American Hospital Association®

Workforce

Background

The Patient Protection and Affordable Care Act (ACA) greatly increases the demand for caregivers, especially primary care physicians and nurses. The law will extend coverage to approximately 27 million uninsured people[1] 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 identifies several initiatives to increase the supply of health care workers. For example, the law provides flexible loan repayment programs for caregivers to increase the workforce pipeline of primary care physicians, nurses and allied health professionals.

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 an invaluable resource in every community. As hospitals' national advocate, the AHA addresses workforce issues on several fronts – workforce shortages, employee relations and employee wellness.

Workforce Shortages. Adequate numbers of competent and well-trained nurses, physicians and allied 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:

- Identify how to create the workforce necessary to meet the primary care needs of patients in a community's delivery system. The AHA is examining how the scope of practice for health care providers can be addressed to provide greater access to care to meet the ACA-related increased demand for primary care services. In January, the AHA released a white paper titled, "Workforce Roles in a Redesigned Primary Care Model," that makes recommendations for redefining the health care workforce to be better able to provide primary care services.

- Define principles to address the roles of the direct care providers of the future. The AHA assembled a roundtable to explore the roles of the bedside care team and multi-disciplinary teams in providing high-quality health care. A white paper with their recommendations will be published this spring.

To help hospitals sustain, grow and enhance the health care workforce, the AHA together with its affiliates, the American Organization of Nurse Executives

[1] As a result of the 2012 U.S. Supreme Court ruling on the ACA that the federal government could not force states to expand their Medicaid programs, the Congressional Budget Office now estimates that the ACA will extend coverage to 27 million uninsured individuals. This is 5 million fewer people than originally projected when the ACA was passed.

(AONE) and the American Society of Healthcare Human Resources Administration (ASHHRA), launched the AHA Workforce Center, www.healthcareworkforce.org, an online hub. The center brings together resources and tools to support workforce recruitment, engagement, retention, succession planning, diversity, culture and models for the future.

In addition, the AHA continues to advocate for the highest level of appropriations for nursing and allied health education programs (refer to the "Annual Appropriations" issue paper). We also recommend Congress continue its support of the education of future physicians through the Medicare graduate medical education program.

Visas. The AHA supports streamlining and improving the immigration process to allow qualified, internationally educated nurses, physicians and allied health professionals to work in this country. We continue to work with Congress and the administration to improve immigration 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 recommend 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. That's why the AHA supports the *Resident Physician Shortage Reduction Act of 2013* (S. 577/H.R. 1180), introduced by Sens. Bill Nelson (D-FL), Charles Schumer (D-NY), and Harry Reid (D-NV), and Rep. Joe Crowley (D-NY), respectively. The bill would increase the number of Medicare-supported physician training positions to at least 15,000 new resident positions, which is about a 15 percent increase in residency slots.

Employee Relations. America's hospitals recognize and appreciate the compassion, hard work and dedication their employees demonstrate in caring for patients and communities, which is why hospitals view employee relations as a top priority. 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. We continue to oppose certain organized labor-supported initiatives that would interfere with hospitals' ability to work directly with their employees to enhance the work and patient care environments. In 2013, labor and employment activities will continue to be concentrated in various regulatory agencies and the courts. Here is a snapshot of issues that may be in play in 2013:

National Labor Relations Board (NLRB). A recent decision from the federal appeals court in the District of Columbia (DC), *Noel Canning v. NLRB*, ruled

that three members of the NLRB were unlawfully appointed in January 2012, and the NLRB therefore lacked a quorum to conduct official business. The ruling potentially calls into question previous and future actions of the current board. The court's reasoning in the case is very broad and arguably suggests that the absence of a quorum potentially could invalidate a number of official actions taken by previous boards, including the promulgation of the expedited union elections regulation – a rule that is already the subject of a continuing legal challenge brought by the U.S. Chamber of Commerce and the Coalition for a Democratic Workplace (CDW). The AHA, ASHHRA and AONE are members of the CDW and joined the HR Policy Association and Society for Human Resource Management in filing a friend-of-the-court brief supporting the Chamber and CDW challenge of the rule.

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 may 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 (and even the AHA) that is necessary to ensure proper compliance with all applicable laws.

In addition, the department's Office of Federal Contract Compliance Programs (OFCCP) continues its efforts to expand the agency's regulatory and enforcement reach over hospitals, asserting that hospitals are federal contractors or subcontractors solely because of the hospital's participation in certain federally sponsored health care reimbursement programs like TRICARE, the U.S. Department of Defense health care program that provides coverage to military personnel. The DOL's Administrative Review Board (ARB) in October 2012 issued its long-awaited decision in *OFCCP v. Florida Hospital of Orlando*, rejecting OFCCP's position that Florida Hospital was a federal subcontractor based on its participation in TRICARE. The AHA and ASHHRA submitted a friend-of-the-court brief in support of the hospital. However, the OFCCP filed a motion asking the ARB to reconsider its decision. While it is unclear when the ARB will rule on the OFCCP's motion for reconsideration, it is clear from the agency's arguments that it plans to continue to claim that hospitals participating in TRICARE are government contractors subject to OFCCP's oversight and enforcement. The AHA will continue to monitor OFCCP's actions and intervene when appropriate.

Legislation. On the legislative front, the AHA and ASHHRA will continue to oppose efforts that limit hospitals' flexibility to determine appropriate staffing patterns for health care workers. Many factors influence a hospital's staffing plan to ensure patients receive appropriate care, including the experience and education of its nursing staff, the availability of other caregivers, patients' needs and the severity of their illnesses, and the availability of technology. Another major consideration is the availability or supply of nurses themselves. The demand for registered nurses and other health care personnel will continue to rise as the number of patients seeking care increases due to the aging of "baby boomers" and the number of people with health coverage grows with ACA implementation beginning in 2014.

The AHA and ASHHRA also will continue to vigorously oppose any legislative effort to amend the *National Labor Relations Act* (NLRA) and reverse existing NLRB guidance on when charge nurses are considered supervisors. Legislation introduced in the past would have removed two functions from the NLRA definition of supervisor – "assigning" and "responsibly directing" other employees. Removing these functions from the NLRA definition of "supervisor" would enable supervisors to be eligible for inclusion in the collective bargaining unit and subject to all union work rules and discipline.

Current NLRB guidance on when charge nurses are supervisors strikes a reasonable balance in establishing the criteria for when charge nurses function as supervisors. Not every charge nurse is a supervisor – it is their responsibilities that make the determination. On a day-to-day basis, charge nurses are often the most visible individuals "in charge" of a hospital unit, stepping in when there is a crisis or conflict and providing a management voice to patients, families and other employees. We must preserve the ability of charge nurses to carry out their roles as the voice of management without being subject to conflicting loyalties and threats of union discipline.