



American Hospital
Association®

Building the Health Care Workforce of the Future

AHA View

A strong and engaged workforce is the lifeblood of America's hospitals. The 5 million women and men who care for patients every day demonstrate the hard work, compassion and dedication that make hospitals such a valued resource in every community. As hospitals' national advocate, the AHA advocates for workforce issues on several fronts – workplace environment, workforce supply and employee relations.

Background

The Affordable Care Act (ACA) will greatly increase the demand for caregivers, especially primary care physicians and nurses. The law has extended coverage to millions of uninsured people and requires public and private insurers to cover prevention and wellness services. To help ensure America has an adequate workforce to meet the health needs of the newly insured, the ACA offered several initiatives to increase the supply of health care workers. For example, the law provided flexible loan repayment programs for caregivers to increase the workforce pipeline of primary care physicians, nurses and other health professionals.

Key Priorities

The AHA will continue to work with the federal agencies, Congress and other stakeholders to:

- Create excellent workplace environments;
- Maintain an adequate workforce supply; and
- Foster employee relations.

Creating the Workplace Environment of the Future

Adequate numbers of competent and well-trained nurses, physicians and other health professionals are essential to address the health care needs of the aging and increasingly diverse U.S. population. The AHA takes a multi-pronged approach to address workforce issues for America's hospitals:

- **Effectively deploy a competent and engaged workforce to deliver high-quality patient care.** The current workforce and models of care will not be able to accommodate the influx of new patients. The AHA is committed to reforming the delivery of care and workforce models to support population health initiatives. The AHA's white paper, "Workforce Roles in a Redesigned Primary Care Model," makes recommendations for retuning the health care workforce to better provide primary care services.
- **Redesign clinical care at the bedside/point of care and the roles of the inter-disciplinary direct care team of providers.** Hospitals are redesigning current models of care to better address clinical care issues such as hospital-acquired conditions, readmissions and overall coordination of care. Research has demonstrated that high-reliability teams of providers are better suited to direct and manage care in the hospital setting, while also integrating patient care across care settings.

- **Create excellence in clinical work environments, and ensure an environment to facilitate workforce recruitment and retention, a safe and competent workforce and appropriate employer/employee engagement.** Work expectations are changing and competition for well-qualified employees is increasing. Health care facilities must strive to provide excellent work environments for clinicians and staff.

For additional AHA, national and state-based workforce resources, please visit www.aha.org/workforce.

Maintaining an Adequate Workforce Supply

The AHA continues to advocate for the highest level of appropriations for nursing and other health education programs. Although the sequester cuts to Title VIII Nursing Education programs were less than other non-defense discretionary programs, the timing could not be worse. The demand for nurses is increasing; however, meeting that demand remains difficult due to nursing faculty shortages and reduced funds for nursing scholarships and loans. The situation is compounded by the aging of the nursing workforce and the increased care burden of patients with multiple co-morbidities. Provisions in the ACA have helped modernize and expand Title VIII programs. Under the Workforce Development Programs, the authorization level for discretionary funding was raised to \$338 million. Although the fiscal year 2015 appropriated funding of \$231.6 million falls short of the ACA-authorized level, the higher authorization level allows for growth.

Visas. The AHA supports streamlining and improving the immigration process to allow qualified, internationally educated nurses, physicians and other health professionals to work in this country. We continue to work with Congress and the administration to improve opportunities for qualified health care professionals, including maintaining the availability of employment-based and non-immigrant visas for shortage professions.

Residency Slots. Given the current and projected shortage of physicians, especially in primary care and general surgery, the AHA continues to urge that the 1996 cap on residency slots be lifted. Limits on the number of Medicare-funded residency training slots constrain the ability of hospitals to train new physicians. The AHA is committed to working with Congress to develop legislation that would increase the number of Medicare-supported physician training programs by at least 15,000 new resident positions, a 15 percent increase in residency slots. The AHA also continues to oppose reductions to Medicare funding for graduate medical education (GME) and supports maintaining full funding for GME conducted in children's hospitals.

Fostering Employee Relations

The AHA is committed to preserving the right of individual hospitals and health care systems to determine the appropriate hospital-employee relationship for

their organizations and communities. That is why we continue to oppose certain organized labor-supported initiatives that would interfere with hospitals' ability to work directly with employees to enhance the work and patient care environments. In 2015, labor and employment activities will continue to be concentrated in various regulatory agencies and the courts. Below is a snapshot of issues.

National Labor Relations Board (NLRB). The NLRB published in the Dec. 15, 2014 *Federal Register* a final rule amending its representation-case procedures to change the process for resolving representation disputes, essentially speeding up the time between filing a petition and holding an election. The final rule is largely identical to a previous rule issued in 2011 and would, among other changes, defer resolution of most voter eligibility questions until after the election, consolidate all election-related appeals into a single post-election process, and make board review of post-election decisions discretionary rather than mandatory. The rule took effect on April 14, 2015. The AHA and two of its affiliated organizations – American Society for Healthcare Human Resources Association (ASHHRA) and American Organization of Nurse Executives – urged NLRB to withdraw the rule entirely, charging that it “single-mindedly promotes quick elections at the expense of a fair process.”

The final rule is the subject of two legal challenges. The U.S. Chamber of Commerce, joined by the Coalition for a Democratic Workplace (of which the AHA is a member) and Society for Human Resource Management filed suit in the United States District Court for the District of Columbia.

Department of Labor (DOL). The DOL is expected to move forward with several regulatory initiatives affecting hospital and health care employee relations. The DOL's Office of Labor and Management Standards plans to finalize a proposal revising the interpretation of the “advice” exemption to persuader reporting under the 1959 Labor-Management Reporting and Disclosure Act. The final rule could narrow the definition of “advice” and, thus, expand circumstances under which reporting is required of employer-consultant persuader agreements. The AHA and ASHHRA oppose this proposed revision and requested that DOL decline to adopt the rule as drafted. We are concerned that the revised interpretation of the advice exemption will interfere with hospitals' ability to receive appropriate labor relations advice from outside counsel (including the AHA) that is necessary to ensure proper compliance with all applicable laws.

Despite its May 2014 announcement of a five-year enforcement moratorium, the DOL's Office of Federal Contract Compliance Programs (OFCCP) expects, ultimately, to expand the agency's regulatory and enforcement reach over hospitals, asserting that hospitals are federal contractors or subcontractors solely because of their participation in certain federally sponsored health care reimbursement programs, such as TRICARE, the Department of Defense (DoD) program that provides coverage to military personnel. During the moratorium period, the OFCCP

will not enforce federal contractor and subcontractor obligations, including obligations related to affirmative action programs and recordkeeping, on health care entities that participate in TRICARE as subcontractors under a prime contract between the DoD TRICARE Management Activity and one of the prime managed-care contractors.

OFCCP, however, plans to do extensive outreach and provide technical assistance during the moratorium period to inform TRICARE participants of their responsibilities under OFCCP's programs. In addition, during this time, OFCCP will work with other federal agencies to clarify the principles governing coverage of health care providers under federal statutes applicable to contractors and subcontractors. The agency also will continue during the moratorium period to process complaints of discrimination against TRICARE participants. That is why the AHA supports legislation to prevent OFCCP from exerting jurisdiction over hospitals and other health care organizations that provide care for uniformed service members and other federal employees and encourages reintroduction of The Protecting Health Care Providers from Increased Administrative Burdens Act.