post pandemic period, they are seeing other job opportunities.

And so that's where the economy starts to put some pressure on our employers as they're competing for workers across sectors. And then there's a new generation of people entering the workforce every day and they have different preferences for their work environment. And we are seeing that in the broader economy that people are saying, "I don't want to work for these long hours where I'm poorly valued, so I deserve better."

Larry Levitt: Gretchen, let me turn to you. Bianca mentioned bad feelings among healthcare workers. You've done quite a bit of work on the current state of mind of nurses in particular. How are nurses faring? How have their attitudes towards their profession, their employers, their workload, healthcare in general changed over time?

Gretchen Berlin: Yeah, thanks so much for the question, Larry, and for having me here with Bianca and Alice. As you mentioned, we have been looking at nursing sentiment really since the start of the pandemic. And I think unfortunately some scary

things have remained constant. I remember when we got the first survey back, about 25 or 30% of nurses saying that they were planning to leave was pretty shocking. But then to see it consistently still happening, although on one hand we've gotten used to it, it's very alarming how consistent it has been. And frankly, we continue to see that today with about 30% saying they want to leave. We published a study last week with the American Nurses Foundation really looking at the sort of mental distress of nurses and unfortunately over 55% of nurses reported experiencing symptoms of burnout. Now, that's not all of the reason why folks are leaving, but that is an unacceptable state for frankly I think what all of society, all of us, through a variety of factors have put on them.

And so it's not surprising that we continue to see folks saying that they plan to leave. And I agree with Bianca's answer, the shortage question is not simple today, but we project that these trends will continue to lead to a shortage. We could be short up to 20% of what we need by 2025. The other thing I would say is while we haven't done as much research in other countries, when we have, this is a global issue. So I think a lot of times people ask the question around immigration policies and can't we just get from other locations? But the reality is a lot of the same things we're seeing in the US are being experienced in certainly developed countries around the world. And at the end of the day, what we're seeing folks say they want is a safe work environment, some work-life balance, a workload that they feel they can successfully deliver on a daily basis. And that's been consistent across time as well as across geographies.

Larry Levitt: Yeah, as Bianca said, those are things everyone's looking for, not simply nurses. Let me tease out a little bit. When you talk about intent to leave, is that leave their current employer, leave the nursing profession in general or leave patient care into non-patient facing positions?

Gretchen Berlin: It's a mix of both. So the number of folks who say they plan to leave their current role has gone up to 40 or 45%. And then those that plan to leave either direct patient care or nursing altogether because obviously there's forms of nursing where you're not providing patient service, tend to be lower, but still pretty high, around 20 to 30%. And while turnover in the industry has come down a bit since the height of Covid, it's still hovering around 22%, which is depending on the cut you look at, 3 to 6% higher than it was before Covid. So still at pretty unsustainable levels.

Larry Levitt: Alice, let me turn to you. Bianca mentioned the long-term care, long-term services and support workforce in particular, and that's a part of the healthcare

workforce that has not recovered from the recession. What are some of the unique factors behind shortages in that sector?

Alice Burns:

Yeah, absolutely. First, the Covid pandemic disproportionately affected the long-term care workforce. And in the early years of the pandemic, a fifth of all deaths were occurring in nursing facilities and staff and employment levels in those facilities are still 10% below their pre-pandemic levels. So that's one piece of it. Another piece is the workforce is a little different and we're talking about a broad range of paid and unpaid services that range from changing someone's catheter, giving them an IV, giving them a shower, preparing their dinner, and that's a really different skillset. Another thing is the payer mix.

Medicare and private health insurance generally don't pay for long-term care, so over half of the expenses are covered by Medicaid and over 25% people are paying out of their own pocket. And that really places this downward pressure on payment rates, which then puts downward pressure on wages. So most of these workers are making \$15 an hour, what they can make at say Target or Starbucks with much less physically and mentally demanded jobs. And Gretchen talked about the immigration, LTSS jobs are disproportionately filled by foreign born workers and the green cards are currently frozen, so nobody who has applied since June 2022 will be considered for a green card, and that is adding additional tension to this situation.

Larry Levitt:

So we've been talking a lot about these kind of shortages or potential shortages in workers. Kind of on the other flip side, the Biden administration has recently proposed new staffing standards in nursing facilities that would increase, potentially increase the number of workers required in those facilities. Describe briefly what the Biden administration has proposed, where we stand in that process and what the effects of that proposal would be if it were finalized.

Alice Burns:

Yeah, sure. So that proposal came out in September and it would require nursing facilities to have a nurse present 24 hours a day, seven days a week. And it would create minimum requirements for the number of registered nurses and the nurse aides. And this is to reflect longstanding concerns about the quality and sufficiency of staffing in nursing homes, low staffing was cited as one of the reasons for all of those Covid deaths in the facilities. The big thing is the rule would not be implemented for a number of years. Facilities would have three to five years to come into compliance.

There would be broad hardship exemptions, and it's unknown how many facilities would qualify. We did look at how many facilities could meet the requirements with their current staffing levels and fewer than one in five would

currently meet them. Again, that's not accounting for the hardship exemptions or the time they have to comply. The other really important piece of the nursing facility situation is ownership. And so when we looked at this by ownership, we found that only 10% of the for-profit facilities have enough staff to meet these requirements. 40%, I mean much closer to half of the nonprofit and government facilities [inaudible 00:13:05].

Larry Levitt:

So I mean we've talked about this kind of potential shortage of workers, now a requirement for more staffing and as you said, nursing facilities might need to pay more to certainly have more staff and to attract more staff. Where would the money come from to pay for that?

Alice Burns:

So that is the question. Because there are also requirements in the home and community-based long-term care sector that would require states to potentially pay more for Medicaid services for people who live in the community. And a lot of the workers are the same people. And so if we just ship them from one sector to another, we're not really addressing the underlying problem. And when we get to the underlying problem, we can look at what states are doing. And so states have been taking all sorts of innovative strategies with some of the extra flexibility and funding they had during the pandemic. And what they found is increasing payment rates is definitely part of it, but also establishing career ladders, helping people have opportunities for advancement, making these jobs a place people want to be.

Larry Levitt:

Alice, I mean, you talked about sort of some of this being fungible, right? Workers can work in one sector or another, people can obviously move from one part of the country to another. During the pandemic, we saw this growth in traveling nurses with, in some cases, much, much higher pay. Bianca, talk a little bit about how this market works. Where are we seeing more severe shortages in certain parts of the country, in certain sectors like behavioral health?

Bianca K. Frogner:

Yeah, thank you Larry, and thank you for that summary, Alice, of what the state of the world is looking like, especially in skilled nursing facilities with these staffing requirements. And I would say hospitals certainly have played around also with the idea of having staff ratios, staff to patient ratios. And this is all with the eye towards quality. And they are good for patients to have the proper number of staff per patient to make sure that patients are getting high quality care. But the problem is where's the supply of workers when you put those ratios into play? And Larry, as you suggested, people are moving around all the time in the healthcare industry and then across industries. There's a lot of dynamics between the hospital sector and skilled nursing facilities where we

certainly have seen in research that I have done with others that people are constantly moving actually between skilled nursing facilities and hospitals.

And I would say to some degree, hospitals and nursing homes have already had a long history of working together in the sense that hospitals are trying to discharge patients into skilled nursing facilities. And then when staffing is low and insufficient in nursing homes, they cannot take on the patient load that maybe they could have before or if they had higher levels of staff. So hospitals are finding themselves having to figure out how to staff their hospitals so that they can take on the increasing patient load or the long patient load that... as patients are sitting there in hospitals, not unable to be discharged, but within the long-term care arena, as Alice kind of pointed out, there's a move to move people into the home and community-based service sector because there's this hope and desire by people that they want to age in place. And so we need more home health workers also, but people are certainly moving between these jobs.

So again, we're kind of seeing people move in and out of these fairly, I would say, jobs that have low barriers to entry, like these nursing assistant jobs, home health aid jobs, personal care aid jobs where they have minimal training requirements to get into these jobs. And then once they're in there, these workers understandably are looking around and asking, "Okay, which job gives me the best benefits beyond wages," like health insurance, having enough money to pay for their transportation to work, for example, do their laundry for their scrubs, et cetera. And then they're looking around to see, well, are there jobs that are a little bit easier and just as fulfilling in other sectors? So again, we are struggling with this competition between sectors. But Larry, you mentioned travelers. Travelers was an interesting kind of byproduct of the Covid pandemic where... I mean, anytime we've seen a crisis around the country, we see travelers emerge to help fill in gaps whenever there's an emergency somewhere in the country.

What was unique about this particular pandemic is that everybody was in an emergency situation kind of simultaneously. It certainly started in urban areas first and then it started to roll out into rural areas. And so as a result, everyone was competing for the same pool of workers. And then as I think Alice and Gretchen also pointed out, immigration has stalled. And so we couldn't pull from a pool of workers internationally to fill our gaps because everywhere else in the world they were also struggling at the same time. So the pool just got limited. And then on top of that, workers themselves were getting sick and were having to make difficult decisions about whether or not to go to work or not, whether or not to care for their families or not. And some just didn't have a choice. Schools closed, caregivers disappeared for children, and healthcare is a

very female dominated field. And so women just had to make incredibly difficult decisions, not only women, but certainly more so that burden fell on women than men.

Gretchen Berlin:

I think, if I can Larry, just building on Bianca's point about the competition between industries, I think there's even growing competition within healthcare as we see increasing shift of care into ambulatory settings, the players in the ambulatory settings that are popping up where you can get healthcare, all require clinical staff. And so there is greater competition for talent in various places. And with that comes greater agency for clinicians too, which to a certain extent is great. But back to Bianca's opening comments of the shortage is not equal in every location, I think where we see it unfortunately most dire, I guess is in traditional med-surg bedside nursing, and to some of Bianca's comments as well, health systems are innovating. It's not as though they're just sitting there bemoaning the problem. And we're seeing a lot of flexibility on schedules to try and provide more flexibility, increasing in childcare, as Bianca was saying, recognizing the gender and other family commitments that are out there.

The other thing is we and others have looked at just what nurses are doing, and as we've increased technology, increased documentation requirements for all of the right reasons around quality, also for some payment reasons, the amount of time that nurses are spending on patient care has come down. And we estimated a few months ago with the ANA Center for Innovation that there's a good chunk of time that can actually be given back to nurses to provide care through either delegation to other team members if it's there as well as automation. And I think health systems are starting to get after some of that. It doesn't relieve the need for folks, but it at least rebalances some of the workload that we talked about earlier.

Larry Levitt:

And Gretchen, let me stay with you. We've had a number of questions about the pipeline for nurses in particular. This is not a static situation. More people could enter the profession, enter programs to train to enter the profession. Where do you see that now and in particular for registered nurses versus nurses with a bachelor's degree, has pay adjusted in order to attract more people into these programs?

Gretchen Berlin:

Yeah, I think the compensation question is interesting, first of all. So every time we've asked nurses what attracts you, what keeps you, compensation is on the list. But in any of the surveys we've done, it's never been number one, it's always been meaningful work, a positive environment, et cetera. And so by all means, folks should be paid at the level that they deserve. But in my mind, it's not all about compensation and also given the competition that we're seeing

across players, it's also not a sustainable way to get and keep staff. But to the education and just interest in the field point, I do think a lot of the trauma that our clinicians were exposed to during Covid was an increasing deterrent. I think frankly, some of the violence that is starting to be portrayed in the news that's playing out in our emergency departments and other care settings is also a deterrent.

And a little bit to my comment earlier about what society has done to nursing overall, I personally really believe that. But when you look at just the education slots versus what we need, our assessment is that we don't have enough and that in nursing care broadly, we could be short of about 800,000. And I do think, Larry, your question of bachelor prepared nurses, other RNs, LPNs, how we think about techs, how we think about advanced practice providers, the whole chain has opportunity to be looked at in how we collaborate as a team so that everyone is truly doing what they need to at the top of their license because there isn't... it's not possible for us to, in the current requirements for education, the clinical hours, et cetera, to make enough, call it baccalaureate prepared nurses to meet the demand.

It's a lot harder to say we're going to get enough RNs to meet the demand. But when you start thinking about flexibility in care teams and how people can see patients including technology by the way, there's more degrees of freedom to get there. But I do think the education system as currently constructed cannot put out enough new grads to meet with the elevated exits that we're seeing.

Bianca K. Frogner:

Larry, could I pick up on Gretchen's points around retention kind of factors that she kind of mentioned there about wages not being a top priority necessarily, like the main necessarily driver? Because I think that's actually a common thing across multiple occupations that there's a feeling of goodwill that we've kind of banked on in the healthcare industry where a lot of people find themselves wanting to be in a caring profession and as a result they're willing to maybe sacrifice a little bit of wage for the sake of having a job that gives them a lot of fulfillment.

And I think to some degree we've really worn our welcome with the goodwill and that people are saying low wages at some point in time is a real factor. I mean, to the point earlier you were asking me about the behavioral health workforce, I mean, we have heard at least anecdotal stories that people are graduating with master's degrees and they're counselors and they can't find a job that pays well and that some of those jobs are paying less than or equal to what bus drivers are making. I mean, that just feels on the face of it, just unsustainable for people who are going to school, getting a high level of... taking

on a higher cost of going for further education, and they have probably loans to pay off and they can't necessarily take on jobs that just don't give them a wage that can help them sustain those kinds of debts.

Larry Levitt:

And Bianca, let me ask you, you mentioned earlier about women being disproportionately represented in healthcare, maybe physicians aside. How much of a role does gender play here?

Bianca K. Frogner:

I think it plays a big role. I think certainly during the pandemic across the board, we realized the importance of women being a big part of the workforce generally, but particularly in healthcare, where again, if you look at the overall healthcare industry, it's something like 75% of workers in the healthcare industry across all jobs are women. And then you look in the long-term care sector, we're up to 80 to 90% of the people in those jobs being women. And many of them have children, but even if you don't have children, and one of them is that you might have older parents that you have to take care of. And we have plenty of people in that sandwich generation that they're taking care of both elderly parents and children at the same time without any financial support from their employers to make that happen. And then you add to that, so childcare is certainly expensive.

We are also trying to figure out how to care for our parents either on our own dime or find home healthcare workers for our own parents. And then you add to that, when those services all stopped during the pandemic or were on hold, it became very difficult for people to figure out how to care for everybody around them, let alone themselves. I mean, that goes back to the mental health part, is that people have been struggling with mental health challenges themselves during this pandemic, and that has been contributing to a rising need for more mental health care.

Gretchen Berlin:

I think it's another example of the diversity of the problem too, because cost of living in New York City is very different than a suburban center in... I don't want to pick a state. But our wages in healthcare aren't as necessarily as diverse as the cost of living. And I think we see health systems therefore compensating with housing, whether it's allowances or literally housing offering, literally providing the childcare when the childcare doesn't exist in the surrounding environment. So it's certainly not equal across our country.

Larry Levitt:

We also had a number of questions about what states are doing here. And Alice, let me start with you. I mean, in long-term care in particular, Medicaid plays a big role in financing it. What are some of the things states have done to alleviate the shortages, alleviate the disparity across areas?

Alice Burns:

Sure. Well, states are increasing their payment rates for both nursing facility and home-based care, and they have primarily increased their fee for service payment rates. But states have told us that the managed care companies tend to follow that pattern. But they're also doing a whole lot of other innovative things, particularly in the home-based setting. And during the pandemic, one of the things they actually increased a lot is paying the family caregivers who are at home taking care of their children, spouses, parents. And historically Medicaid has not allowed people to be paid to care for their legally responsible relatives.

But that is something that CMS has increasingly allowed and states really picked up during the pandemic recognizing that there weren't caregivers available. And so most states used temporary authorities to start doing this. The real challenge is a lot of those programs ended November 11th. And so people may find that either they can no longer be paid to care for their child, but there's no paid professional to take over, or they may find that they can only be paid for 20 hours of care even though they're providing 40, 50, 60 hours of care. And so I think what we'll be watching is how does this play out in the year ahead.

Larry Levitt:

And Bianca, I mean, both you and Gretchen mentioned geographic disparities. We had a question about underserved areas and what could be done to attract workers, healthcare workers to those areas. Do you see anything states have done or the federal government has done to try to address that?

Bianca K. Frogner:

Sure. I mean, a lot of the attention tends to go to rural communities in particular who have a hard time keeping particularly high wage workers. And some of that is attributed to challenges that people have in terms of finding partners, actually to be honest, or keeping a partner employed in some of those rural areas as well as finding the schools and the other services that they might want to raise their children in rural communities. Not to say that rural communities don't offer wonderful other values, but this is something we're hearing from folks who move to a rural community for a short period of time and then leave, is that what they're struggling with is kind of challenges around making sure that their family is getting all their needs met too simultaneously. I think among the things that seem to be working are... so loan repayment programs do help keep people for a short period of time, but we need longer term solutions like recruiting actually from those communities and investing in those communities, in the members of the communities themselves.

Because I think what we are certainly finding is that people who are from rural communities, go to school in rural communities, they're more likely to maybe stay and live in a rural community, whether it be the one that they grew up in or another one. So that certainly can help a lot. I mean, similarly for underserved

communities, and we can certainly do more to diversify our workforce, especially at the higher wage jobs. We have a lot of diversity actually in our low wage jobs in the home health and nursing facility jobs.

But we need to do more to invest in our underserved communities to make sure that people have opportunities to move up the career ladders, become nurses, become physicians, become pharmacists, and have these high wage jobs. And part of it, again, is recruiting from the community themselves. And this is good for patients. I mean, we need a workforce that looks like the patients that's being served, so patients feel like they're being understood. So when it goes to questions around, again, back to shortages, what we certainly have a shortage of is a shortage of a workforce that represents the patients that are being cared for.

Larry Levitt:

Bianca, let me stay with you. We had a number of questions about strikes in healthcare. We saw a strike at Kaiser Permanente, we've seen strikes among pharmacists, walkouts not strikes at CVS and Walgreens. Is this unusual in healthcare? What do you think is driving it and looking ahead, do you see this happening more often and why?

Bianca K. Frogner:

Yeah. The strike with Kaiser Permanente was particularly interesting because it was everyone but doctors and nurses who really were the ones going on strike fighting for their rights when a lot of times what we tend to hear more in the news are nurses tending to go on strikes. And I think what it shows is that all of the healthcare system, all kinds of healthcare workers are feeling the stress right now. And certainly physicians and nurses walked out in support of these other workers, but it was really with the eye on these other workers that felt the stress. And so that was a particularly unique thing about that strike. And what's great is to see that it seems like it's been resolved, it's getting written up. What happened here in Washington state is that Washington State, Kaiser Permanente workers striked afterwards or were planning to strike afterwards and kind of ended up signing on to the deal that had happened with the other states workers who are with Kaiser.

And what it seems like is that there seemed to be a good agreement around wages and benefits and providing the things that we've been all talking about, about what it takes to retain workers. I think in the pharmacy sector, it's a little different. This is an area that has kind of been ongoing and struggling for some time and doesn't quite probably get the attention it deserves. It's that... what's happening in the pharmacy sector, there's a lot happening there. I mean, between your pharmacy benefit managers and trying to figure out how to navigate what is happening with acquisitions of pharmacies, especially your

community pharmacies by your larger retail pharmacy chains, we need a better grasp of what's happening there. But generally the feeling is twofold. One is that pharmacy technicians are really hard to retain. Again, this is another job that doesn't take a lot of education to get into.

And so these workers, they're being sought after or they're finding jobs in other sectors. So that's one piece of it. And then you add to that, pharmacists are feeling a lot of pressure to do a lot of dispensing, and they're looking at themselves thinking, "I have a five-year doctorate. Why am I only dispensing? I'm trained to do so much more." But they're really not paid to do that kind of work. And so again, they're feeling this burden of just doing a lot of volume of prescriptions without feeling the value again of their work. And I think we need to have a better discussion about whether or not we're really leveraging the scope of practice of pharmacists and really using them to the top of their scope. And actually that is really driven by payment and the fact that we're really not paying them to do that kind of work. We just don't have a model that does that.

Larry Levitt: And very different in the US than in other countries. Pharmacists are in many ways the front lines of healthcare in many other countries.

Bianca K. Frogner: And they certainly could be here.

Larry Levitt: Yeah. Gretchen, so Bianca mentioned payment. We've had a whole bunch of questions about insurance payment, how that relates to it, kind of insurance in general, I mean prior authorization paperwork that clinicians have to do increasingly, electronic medical records. How do you think about that? How does that affect quality of work life for nurses in particular?

Gretchen Berlin: Yeah, I mean, it's an interesting question. We haven't teased out how much of the workload exactly can you tie back. However, what I can tell you is the workload is always number one or number two in terms of what's driving people's decisions to stay or leave. And then when we have dug into what is in the workload, only about 54% of that is actually direct patient care. There's some other things in there like breaks and learning, which I think we would all say teaching are good. They estimate that about 15% of their time today is spent on charting. What was really interesting is we asked, what's your ideal time? And it only decreased a little bit, which I think is twofold. One, people wish they weren't spending as much time doing it, but if they have to do it, I think they wish they got more time to do it.

And we don't spend a bunch of time talking about pajama time for nurses the way that we do for physicians and other advanced practitioners. But I think

there is an element of that in there. And when you actually look at what a nurse is doing in documentation, obviously some of it is very important for handoffs and for the care plan and for the care team. But a big part of it is checking boxes to make sure you are hitting what you need to for payer requirements, for prior authorizations, for appropriate coding and therefore reimbursement. And the cost of care is in large part driven by the cost of labor. On the health system side, about half of the cost is workforce, and it varies, but about half of that is nurses.

So it is a huge investment when you add it up that we are putting in to then be paid on the backend. One of my favorite things to try and find right now is opportunities where providers are wasting time on things like that, and health plans are wasting administrative effort on it. And there's all these double costs that we have in our healthcare system as we've created such a complex piece of it. So I can't give you an exact answer of if we could get rid of prior auths, we would retain X number of nurses. But the connection points are certainly there.

Larry Levitt:

And Gretchen, you mentioned earlier some innovations in delivery that could help both with quality of work life, but also the need for staffing. Talk a little bit about that and what's the potential for AI or other new technologies here.

Gretchen Berlin:

I think everyone's very excited about AI, and everyone likes to talk about the really clinical applications of it, but I'm actually most excited about the nonclinical less sexy applications of it. And forget about even the gen AI. In healthcare, we have so much opportunity to leverage just the data we have for analytics. So on the staffing front, I think one of the most promising things is actually projecting demand for patients, which there is of course, unforeseeable events in healthcare. You're always going to have folks walking into emergency rooms with heart attacks, you're going to have car accidents, et cetera. But the vast majority of it is relatively predictable, and even those events are pretty consistent over time. And so how do you leverage that data and the technology that we have to project, therefore, where do you need staff and what kind of staff? Because anytime we look in a health system, you have units that are short what they would need entering the shift.

And so you have this frenzy of calling people on, doing overtime, et cetera, which no one really likes. And then you have other areas that are a bit overstaffed, or maybe that's the way it looks throughout the day. And so I think there's an opportunity to really optimize even with the resources we have, recognizing there aren't enough resources. So I think that's the first thing. The second thing is just leveraging technology to help. And it's hard because every time a system adds a technology, it's yet another interface for staff to work

with. And so figuring out how to integrate all of them either automatically into the EMR or automatically into the communication system, I think is key so that we're not adding on top. But there are technologies out there now with Bluetooth on various devices that nurses may be looking for. Nurses told us that they spend over 5% of time in a hunting and gathering category.

But you think about that over the course of a year for the number of nurses we're talking about, it's a massive amount of time versus how we have it in other parts of our life where you can find your keys on your phone in 10 seconds. Why do we have nurses running around looking in closets for things? So there's technologies like that that can just help and free up time. And again, that doesn't mean that we can use fewer nurses necessarily, but perhaps that nurse actually has more time to go to the bathroom or eat a sandwich or coach a peer or be coached so that they're part of that valuable workforce that they want. There's a lot of talk on virtual nursing supporting. There's a lot of automation and technology supporting, med administration, et cetera, et cetera. But I actually think some of the simplest kind of analytics upfront that frees up nurse managers and nurses' time from dealing with the chaos that is still staffing and scheduling is most promising.

Larry Levitt:

Bianca, you mentioned earlier issues of scope of practice. If you could talk a little bit more about that. And I mean, one could imagine that playing out in multiple ways. I mean, asking nurses or expecting nurses or allowing nurses to do more relative to physicians could increase the demand for nurses. On the other hand, making greater use of pharmacists, as you said, or community health workers or family caregivers that Alice talked about could expand the potential workforce here.

Bianca K. Frogner:

Yeah, thank you for that question. One thing that your question earlier about some state innovations that are happening to help with some shortage issues. During this pandemic, we've actually saw a lot of state innovation around scope of practice. There were a lot of changes, regulations that were experimented with over the course of the pandemic to expand scope of practice as a way to get people quickly into workforce or getting the capacity that we needed to care for all the people that were needed. But some of these scope of practice things were fairly simple. And it goes back to some technology issues around telehealth, whether or not you needed to have prior authorization from some other provider in order to be able to see a patient or having to see a patient in person before you ever see them online.

And some of those things just... we waived those requirements for at least a couple years until the public health emergency ended, in which case now

they're all being rolled back and we need to... they're all being rolled back without doing any proper study about whether some of these things actually worked out pretty well. Some of these things, when we talk about scope of practice, where the conversation tends to go is about fighting over a turf, like territorial battles over the activities that say a nurse practitioner can do versus a physician.

And then we have a conversation about who does it better, rather than having a conversation about, well, what's the need that patients actually have and who is there to provide that care, and what else should people be doing perhaps instead? So for those physicians who feel like they're overlapping with nurse practitioners, well, there's plenty of demand to go around. So those nurse practitioners can certainly take it on. Maybe we should be having a conversation with the physicians and say, "Well, what other activities should you be doing with all that training that you have?" Because their physicians certainly feel that they have the capacity to do something better than nurses because they've had so many years of training.

But I think we're not having that conversation to say, "But what are those things that we're not leveraging your education to do that we could be incentivizing you to do more of?" And this happens across many jobs. I don't mean to just focus on nurses versus physicians. This kind of discussion happens between dental hygienists and dentists. It happens between pharmacy technicians and pharmacists. And I think the key question is really try to figure out how to leverage all workers to take advantage of all the education that they have. But one problem that we have is that not everyone understands how each other were trained and what they're actually trained to do, and there isn't... while people work side by side, I think there's a lot of respect that does actually happen on the floors of these clinics, of these hospitals where people respect each other, but there isn't enough opportunity to have a dialogue to say, "But what were you really trained to do? What can we do to make sure that you as a worker here feel like you're contributing and taking advantage of all the education that you have?"

Larry Levitt:

And Alice, let me ask you, in long-term care nursing facilities in particular, how does this play out?

Alice Burns:

Well, right now, the biggest shortages we're seeing in nursing facilities are for nurse aids, which are actually the least skilled workers. And to me, that reflects more this crisis we're seeing with the direct care workforce. And these are people that don't have formal training. Turning back to the pipeline issue, there really is no pipeline for direct care workers the way there are for nurses. And

there's growing recognition at the federal level that maybe that's a gap in policy where we might want to start going into undergraduate programs and saying, "This is a career. This isn't just a job." But some of the most acute shortages are for the least skilled workers. And so then what happens is family caregivers end up being asked to do something like change a catheter, which most parents don't feel equipped to do. And so we end up with a situation where people with very little training are taking on pretty skilled activities.

Larry Levitt: So we are unfortunately coming to the end of our time, but I want to give each of you an opportunity to... or ask each of you to say one thing you're hopeful about looking ahead and one thing that keeps you up at night. Gretchen, maybe I'll start with you.

Gretchen Berlin: Sure. I think the thing I'm hopeful about is the focus on the collaboration between health systems and educators. Sometimes that line is even blurring now as we try and solve the inflow. And I think the thing that keeps me up at night is the global challenge of this that I mentioned earlier.

Larry Levitt: And Alice?

Alice Burns: I'm hopeful that there is really a bipartisan consensus that something is needed in the LTSS space and states are actively experimenting, which gives us a chance to learn what works. I think the thing that keeps me up is I'm putting on my former congressional budget office hat and the question of how are we going to pay for this.

Larry Levitt: And Bianca?

Bianca K. Frogner: I think what I'm hopeful for and what keeps me up at night may be the same thing. So on the one hand, I am excited that health workforce seems to be a topic of conversation across many different groups of people, whether it be those on the hill, employers, just even the public reading the news. Almost every day I see some story about the health workforce, and I'm really glad that people are talking about it, that maybe healthcare workers' voices are being heard. But at the same time, it worries me. I think we may be missing a policy window, [inaudible 00:48:01] policy window. This is the opportunity right now, and we may be passing it by and not see as much movement as maybe we should. I think we need to listen to the workers themselves. I think those strikes are certainly a sign that workers are not going to take it anymore.

This is their moment to have their voices heard. Not every worker is... they're certainly... occupations are not very big and they're not well represented out

there. Nurses are one of those biggest occupations out there, and they're well organized sometimes by unions, and so their voices are being heard loudly, but they're really a canary in the coal mine for all the other healthcare workers who might be working alongside them and just don't have that same voice and power. And I think now is that time that hopefully we are listening and paying attention to kind of what's happening on the ground, because if we don't, we're just going to repeat the same mistakes later on.

Larry Levitt: Well, I do think of health policy as Groundhog Day. We kind of wake up...

Bianca K. Frogner: It's true.

Larry Levitt: Year after year, decade after decade, and deal with the same issues. But I agree with you, Bianca. It feels a little bit different now in that there's a greater policy focus and as Alice said, some bipartisan attention to some of these issues. Well, Bianca, Gretchen, Alice, thanks for a great discussion. Thanks for the audience for listening and participating, and join us next time for The Health Wonk Shop.

Bianca K. Frogner: Thank you so much for having us.

Gretchen Berlin: Thank you. Take care-

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