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March 20, 2023

The Honorable Bernie Sanders
Chair
Committee on Health, Education, Labor & Pensions
United States Senate
Washington, DC 20510

The Honorable Bill Cassidy
Ranking Member
Committee on Health, Education, Labor & Pensions
United States Senate
Washington, DC 20510

Re: Healthcare Workforce Comments

Dear Chairman Sanders and Ranking Member Cassidy,

The Society of Hospital Medicine (SHM), representing the nation's hospitalists, is pleased to offer our comments on your Request for Information (RFI) regarding health care workforce shortages. Hospitalists are front-line physicians in America's hospitals whose professional focus is the general medical care of hospitalized patients. As a result, hospitalists were and continue to be on the frontlines of the COVID-19 pandemic, combatting a deadly virus while simultaneously dealing with significant staffing shortages. While the pandemic may have highlighted the pressing need to bolster and expand our healthcare workforce, staffing shortages related to burnout, the medical school pipeline, and ever-increasing administrative pressure existed prior to the onset of the pandemic, and have become even more severe as we emerge to a "new normal" post pandemic.

According to a study published by the Association of American Medical Colleges (AAMC), the United States is facing a physician shortage of upwards of 135,000 by 2035.[1] Additionally, record numbers of medical professionals left the profession during the COVID-19 pandemic. The lack of physicians puts patients at risk, limits care quality, and places additional strain on remaining healthcare workers. In addition, long term care trends have been shifting as much care as possible from inpatient to outpatient settings, meaning we are treating patients in the lowest and safest level of care. In effect, this has resulted in increased complexity and acuity of hospitalized patients, increasing the stress and workload for hospital-based clinicians. The shortage is a multi-pronged issue that will require varying interventions to address both short and long-term challenges related to sustaining and maintaining our healthcare workforce. As

[1] Association of American Medical Colleges, The Complexities of Physician Supply and Demand: Projections from 2019 to 2034, June 2021. https://www.aamc.org/media/54681/download?attachment

physicians working in the hospital inpatient setting, SHM members have firsthand experience with the challenges presented by inadequate and ongoing

staffing shortages. We are pleased to provide comments outlining some interventions to help address the healthcare workforce shortage.

Maintaining Existing Workforce

Healthcare workers have been leaving the industry in record numbers since the onset of the pandemic, many of whom cite burnout and staffing challenges as a primary reason for departing the field.[2] As physicians and other professionals leave the workforce, those who remains face added pressure, as they must take on additional work with fewer staff and resources. This greatly contributes to their burnout and creates a downward spiral of ever-increasing pressure and burnout within the remaining workforce. To maintain the existing workforce while simultaneously attracting new workers, we must begin to seriously address drivers of burnout that are within our control.

Reduce Administrative and Reporting Burden

Hospitalists across the country cite excessive administrative reporting and documentation requirements as a leading cause for burnout. They often spend hours charting and documenting, drastically limiting their face-to-face time with patients. Furthermore, many Medicare reporting programs require significant data reporting requirements, further fueling burnout. As hospitalists and other physicians spend more and more time on these administrative tasks that are often viewed as not adding value, they are distanced from the reason they went into medicine, which is the actual work of practicing medicine and healing patients. As administrative tasks continue to dominate more and more of their day-to-day responsibilities, discontent will continue to rise alongside the resultant decline in the workforce.

Within the Medicare program, there are a number of policies purported to improve care quality and/or prevent fraud, but in reality, create significant administrative burdens that pull physicians away from the bedside and, increasingly, leads them out of the profession. Significant time and resources are increasingly devoted to complying with policies that have unclear benefits to patients. Examples include:

- Navigating outdated observation care policies, including the three-day inpatient stay rule for Medicare coverage for skilled nursing facility (SNF) care. This payment policy leads to discussions with patients and families about why necessary SNF care is not covered, which worsens the provider-patient relationship and leaves clinicians and patients frustrated.
- Prior authorization rules and procedures that differ between payers and contribute to delays in the provision of needed care or worse, prevent patients from accessing care their physician recommends.

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[2] Levine, David. "U.S. Faces Crisis of Burned-out Health Care Workers." *US News & World Report*, US News & World Report, 15 Nov. 2021, https://www.usnews.com/news/health-news/articles/2021-11-15/us-faces-crisis-of-burned-out-health-care-workers.

- Compliance with overlapping and complicated quality measurement and pay-for performance programs, including the Merit-based Incentive Payment System (MIPS), Hospital Value-Based Purchasing Program, Hospital Readmission Reduction Program, and others.
- Excessive documentation requirements embedded within Electronic Medical Records (EMRs) that are primarily designed and structured for the purposes of meeting billing rules, not for providing patient care.

Congress should work with relevant stakeholders to identify administrative and reporting processes that can be streamlined or eliminated. If a requirement does not add value to patient care, it should be seriously examined so we can allow hospitalists and other clinicians to get back to what they were trained to do and what they are driven to do – care for patients.

Confront Violence Against Healthcare Workers

Violence in healthcare settings is an acute, and growing, problem. It takes a significant toll on the morale and sustainability of the healthcare workforce. A recent analysis from the Bureau of Labor Statistics showed that healthcare workers accounted for nearly three-quarters of nonfatal workplace injuries and illnesses due to violence in 2018, and that rate has been steadily growing since 2011.[3] Another analysis published in 2019 showed that 69% of healthcare workers experienced workplace violence.[4] This is unacceptable and must be addressed.

Strengthen the Diminished Social Safety Net and Address Lack of Alternative Care Settings

Many patients find themselves in the hospital setting not necessarily because they need hospital level care, but because they have no alternatives and have nowhere else to go. In many parts of the country, the hospital is the safety net. This is driven by multiple factors related to both the fraying of the safety net around the country, as well as social determinants of health such as poverty, drug addiction, homelessness, or the lack of a support network that allows individuals to adequately care for themselves. While hospitalists strive to get these patients the care they need, alternative sites of care and other social services are often unavailable. There are limits to what can be done from the hospital perspective – particularly when the patient's needs should otherwise be addressed by social support services and related programs. The result of this scenario is a revolving door of patients who are unable to get appropriate care and services outside of the hospital setting. This increases the strain on the hospitalists who are simultaneously caring for much more acute patients in need hospital level care.

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[3] U.S. Bureau of Labor Statistics. Fact Sheet: Workplace Violence in Healthcare, 2018. (April 2020). https://www.bls.gov/iif/factsheets/workplace-violence-healthcare-2018.htm.

[4] Nowrouzi-Kia B, Chai E, Usuba K, Nowrouzi-Kia B, Casole J. Prevalence of Type II and Type III Workplace Violence against Physicians: A Systematic Review and Meta-analysis. Int J Occup Environ Med. 2019 Jul;10(3):99-110. doi: 10.15171/ijoem.2019.1573.

Align Multi-state Licensure

Current licensure requirements fall to the states, which can limit the flexibility of our existing workforce. To truly meet patient's needs wherever they are and to be prepared for the next health emergency, we need an adaptable, nimble workforce. In the early months of the pandemic, many state licensing bodies loosened licensure requirements to allow out-of-state providers to bypass the red tape of individual and varied state requirements and go to where care was most needed. This allowed for more rapid staffing as COVID-19 hotspots arose both regionally and nationally. A focused effort to establish multi-state or even national licensure would help to address this problem.

Multi-state licensure is also a key component of establishing and operating telemedicine programs. Telehealth is not limited by state lines and requirements for licensure in each state where patients reside add onerous costs and boundaries to effective telemedicine programs.

SHM has also encouraged state licensure boards to move away from invasive mental health disclosures on license applications. It is important to ensure providers are healthy, both physically and emotionally, and are able to care for their patients. However, a physician receiving a mental health diagnosis and accompanying treatment must be distinguished from being impaired as a result of a diagnosis. Current mental health disclosures on state licensures often serve to penalize, stigmatize, or otherwise discourage providers from seeking necessary treatment and care. This unmet mental health need can ultimately drive physicians out of the workforce. More work needs to be done to destigmatize mental health. To ensure a sustainable healthcare workforce, physicians should not be penalized for seeking necessary treatment for conditions that do not otherwise impair their ability to practice.

Healthcare Workforce Training Pipeline

To holistically address the healthcare workforce shortage, we must also address the significant barriers to becoming a physician. While becoming a physician requires significant training, the costs associated are a huge barrier to both entry and sustainable practice, particularly for low-income and first-generation medical students. The prohibitively expensive cost of training limits the number of physicians we produce each year and limits the options for those we do produce by forcing them into high paying specialties or higher paying locations so they can sustain a practice. Furthermore, limited internship and residency slots further contribute to a lack of available physicians. We need to increase the number of GME slots and lower the cost of training to ensure an adequate number of physicians to care for our aging population in the years to come.

Stability of Payment System

With alarming regularity, the Medicare physician payment system faces looming cuts, most recently PAYGO-related reductions and other statutory cuts that, if implemented in full, would be disastrous for patient care and the healthcare system at large. While Congress has minimized or averted most of these cuts in recent years, the lack of predictability for adequate reimbursement is not sustainable. Congress needs to develop a sustainable, long-term funding solution for Medicare. Medicare cuts - and the

ongoing threat of cuts - directly contributes to staffing issues, placing increased pressure on the remaining healthcare workforce.

Attract and Keep Immigrant Workforce

While we recognize this is not within the jurisdiction of HELP, it cannot be ignored that in the face of a years-long training pipeline, more providers are needed right now if we want to maintain our workforce at current strength. Immigration reform is a key area in which Congress can help bolster our healthcare workforce, particularly in rural and underserved areas where recruitment and retention is extraordinarily challenging. SHM has supported various legislation to bolster the healthcare workforce, such as the Fairness for High Skilled Immigrants Act, The Conrad State 30 and Physician Access Reauthorization Act, and the Healthcare Workforce Resilience Act. We need to pass legislation to attract and retain high quality healthcare workers from abroad. Immigration reform is a vital and necessary component to holistically address the healthcare workforce shortage.

Conclusion

SHM appreciates the opportunity to provide comments on the Healthcare Workforce Shortage RFI. We look forward to continuing to work with the Committee to address this important issue. If you have any questions, please contact Josh Boswell, SHM Director of Government Relations and Chief Legal Officer at jboswell@hospitalmedicine.org or 267-702-2632.

Sincerely,

Rachel Thompson, MD, MPH, SFHM
President, Society of Hospital Medicine