Addressing the Health Care Workforce Crisis

Virtual Princeton Conference Summary, October 19th, 2022

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Overview

On October 19, 2022, the Council on Health care Economics and Policy, led by Stuart Altman and Michael Doonan, held its 29th Annual Princeton Conference, "Addressing the Health Care Workforce Crisis." Around 120 attendees, including national policymakers, health services researchers, industry leaders, and the public, joined in a dynamic conversation with the four key speakers about strategies and solutions to address workforce issues in many health care settings, including hospitals, nursing homes, and the community.

Karen Donelan chaired the event and laid out the landscape and scope of the workforce crisis. Dr. Michael Tutty of the American Medical Association (AMA) addressed physician burnout and shortages and provided examples of policy solutions at the hospital, state, and federal levels. Dr. Alice Bonner of the Institute for Health care Improvement (IHI) reviewed challenges and regulation solutions for improving workforce gaps in nursing homes. Finally, Dr. Bianca Frogner from the University of Washington's Center for Health Workforce Studies examined how better integration of community-level workers could fill gaps in care. The panel concluded that supply-focused policymaking, including; better regulations, cross-sector and cross-professional collaboration, improved pay and benefits, and support for unpaid family and friends, are the most critical levers to address workforce problems. Below is a more detailed summary of each presentation.

Welcome

Stuart Altman, Sol C. Chaikin Professor of National Health Policy, The Heller School for Social Policy and Management, Brandeis University

Stuart Altman welcomed the conference participants to the 29th Annual Princeton Conference and thanked the generous sponsors and the broad group of advisors that helped shape this year's theme. He explained that this conference would focus on unpacking the root causes of the workforce shortages across the continuum of health care settings due to COVID-19 impacts and pre-existing trends. The speakers would also focus on innovative state and federal solutions.

Conference Keynote: Landscape and Scope of Workforce Crisis

Karen Donelan, Sc.D., Ed.M., FAAN(h) Stuart H. Altman Chair in U.S. Health Policy, The Heller School for Social Policy and Management, Brandeis University

Summary

Donelan provided background on the crisis in the context of COVID and an uneven economic recovery to set the stage for discussing potential solutions. There is a critical need to right-size the supply and increase compensation to meet the care needs of the new and traditionally vulnerable populations. Future workforce training needs a foundational focus on equity and inclusion, and providers must embrace technology as a reality for improving the delivery system y and reducing labor and administrative expenses. In addition, a more holistic view of labor supply is needed, including thinking about optimal team care that includes patients and families. A national health workforce strategy, which

was initially proposed in the ACA but never came to fruition, is needed today. Finally, trust needs to be re-established between providers and patients. Below is a review of supporting data and background information that informed these findings.

Root causes of supply-side inequities included differences in wages, roles of workers, and representativeness of workers:

1. There was a significant increase in physician **wages** but low to no growth for a wider range of caregivers, particularly at the lower wage end.

2. The **supply of roles** is changing differentially. Physician supply is increasingly flattening compared to nurses and social workers.

3. In addition to the type of clinical providers, there are also significant issues in the **types of services provided**, particularly primary care and mental health. Despite the critically low supply of primary care workers, these providers are burdened with requirements to manage and maintain services like immunizations, electronic health records, and being the first point of contact for health problems. The supply of nurse practitioner could be expanded to help provide many of these services. This would require nationwide reforms around the scope of practice. The unlicensed workforce, including navigators, coaches, and community health workers, are increasingly being used to great effect. However, these increasingly essential workers are underutilized because they often are not accepted as independent providers by many government and private insurers.

Background in demand-sided changes and how the public interacts with the workforce:

The introduction of DRGs reduced hospital stays and shifted some services from inpatient to outpatient care. This result created a significant increase in outpatient specialty care and reduced inpatient hospital use. Now, thirty percent of older adults see five or more clinicians. The result is a whole network of care management programs led by nursing and social work professionals that are trying to buttress the primary care shortage. The public trust in health care is primarily with hands-on care providers, not insurers, hospital executives, employers, or the government and seeks their advice and care accordingly. Unfortunately, this influx of interactions with the public is not always a net positive. About half of the health workers reported experiencing disrespectful treatment by the public, families, or colleagues.

Team-based practices, home-based care and, telehealth offer promise to help address acute staffing shortages

1. **Team-based practices** (which include registered nurses and social workers as integral roles in the care team) can address the care of frail older adults well. This approach has significant labor savings, as outlined in the table below.
2. **Home-based care** delivery could also be less costly. These models have been seen in palliative care/hospice, rehabilitation, hospital urgent care, and even primary care. Pre-pandemic, fewer than 5% of primary care physicians and geriatricians provided home visits to patients 65+, and practices were more likely to provide this service if they had nurse practitioners. While these models provide an accessible promising new delivery of care, shortcomings include:

a. Harder to implement in regions that are more rural or spread out.
b. The underlying reliance on family caregivers juxtaposed with a declining caregiver support ratio over time in our nation is problematic. It is vital in solutions to consider the supply of both the paid workforce and the **unpaid workforce**.

3. **Telehealth** could serve a role in long-term solutions for specific types of care, particularly mental health and substance use disorders, as long as it is implemented in a mixed-mode method with some in-person interactions. While telehealth has demonstrated its true value in reducing commute time and logistics to appointments, many older adults continue to struggle with this modality.

Panelist 1: Addressing the Health Care Workforce Crisis: Physician and Hospital Perspectives and Solutions

Michael Tutty, Ph.D, Group Vice President of Professional Satisfaction and Practice Sustainability at the American Medical Association (AMA)

Summary

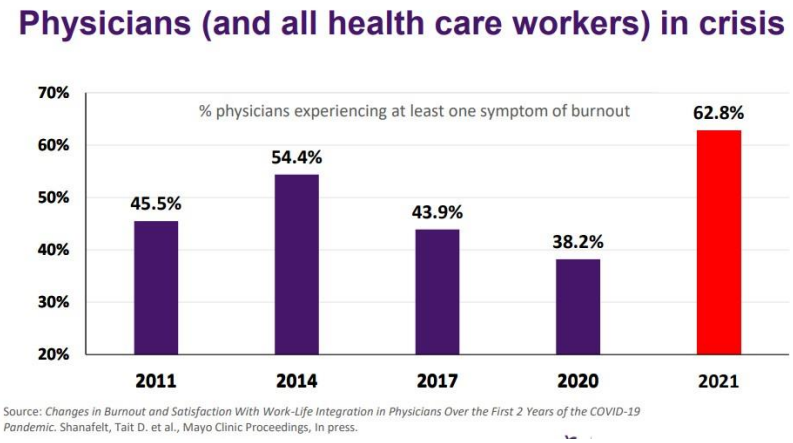
Tutty's presentation focused around professional satisfaction and practice sustainability for physicians. He presented research on these topics and their impact on supply. Potential areas for resolution include: 1. Enhanced education (at an earlier academic level—i.e., high school) and training in primary care specialties based on equity and implemented in diverse geographic regions. 2. Simpler relevant, predictable payment systems for physicians. 3. Eliminate administrative burdens that take away clinician focus from patient care. 4. Support advances in new technology and delivery models, like home care models or telemedicine, that advance high-quality patient care. 5. Turn the tide on misinformation and increase support for the sciences. Below is a more in-depth discussion of the data supporting these recommendations.

Root causes of a supply-side strain are concentrated at the junctures of 1. entering graduate medical school (GME slots) and 2. leaving the workforce (retirement and burnout):

According to the AAMC, applicants to medical school increased by 17.8% for the 2021-22 school year. The latest class accepted into medical school was >50% female and almost 50% identified their race/ethnicity as other than white, so the **mix of students is becoming more diverse** to look more like the population. Once students graduate, many are concerned that the number of residency spots is too low. This is also called the "**GME**[1] **squeeze**." More GME slots are needed, particularly for certain types of specialties facing significant shortages. The Consolidated Appropriations Act of 2021 added another 1,000 Medicare-supported GME slots. GME is an 18-billion-dollar public investment, with $11 billion from Medicare and the rest from the VA, HRSA, and state Medicaid programs. There are opportunities for greater oversight over the types of slots available based on the significant public investment.

[1] Graduate Medical School Education

The other issue besides entering the workforce is physicians leaving the workforce. In the next ten years, 2 out of 5 physicians will be at retirement age. Additionally, **after completing their training, many physicians are now leaving clinical care to choose another career in non-clinical care settings (such as consulting or administration).** Burnout is a primary driver for leaving clinical care, as seen in the graphic below.

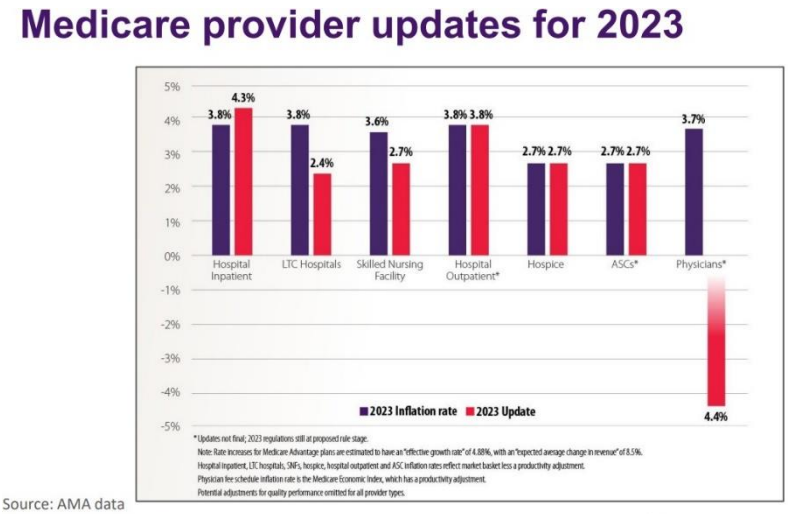


In **2021, the U.S. reached the highest level of physician burnout** since the AMA began tracking it in 2011. Contextually, the U.S. went from celebrating health care workers in 2020 (with a somewhat decreased workload in postponing elective care) to a completely changed perception of workers with the political debate surrounding mask-wearing and vaccines parallel to the drudgery of working in a pandemic so long. Because of the stress in the workforce, one in three physicians intend to reduce their clinical hours in the next year, and one in five intend to leave medicine altogether in the next two years.

One driver of burnout is maintaining patients' electronic health records (EHR). It is estimated that for every hour physicians spend with patients, they spend nearly two additional hours doing EHR and administrative work. This burden is unevenly distributed to female physicians over their male counterparts. Additionally, the move to integrate inbox messages in EHRs has led to a 157% increase in patient message volume post-pandemic. Nevertheless, reimbursements in an FFS environment are primarily concentrated toward direct patient-provider interactions and not for all the additional work outside of the patient encounter.

Another **driver of burnout is mistreatment and discrimination**, particularly of doctors who are female or part of a racial/ethnic minority group, by patients, families, and visitors. **Lack of childcare** is an additional driver of burnout, with high childcare stress associated with 80% greater odds of burnout in all health care workers. In terms of uncertainty in and shifting dynamics in the health care system, **payment, financing, and ownership** add additional stress to providers.

Finally, it was suggested that low **reimbursement rates** continue to be a problem, with the Medicare provider rates updated for 2023 not being adjusted consistently for physician practices as for other providers and settings as seen in the graph below.



Source: AMA data

Despite these drivers of burnout, physicians remain highly resilient compared to the general employed U.S. population.

Panelist 2: Improving the Nursing Home Workforce and Resident Quality of Life Using State and Federal Policy Levers

Alice Bonner, Ph.D., RN, FAAN, Adjunct Faculty at John Hopkins University School of Nursing, and Senior Advisor for the Institute for Health care Improvement (IHI)

Summary

Representing IHI, Bonner transitioned the conversation to workforce issues in nursing home settings—a part of the health care system frequently overlooked. This session covered the mass exodus of workers

from the nursing home settings due to low pay and poor COVID safety, the demographics of existing workers being predominantly older women of color who are underpaid and underinsured, and what needs to be changed to make nursing homes safer and sustainable for residents including bolstering the workforce through paid benefits and education. 1.3 million people live in nursing homes in the U.S., representing one of the most vulnerable populations. Over 240,000 nursing home workers left their jobs during the pandemic, and more are leaving daily. Primary characteristics of most nursing home jobs include low pay, low supports, low educational requirements, and high stress and turnover.

Over, 1.5 million people work in nursing homes. Workers are comprised chiefly of aides who are people of color who do the most critical work and are compensated the least through low wages and little to no non-wage benefits. The pandemic created challenging working conditions with a high risk of COVID-19 infection that made working in a nursing home environment unsustainable for most workers—and many left.

There are estimates that 300-500 nursing homes closed during the pandemic, and 400 are predicted to close in 2022 alone. While there is a continual push for community options, not all states have a substantial home and community-based program alternatives for older adults who would no longer live in a nursing home.

To address workforce concerns, **increased resources for state workforce centers and federal integration for these centers** across states are needed. To some extent, these centers have successfully developed and implemented programs to identify, recruit, retain, support, and sustain nursing home workers. States such as MI, UT, WA, CA, GA, DE, IN, and WI have included initiatives with bonus payments, volunteers, temporary staff, and lists of available workers. More national tracking of these is needed to compare outcomes and strategies.

The "**Moving Forward Nursing Home Quality Coalition**" initiative shows promise as another solution. This program takes recommendations from the 2022 National Academies of Sciences, Engineering, and Medicine quality report and prioritizes them into seven categories to build action plans that can be imminently tested.

Finally, more requirements and supports to meet those requirements are needed for each role. A **higher level of education in working with teams or interpersonal skills should be required for roles involved in nursing home oversight**, including Directors of Nursing and Licensed Nursing Home Administrators.

Solutions need to be informed by a more detailed analysis of the role and challenges for certified nursing assistances (CNAs), registered nurses (RNs), directors of nursing (DONs), and Licensed Nursing Home Administrators (LNHAs).

Certified Nursing Assistants (CNA)

There are over 520,000 CNAs across the nation in nursing homes, and they **spend the most hours daily with residents**. Their **wages are meager**, with an average of $15.41 per hour, and 34% of CNAs require public assistance like Medicaid. They are, on average older, with a median age of 38, women (91%) and many single parents, BIPOC (58%), and a large proportion are born outside the U.S. (21%). **Overall, they do not have benefits such as paid sick leave, childcare, transportation, funding, or time off for continuing education.** Nationally, they are **only required to take 75 hours of basic training** and pass a national certification exam to work in a nursing home (while some states have mandated 120 hours),

despite the complexity and challenges of their work. Some CNAs have cited leaving their job for a different industry, such as fast food, that pays the same without the same challenges as CNA positions.

Registered Nurses (RN)

RNs make up only 12% of nurses in nursing homes and are primarily in administrative and supervisory roles, while in hospitals, they make up nearly 100% of nurses and are more in clinical roles. Research found that about **75% of nursing homes were not in compliance with RN staffing levels**. **Average hourly wages** for nursing home RNs are about $31.00, which is about **$10,000/year less than an RN could earn in a hospital.**

Directors of Nursing (DON)

DON is the top clinical leader in a nursing home due to its role of oversight regularly. Due to high turnover, **42% of DONs have been in their position less than a year, and often have lower education than a bachelor's degree with limited training or management**. Nearly half also report being pulled to work on the floor daily or weekly. Additionally, **turnover of all other staff RN/LPN/CNAs is over 100%** in many areas.

Licensed Nursing Home Administrators (LNHA)

LNHAs are the top administrative person overseeing operations, strategy, and vision for nursing homes, and only slightly over half of the states require them to have bachelor's degrees. Eight states require an associate's degree, six require a high school diploma, and four have no minimum eligibility requirements. These **low educational requirements and similarly low requirements for DONs, CNAs, and understaffed RNs can create a very unsafe environment for workers and families.**

Panelist 3: Supporting the Health Workforce: State and Federal Policy Levers

Bianca Frogner, Ph.D., Professor in the Department of Family Medicine, School of Medicine, University of Washington, Director of the UW Center for Health Workforce Studies (CHWS), and Deputy Director for the Primary Care Innovation Lab (PCI-Lab), Department of Family Medicine

Summary

Frogner concluded the panelists with an overview of the impact of COVID on the health care workforce and community health workers. Her analysis with the University of Washington uncovered supply issues related to the adequacy of jobs to support even basic life needs. Solutions to help these low-income workers include addressing the high costs of housing, transportation, as well as opportunities for career growth, and even access to health care coverage. Another way to improve the worker experience is to maximize training and education by ensuring they are doing what they were trained to do through alignment of scope and regulations.

A few key examples of existing promising practices included:

Employers and developers in the Anacortes, WA region, are **converting a motel into workforce housing for health care workers** as a priority group. Similarly, Nantucket Cottage Hospital recently purchased duplexes in Nantucket, MA, to support their employees.

Washington state created a **Sentinel Network** (which has been replicated in CT and NC). This network biannually asks many different types of employers in the health care industry to participate in conversations surrounding vacancies and how they address them. Initial thematic findings have included creative ideas like; providing flexible schedules, tuition reimbursement, etc., and more expected suggestions like wages. A critical finding from this program is the importance of health care employers working with other workforce development systems, like the state workforce board or the local city, to creatively collaborate on sustainable solutions.

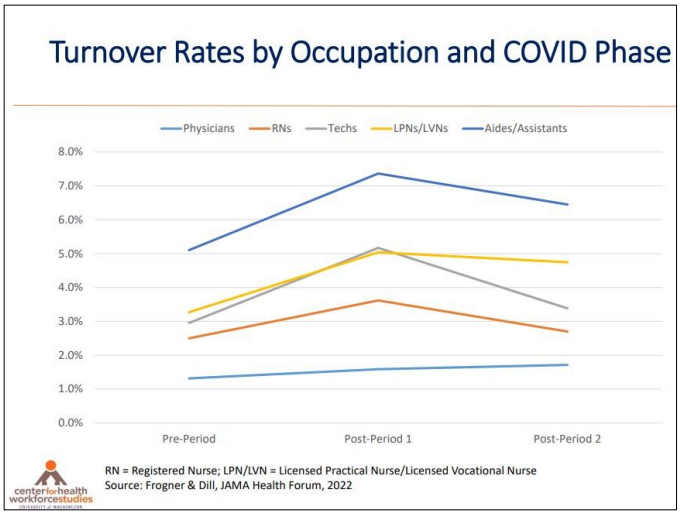
These policy solutions were developed from the supporting evidence summarized below.

Job loss and recovery were unevenly distributed by health care sectors.

An **estimated 1.4 million health care jobs were lost** at the first peak of the pandemic in April 2020. **Each sector of the health care workforce recovered differently**, with nursing and residential care facilities experiencing only a slight recovery from the peak. Hospitals finally recovered after about 30 months to pre-pandemic staffing levels. All other sectors now exceeded their pre-pandemic levels of employment (including physician offices, other ambulatory care, and home health care). **Each sector is interconnected**; the job loss in nursing and residential care impacts the hospitals. Hospitals are understaffed in part due to a bottleneck of patients where they do not have a place to discharge their nursing home-eligible patients to.

Job turnover continues to be highest for community health workers in long-term care settings.

Using COVID as a time marker, the **turnover rates** in long-term care continued increasing since the pandemic started, while turnover in hospital and ambulatory settings peaked and then decreased back to its original levels. However, hospitals in rural areas have experienced a much slower recovery than those in urban areas. Throughout COVID, **aides and assistants experience the highest turnover rates** as seen in the chart below.

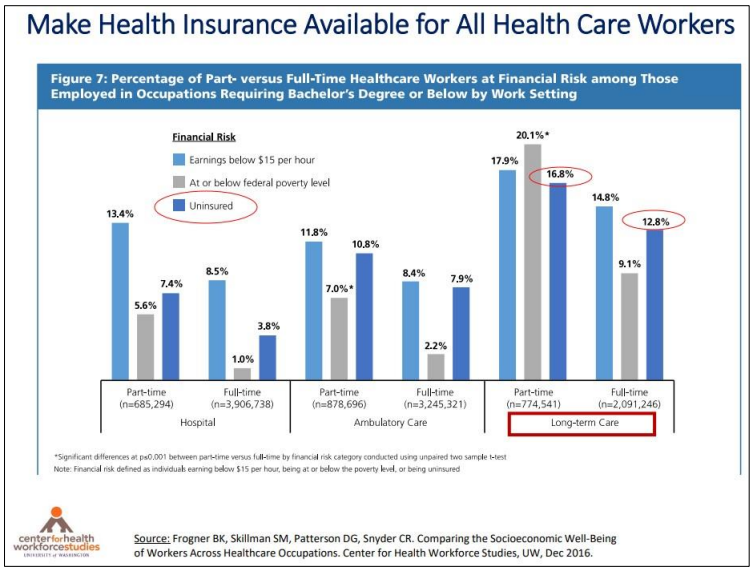


A few surprising turnover findings included:

- Physicians were found to be leaving at increasing rates; however, those rates were far below other types of workers.
- Nurses (RNs) did not seem to be leaving in droves as anecdotally described (although the data only goes to October 2021).
- LPNs/LVNs are actively struggling to recover still.
- Aides/assistants, including titles like medical assistants, home health aides, and nursing assistants, continue to experience the highest turnover pre and post-pandemic. This is particularly concerning because out of the 17 million health care workers in the U.S., about 25% have an aide/assistant title, so this is a significant number of people in the workforce. **The aide and assistant jobs have very low barriers to entry in terms of education and post-secondary education, so while it is easy to move into the jobs, it is easy to move out too.**

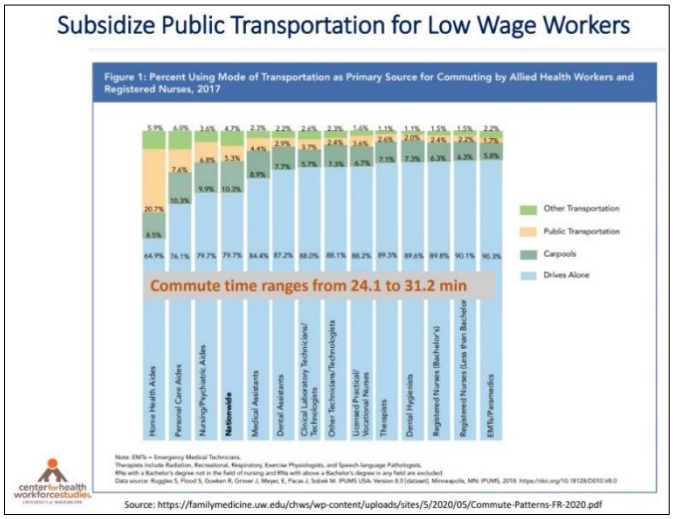
Social determinants are a driver for job loss and turnover in community health workers in long-term care settings.

Poor benefits and social determinants coverage are critical drivers of turnover—specifically **health insurance coverage**, as seen in the graphic below.



There are high rates of uninsured long-term care workers, even those working full-time, compared to other sectors. During the pandemic, these individuals did not have health insurance, let alone paid sick leave, leaving a critical opportunity for improvement for retention.

Another driver for turnover is reliance on **public transportation** for the community health workforce. Looking at the left side of the graph below, home health aides and personal care aides significantly rely on public transportation (in the lighter yellow color) to get to work.



During the pandemic, public transportation was disrupted and continues to be due to their own workforce shortages. This also serves as another opportunity for improvement in thinking about providing a benefit to subsidize public transportation. It is also important to note the average commute time range for health care workers (24.1 to 31.2 minutes) and juxtaposed to remote work; people wonder if their commute time is worth it.

A final determinant found to influence turnover was **affordable housing**. About half of the health care assistants and aides rent, instead of owning a home, compared to about three-quarters of RNs and MDs who report owning a home. Additionally, the monthly rent of aides and assistants was higher than the monthly mortgage of RNs and MDs. This is at a time when interest rates are increasing, adding further barriers to home ownership, as well as increasing rents too. These challenges make it harder for aides and assistants to live near where they work and influences them to leave their jobs.

Audience Discussion

Stuart Altman led the post-speaker discussion by identifying key thematic questions posed by the audience.

Question: Should the federal government have greater involvement in the type of residencies established, and should more residencies be allocated towards primary care directly?

Tutty responded that collectively, the federal government has a social contract to pay for the education of our physicians, yet the institutions that provide the education decide how to create those slots. There is no national policy about this. We need to start tracking where doctors practice after residency and measuring GME outcomes to honor this social contract. Many other countries are more prescriptive about the specialty, training, and region, whereas the U.S. has always had more choice and freedom, but

this system is not meeting primary care needs nor supporting rural Americans. We need more GME slots to fill specific physician needs that vary by specialty and geography.

Question: Based on Karen's presentation, how much primary care is being delivered by specialists?

Donelan suggested the answer is likely embedded in Medicare claims-based data. Specialty care used to be concentrated in longer hospital stays, so when those stays were shortened, the specialty consultations were also forced to be outpatient care. That phenomenon, plus a surplus in specialists overall, could lead to greater utilization in specialty over primary care. Specialists are not covering much primary care overall, albeit likely that some specialties provide more primary care services than others. For example, oncology, cardiology, and pulmonology--- specialties where people have long-standing chronic illnesses could overlap more with primary care issues. In many markets, it is often easier to see a specialist for a specific symptom than your primary care physician.

Question: How do we balance the suggestions on lowering some regulations in nursing homes to allow a better scope of practice without lowering quality?

Bonner responded that one challenge is overgeneralizing "the regulations." Some may seem pickier than others, but it's important to understand their reasoning. If there is, for example, a specific regulation around the temperature of equipment in a nursing home kitchen, it may seem overly picky, but is essential to prevent food poisoning. To enhance patient protection, CMS recently implemented the third stage of the CMS Quality, Assurance, Performance, and Improvement (QAPI) regulations. Additionally, the newest NASEM report touched on emergency preparedness and the failures of nursing homes during COVID due to poor enforcement of regulations. So, CMS needs to be nimbler in terms of revising, amending, changing, updating, and making old regulations more contemporary. Bonner also noted that survey inspectors or often seen as "rule enforcers" rather than as a collaborative assets to help enhance quality and safety.

Frogner added that it is challenging to track the differences in state regulations, but the National Conference of State Legislatures is trying to do this for each occupation. While state flexibility is important, each state typically makes decisions without convening with other states to learn from each other across professions. For example, in some states, home health aides cannot put in eye drops for their patients, which has very little evidence base, but in other states, they can. We can also better track quality through improved data transparency. Additionally, regulation needs to be rationalized to account for and help address workforce issues. Otherwise, we may be setting up institutions for failure.

Question: Are we beginning to see the use of technology and telehealth in non-mental health specialties, and how is the medical community handling this?

Tutty answered that COVID did more to advance the adoption of telehealth in the span of four weeks in March 2020 than in the last 10 years. The hype is always ahead of reality. Clinicians are excited; they are doing a lot of work in the hospital at home; the technology is there, but these systems still rely on this unbalanced workforce, and they are not autonomous. Many advancements in the use of telemedicine are allowed now through Emergency Use Authorizations, so additional regulatory work is needed for sustainability in the adoption of this technology.

Donelan added that physicians have always asked for reimbursement for telephonic care. In COVID, older adults could not make the shift to videoconferencing platforms and reverted to the telephone. For

specialties outside mental health, they have expressed not knowing what quality looks like if telehealth is the sole approach, so for now, physicians expressed the most contentment in having the options of a mixed mode of in-person and telehealth.

Question: How does the AMA react to all these regulations? Can we find common ground with the scope of work?

Tutty answered that it is easy to say we are over-regulated. Physicians love their NPs and PAs and most practices have them working together; the issue concerns the scope of practice. The idea that an NP is an equal substitute for a physician is not true due to unequal training; NP graduate training includes two years of schooling and as little as 500 clinical hours, whereas a physician requires four academic years and tens of thousands of clinical hours. Some evidence shows NPs deliver more costly care (even when accounting for salary differences) with poorer outcomes. NPs and PAs are important for fulfilling health care needs, but they must be deployed properly. Even NPs and PAs are experiencing increased specialization, so the system needs to be fixed together with the right people in primary care.

There are additional burdens like prior authorization, which creates a large time sink to practices and delays care. There is legislation moving in congress that passed the House and is now in the Senate that will add sensible requirements for prior authorizations for Medicare Advantage, but these burdens continue to hinder providing care.

Donelan countered that the conflict between physicians and NPs is well-documented on several points of comparative practice over many years, but fundamentally not all physicians love NPs and PAs. Only about half of primary care practices include them. There are major barriers to the inclusion of NPs and PAs at full scope in many states, and 85% of NPs indicate they want to practice with physicians. The NP and PA roles grew in places where there were shortages, and the whole profession arose out of unmet needs and demand for access, so they are important. Nurses themselves create barriers too in putting up the opposition for home health aides or paramedicine to administer medication in some states. As we start to think about moving personnel around to practice intensive care, we need more national-level policies to understand what the workforce would look like if we lowered these barriers to work together in teams.

Question: Could the emergency reductions in the restrictions around scope of practice and delivery in the system become permanent law? And what are general thoughts around increased federal activity across the board?

Frogner noted that there are interesting aspects of Medicaid that should be looked at. Waivers have given states different abilities to address workforce issues. But Medicaid really needs to be in more parody with Medicare to properly address these problems; Medicaid is fundamentally not reimbursing in a sustainable way to incentivize change. Patient-driven payment models (PDPM) in skilled nursing facilities have made post-acute care patients more attractive than long-stay patients, but it's hard to parse out how payment models affect staffing as they happened concurrently with COVID.

Question: Are the physicians working at private entities like Optum less likely to burn out?

Tutty responded that it is too early to tell. Optum, the largest employer of physicians in the US, has been buying practices and initially letting them run as they normally run, so the physicians at those sites might not see a big difference yet. The younger generation of workers will move around more in their careers,

so physicians will likely move to the setting that best fits how they want to deliver care. There is also the trend of private equity money coming into practices, when the contracts come up at 36- or 48 months with investors expecting specific returns, there may be some more unsatisfied physicians.

Donelan added that over a five-year period, they did many site visits at Oak Street, Iora, etc., several models of home-based primary care. Several facilities were working akin to a PACE-based model with team-based care with the physician as the lead over a few nurse practitioners and a broader team, and it improved the quality of life for all the workers on the team. Oak Street, for example, was recruiting in neighborhoods, so people didn't live too far away from where they worked. It is unclear how these models worked in a scaled-up approach.

Question: Could Dr. Frogner expand on some of the community-level workforce innovations highlighted from WA?

Frogner explained that her work in WA around their central network has been a useful tool for state solution-making conversations; their qualitative work helps fill in what is happening and becomes a trusted source of information for employers to connect on. These tools have been useful for stakeholders such as state representatives and employer health care organizations to convene around and discuss issues such as childcare and compare notes on employers that were able to mobilize activity around this successfully. Due to the competitive aspect of health care, there are not many good opportunities for employers to convene and problem-solve, but as an example, the WA Workforce Development Board creates a non-competitive space for collaborative convening.

Question: Is there any hope to make the home-related care work?

Bonner responded that nursing homes at home are being studied now in addition to hospitals at home. There are a lot of policies around the home and community-based services programs and work at CMMI around this. ARPA money is needed to increase salaries and budgets to make these jobs that people want to do.

Closing Remarks

The conference highlighted workforce challenges being felt throughout the health care system in every setting, from the community, to the hospital, to nursing homes. This is the fundamental challenge of our time. Health care needs are increasing with an aging population and the tightest workforce we have seen in generations. There is no silver bullet or one solution that will wholly resolve these problems at once. COVID exacerbated the strain on the workforce but also uncovered some targeted opportunities for improvement. Public and private innovation at all levels of the health care system, along with government intervention at the national and state level, will be essential for real movement towards resolutions. Promising ideas were presented today, and we will continue to focus on this issue. We are thankful to our speakers, funders, and audience for the dynamic Q&A and participation in community solution-making.

NOTE: All the speaker's comments and recommendations expressed in this material are theirs only and do not necessarily reflect the views of the organizations and institutions they work for.