SPECIAL EVENT

BUILDING A ROBUST HEALTH CARE WORKFORCE IN MASSACHUSETTS

FINDINGS, CHALLENGES, AND OPPORTUNITIES

MASSACHUSETTS
HEALTH POLICY COMMISSION

MARCH 29, 2023

HEALTH CARE WORKFORCE TRENDS AND CHALLENGES IN THE ERA OF COVID-19: CURRENT OUTLOOK AND POLICY CONSIDERATIONS FOR MASSACHUSETTS

SPECIAL FOCUS ON REGISTERED NURSES, DIRECT CARE WORKERS, AND BEHAVIORAL HEALTH PROVIDERS

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MASSACHUSETTS
HEALTH POLICY COMMISSION

Legislative Charge

In two recent laws, the Legislature directed the HPC to analyze the impact of COVID-19 on the Commonwealth's health care workforce:

- **Section 64 of Chapter 260 of the Acts of 2020:** *An Act promoting a resilient health care system that pubs patients first,* tasked the Massachusetts Health Policy Commission (HPC) with analyzing the impact of COVID-19 on the Commonwealth's health care workforce, including an examination of investments in health care worker readiness and engagement.

- **Section 80 of Chapter 102 of the Acts of 2021:** *An Act relative to immediate COVID-19 recovery needs* tasked the HPC with completing a report on the state of the Commonwealth's health care workforce, including an examination of workforce shortages across sectors of the health care system and workforce development initiatives.

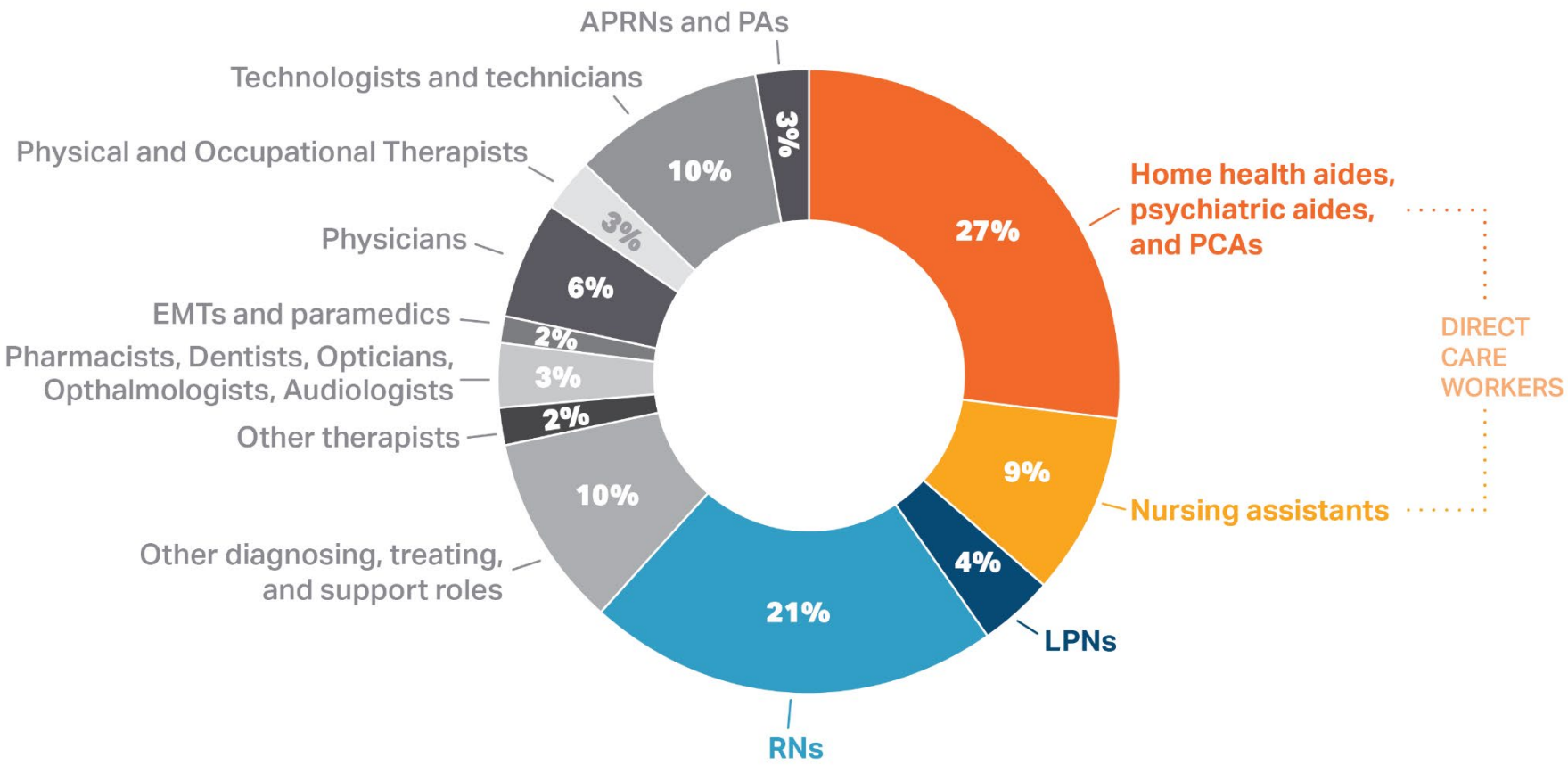
Scope of this Report

- This report takes a high-level perspective on **system-wide** trends and challenges **throughout the workforce life cycle,** as well as contextual factors such as cost of living.
- The report also examines three priority workforces who provide care in multiple sectors and settings of the health system, and which together make up about two-thirds of the Commonwealth's health care workforce: **registered nurses, direct care workers, and behavioral health care providers.**
- Recognizing that there are important workforce pressures and trends in additional health care sectors, the HPC anticipates **future reports** that will more closely examine additional professions (**e.g. primary care providers**) and settings of care (**e.g. community health centers, ambulatory care**).

Elements explored for each stage of the workforce life cycle include:

This report focuses on registered nurses, direct care workers, and behavioral health providers, together representing about 65% of the Commonwealth's health care workforce.

Composition of the Massachusetts health care workforce, 2021



Notes: APRN = advanced practice registered nurse; PA = physician assistant; PCA = personal care aide; LPN = licensed practical nurse; RN = registered nurse; EMT = emergency medical technician. "LPNs" also includes licensed vocational nurses. "Home health aides, psychiatric aides, and PCAs" also includes orderlies. "Other therapists" includes roles such as speech-language pathologists, radiation therapists. "Other diagnosing, treating, and support roles" includes roles such as dental hygienists and assistants, phlebotomists. "Technologists and technicians" includes roles such as ophthalmic and nuclear technicians, hearing aid specialists, prosthetists. Roles excluded from this exhibit: chiropractors, massage therapists, acupuncturists, health information technologists, medical records specialists, medical transcriptionists, exercise physiologists, athletic trainers, dieticians, and veterinary roles. Total health care workers included in this exhibit: 408,470. Previous HPC exploration of the APRN workforce includes Policy Brief: The Nurse Practitioner Workforce and Its Role in the Massachusetts Health Care Delivery System (May 2020). Available at https://www.mass.gov/doc/policy-brief-the-nurse-practitioner-workforce-and-its-role-in-the-massachusetts-health-care/download and Certified Nurse Midwives and Maternity Care in Massachusetts Chartpack (January 2022), Available at https://www.mass.gov/doc/certified-nurse-midwives-and-maternity-care-in-massachusetts-chartpack-1/download

1 Quarterly Census of Employment and Wages, Bureau of Labor Statistics, Q2 2022

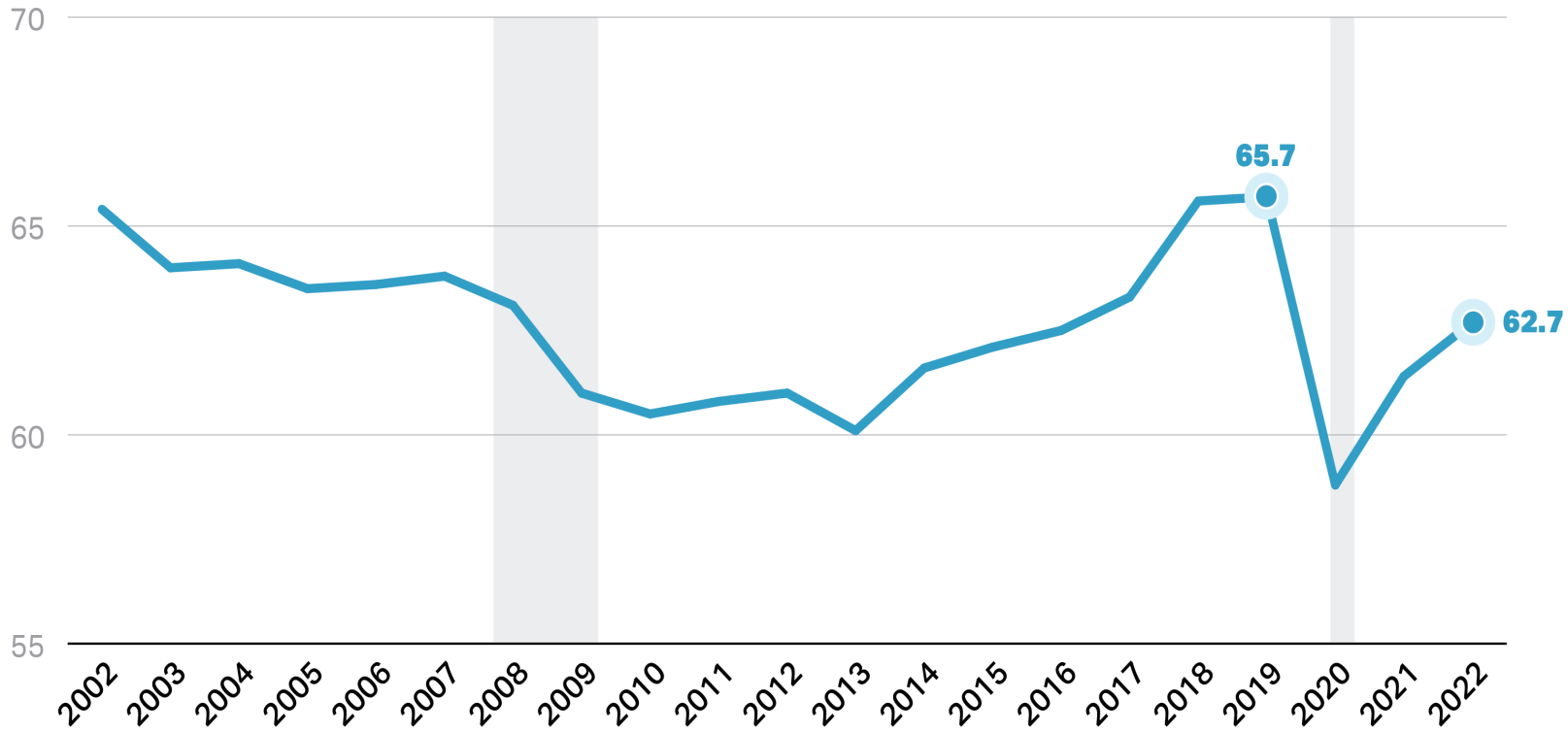
Exhibit and 2 Bureau of Labor Statistics, U.S. Department of Labor, Occupational Employment and Wage Statistics, 2021.

About 40,000 workers (6%) in this figure care for patients in behavioral health settings, including offices, outpatient treatment centers, and inpatient or residential psychiatric facilities.[1]

There are also roughly **24,000 additional social workers, mental health counselors, and marriage and family therapists** providing behavioral health care in the Commonwealth not depicted in the graph.[2]

There is a general shortage of workers, leading to a tight labor market overall and greater worker leverage. For example, the ratio of workers to the total population in Massachusetts is substantially below the pre-pandemic level.

Employment to population ratio, Massachusetts, 2002 - 2022



Notes: Shaded area indicates a recession. Ratios represent annual averages of percent of civilian labor force (≥16 years old) in the Massachusetts non-institutional population.

1 Favilukis, Jack Y and Li, Gen, The Great Resignation Was Caused by the COVID-19 Housing Boom (January 24, 2023). Available at SSRN: https://ssrn.com/abstract=4335860

2 Massachusetts unemployment rate as of Dec, 2022. Bureau of Labor Statistics: https://www.bls.gov/eag/eag.ma.htm

Exhibit sources: U.S. Bureau of Labor Statistics, Employment to Population Ratio, 2022. Dates of U.S. recessions as inferred by GDP-based recession indicator, +1 or 0, Quarterly, Not Seasonally Adjusted, Federal Reserve Economic Data.

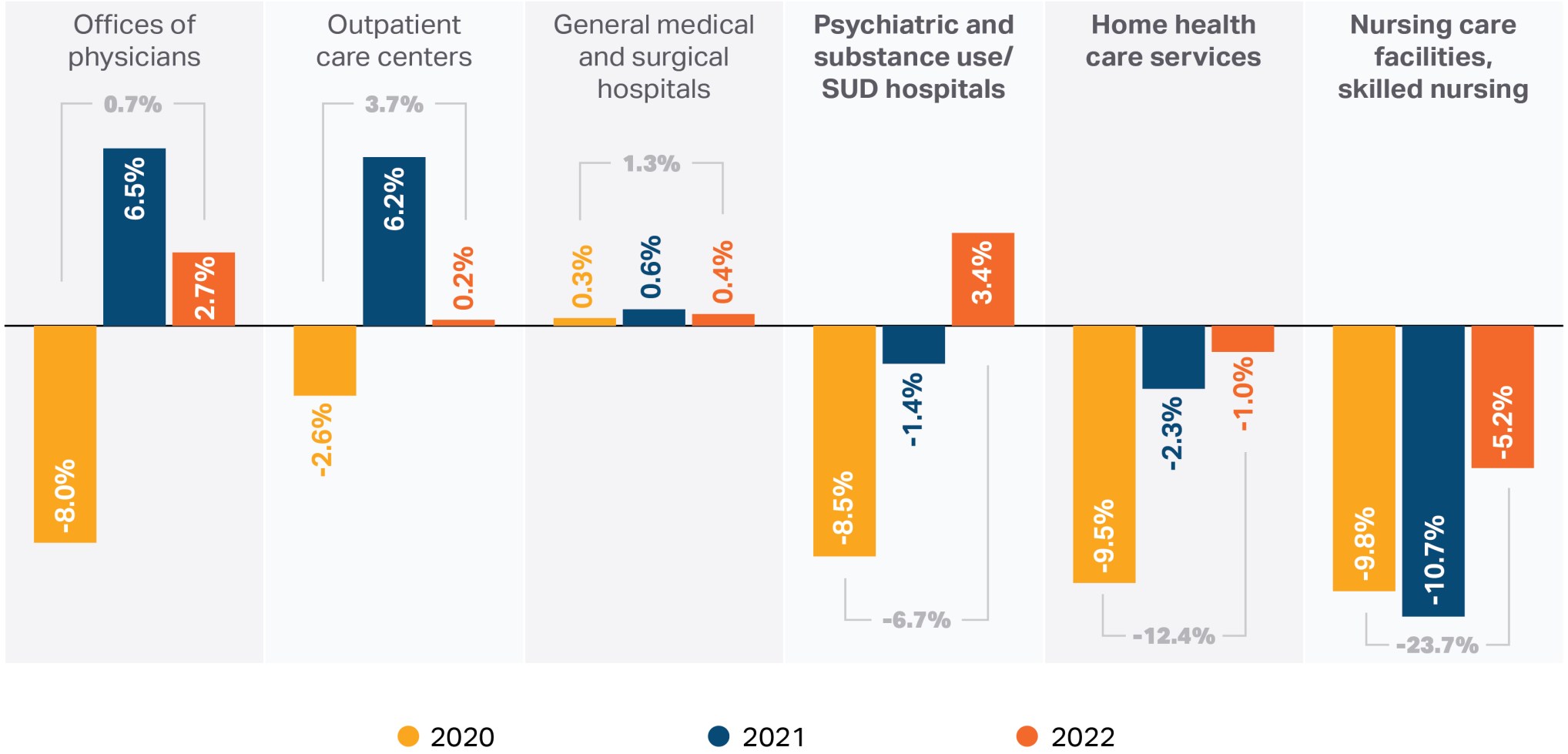
The lower post-pandemic ratio is primarily due to a reduction in labor force participation among older workers.[1] The same phenomenon is occurring nationally.

This ratio is not expected to improve as the large baby boom generation continues to leave the workforce.

The Massachusetts unemployment rate was at a historic low of 3.3% at the end of 2022.[2]

The supply of workers in Massachusetts has dropped the most in health care sectors that are less highly paid, such as home health care and nursing facilities.

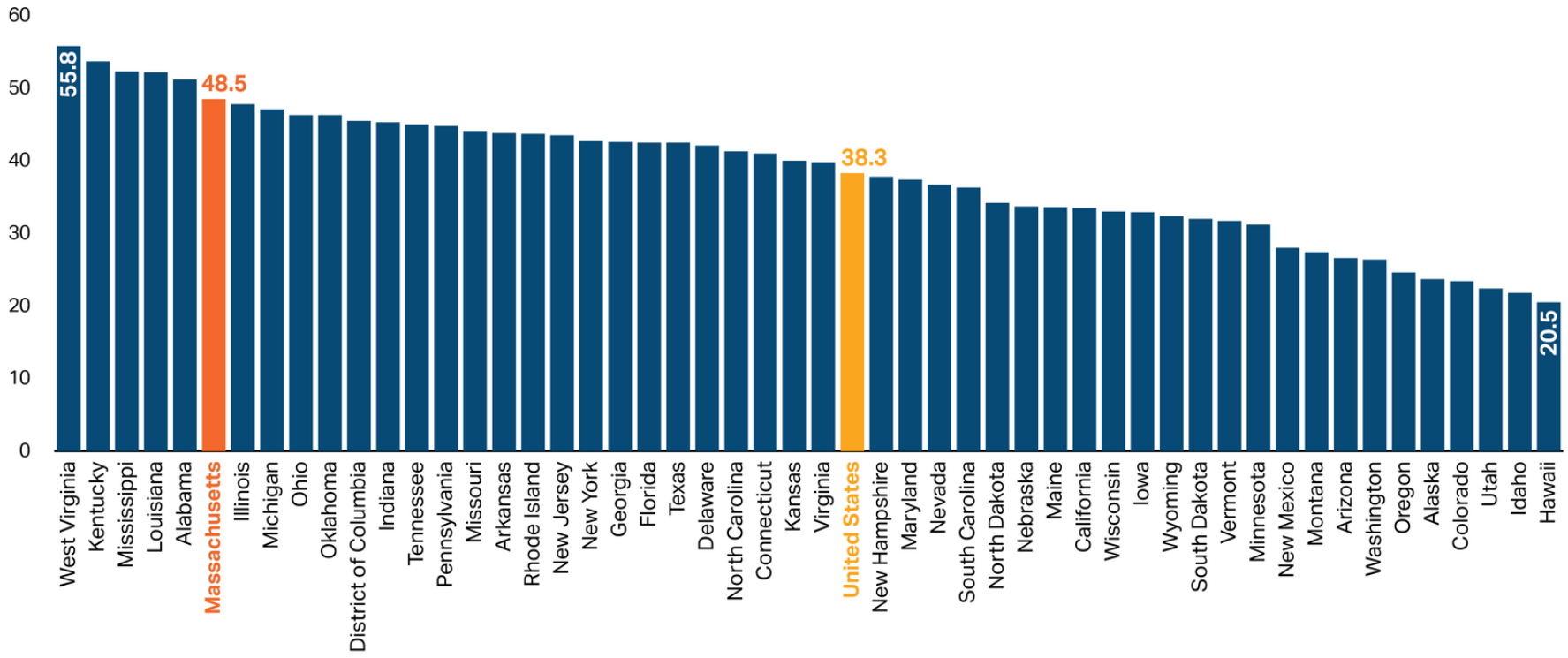
Year to year percent change in employment (Q1 – Q2 average), Massachusetts, 2020-2022



Notes: Employment refers to average monthly employment. Numbers in brackets represent a cumulative change from 2019.
Sources: Quarterly Census of Employment and Wages, Bureau of Labor Statistics, Q1 2019 - Q2 2022

Workforce gaps are exacerbated by Massachusetts' exceptionally high rate of avoidable hospital use.

Avoidable hospital admissions per 1,000 Medicare beneficiaries by state, 2019



Notes: Data includes only beneficiaries enrolled in Medicare fee-for-service aged 65+ and combine admissions for the following ambulatory care-sensitive conditions: diabetes, COPD, asthma, hypertension, CHF, dehydration, bacterial pneumonia, UTI and lower extremity amputation.

1 HPC analysis of the Center for Medicare and Medicaid Services Geographic Variation Public Use file, 2019

2 Radley DC, Baumgartner JC, and Collins SR. Scorecard on State Health System Performance: How Did States Do During the COVID-19 Pandemic? Appendices. Commonwealth Fund. June 2022. Available at https://www.commonwealthfund.org/sites/default/files/2022-06/Radley_2022_State_Scorecard_Appendices.pdf. "Healthiest state" is based on the Healthy Lives index.

3 HPC original analysis of data from the Health Costs and Utilization Project (HCUP)

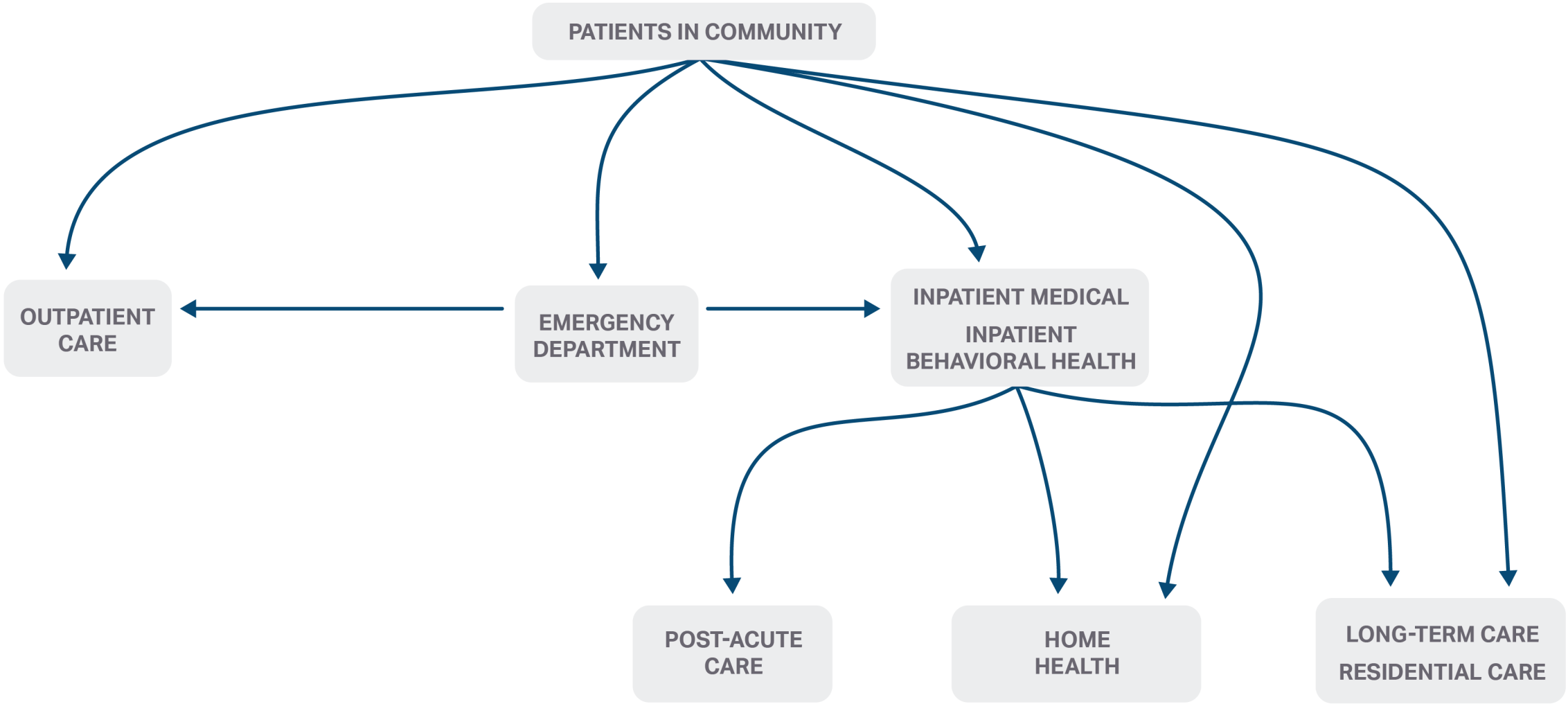
4 KFF. Hospital Emergency Room Visits per 1,000 Population by Ownership Type. 2021. Available at https://www.kff.org/other/state-indicator/emergency-room-visits-by-ownership

Exhibit source: HPC analysis of Chronic Conditions Data Warehouse (CCW) data, via CMS Geographic Variation Public Use File

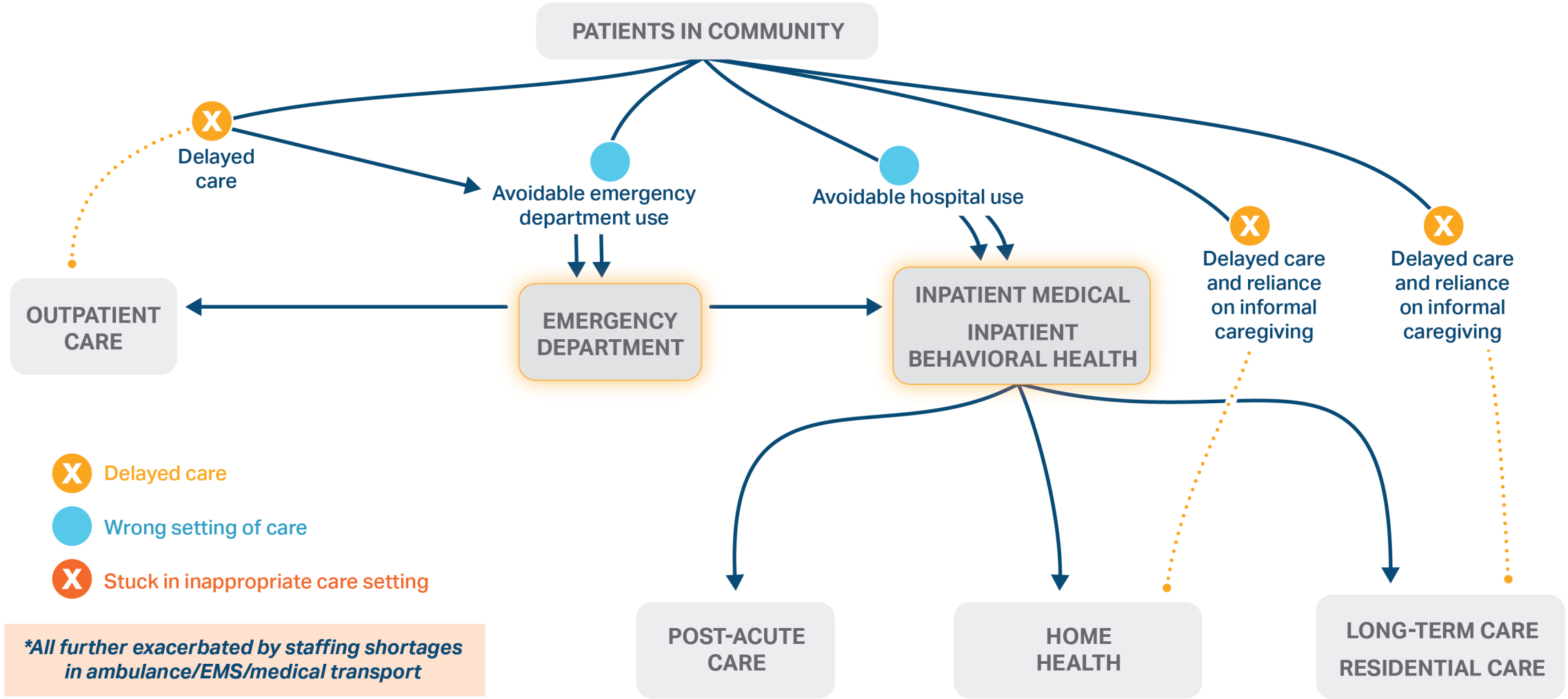
Compared to other states, MA:

- Has the second highest **Medicare readmissions rate.**[1]
- Is ranked **first in "Healthy Lives" but 35th best in "Avoidable hospital use and cost"** (2017-2020).[2]
- Has the highest share of **ED patients admitted for a full hospital stay** among 35 states.[3]
- Has the 14th highest rate of **ED visits.**[4]

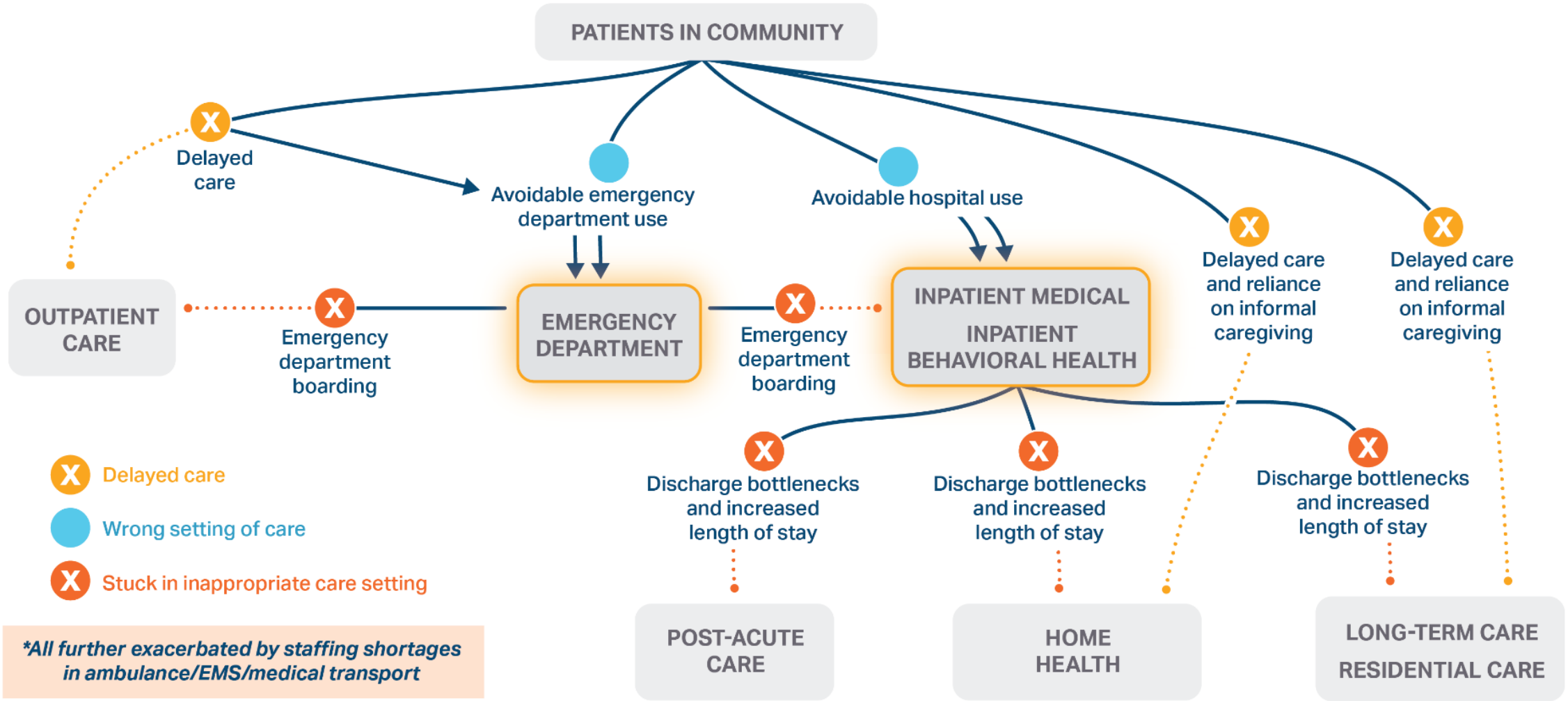
Ideally, patients would access appropriate settings of care in a timely way.



During times of workforce shortages, patients can end up with delayed access to care, and with avoidable ED and hospital use.



Workforce shortages throughout the health care system can create ripple effects impeding patient flow across settings, resulting in patients unable to access needed care.

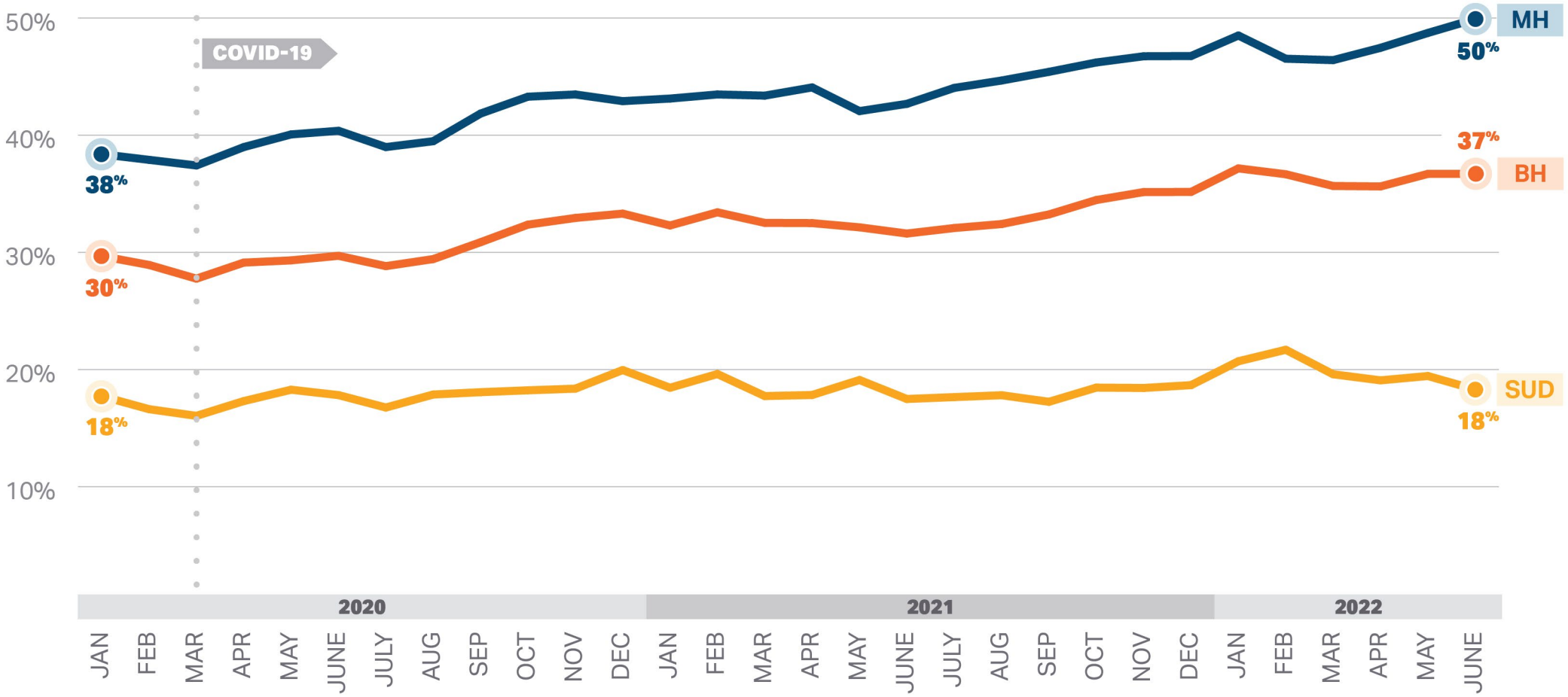


1 Massachusetts Health and Hospital Association. An Acute Crisis: How Workforce Shortages are Affecting Access & Costs. October 2022.

2 Lazar K. There's a new cause for Boston's ambulance delays: Hospital overcrowding. The Boston Globe. January 30, 2023. Available at: https://www.bostonglobe.com/2023/01/30/metro/boston-ambulance-response-times-slow/

By mid-2022, 50% of patients admitted to emergency departments for mental health conditions boarded for longer than 12 hours, partly due to staffing shortages in behavioral health facilities.

Behavioral health emergency department boarding by primary condition, 2020-2022

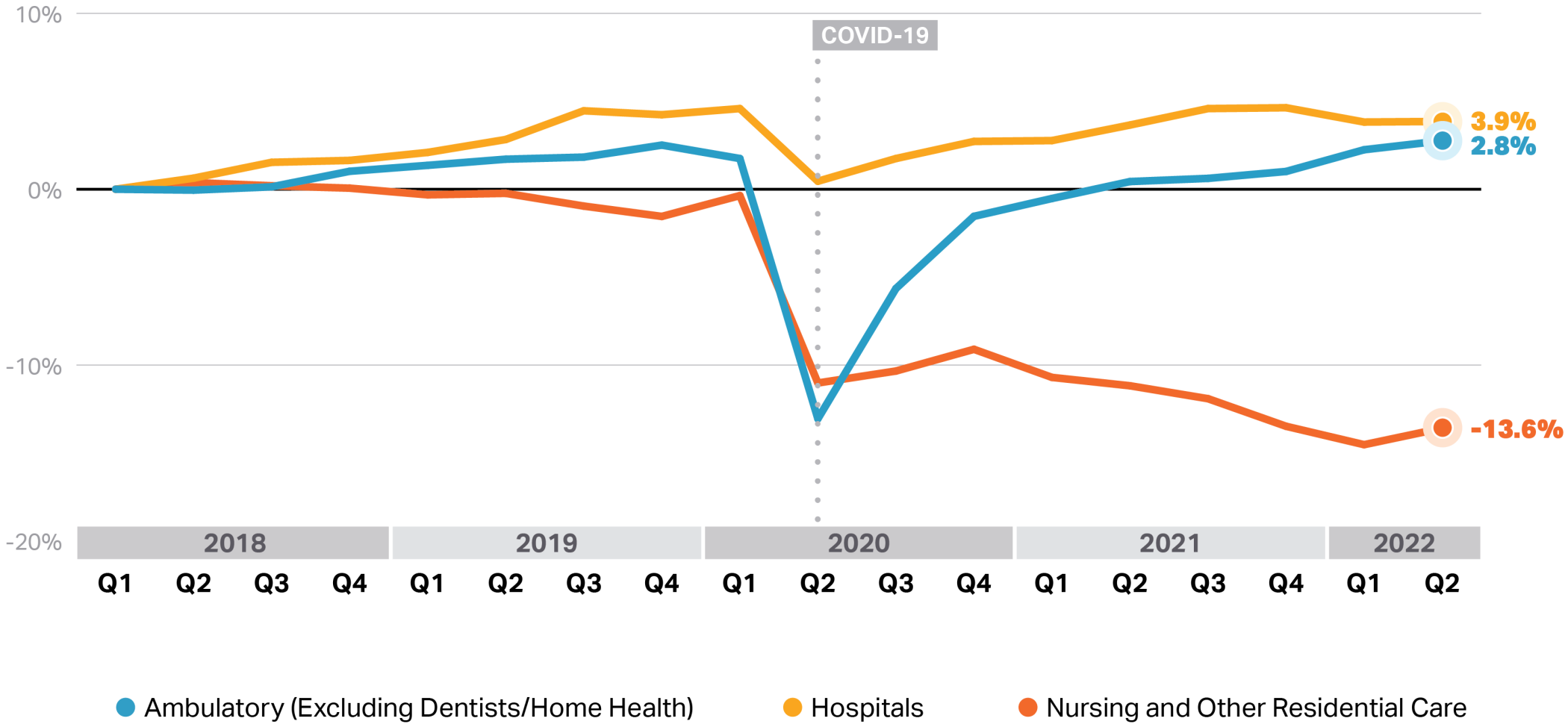


Notes: MH = Mental Health. BH = Behavioral Health. SUD = Substance Use Disorder. The HPC defines ED boarding as greater than or equal to 12 hours in the hospital ED. ED visits where patients were admitted to the same hospital were excluded. Behavioral health visits were identified using AHRQ's CCSR for the primary diagnosis (BH: MBD001-MBD034, Mental Health: MBD001-MBD013, Substance Use: MBD17-MBD34). The following EDs were excluded due to missing data or missing/irregular hours spent in the ED: Lowell General Hospital (Main and Saints campus), Tufts New England Medical Center, Sturdy Memorial, Metrowest (Framingham and Leonard Morse campuses) and Saint Vincent Hospital.

Sources: HPC analysis of the Center for Health Information and Analysis (CHIA) Hospital Emergency Department Discharge Database, January 2020 to September 2021, preliminary data October 2021 to June 2022.

Total employment in nursing and residential care facilities in Massachusetts remains 14% below 2018 levels, contributing to post-acute discharge bottlenecks.

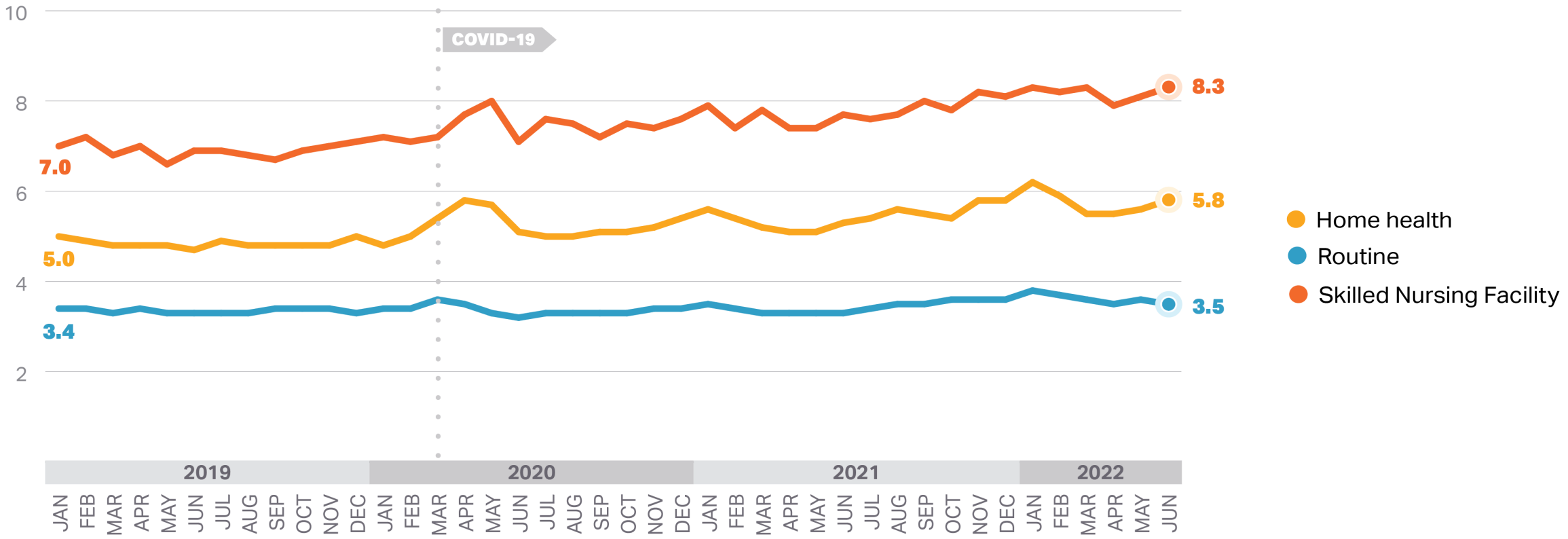
Quarterly change in total employment relative to Q1, 2018 by broad health care sector, Massachusetts, Q1 2018 – Q2 2022



Notes: Employment refers to average monthly employment.
Sources: Quarterly Census of Employment and Wages, Bureau of Labor Statistics, Q2 2022

The staff shortages in post-acute discharge settings leads to patients spending more time in the hospital than needed.

Average length of stay (days) for scheduled admissions and admissions from the ED (combined) by discharge setting, 2019-2022

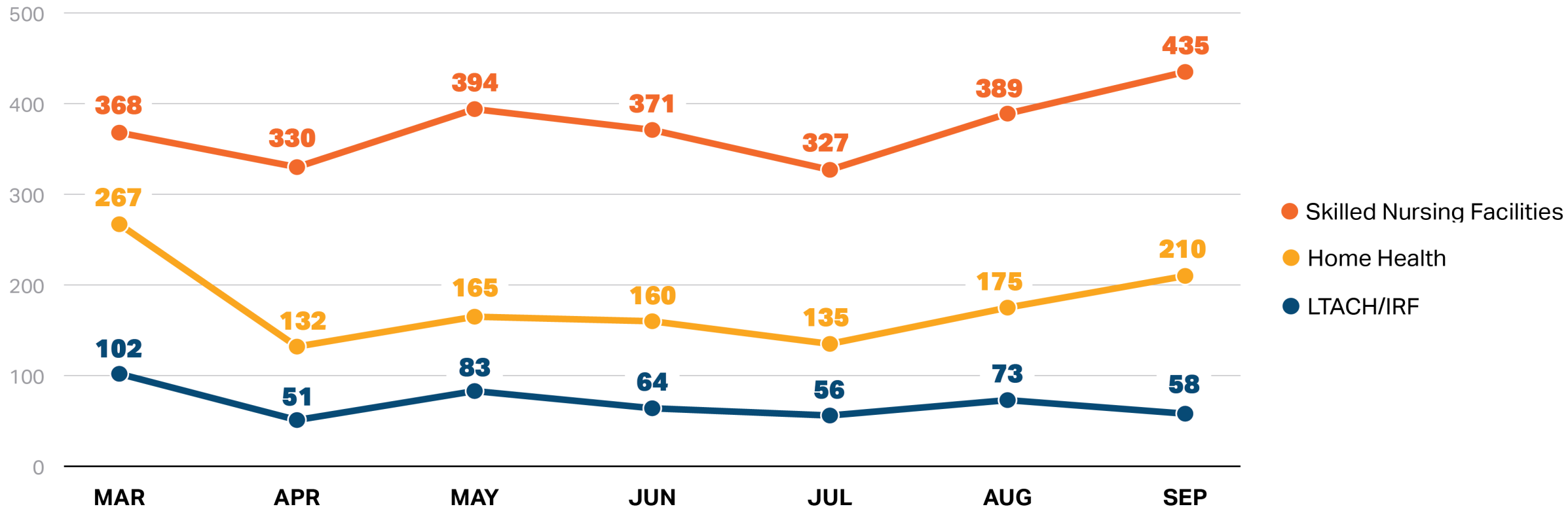


Notes: Based on patient discharge date and includes only admissions from the emergency department and scheduled admissions. COVID-related discharges are excluded. Excludes pediatric, maternity, BH, and rehabilitation admissions and admissions with length of stay greater than 180 days. The following hospitals were excluded for the entire study period due to missing data for one or more quarters: Melrose Wakefield Healthcare (Melrose-Wakefield Campus and Lawrence Memorial Hospital Campus), Lowell General Hospital (Main Campus and Saints Campus), Tufts-New England Medical Center, and Sturdy Memorial Hospital. In calendar year 2019, these hospitals accounted for 7% of all hospital inpatient discharges.

Sources: HPC analysis of the Center for Health Information and Analysis (CHIA) Hospital Inpatient Discharge Database, January 2019 to September 2021, preliminary data October 2021 through June 2022

Hundreds of patients remained in hospitals awaiting discharge throughout 2022. This dynamic further strains hospital resources and staff.

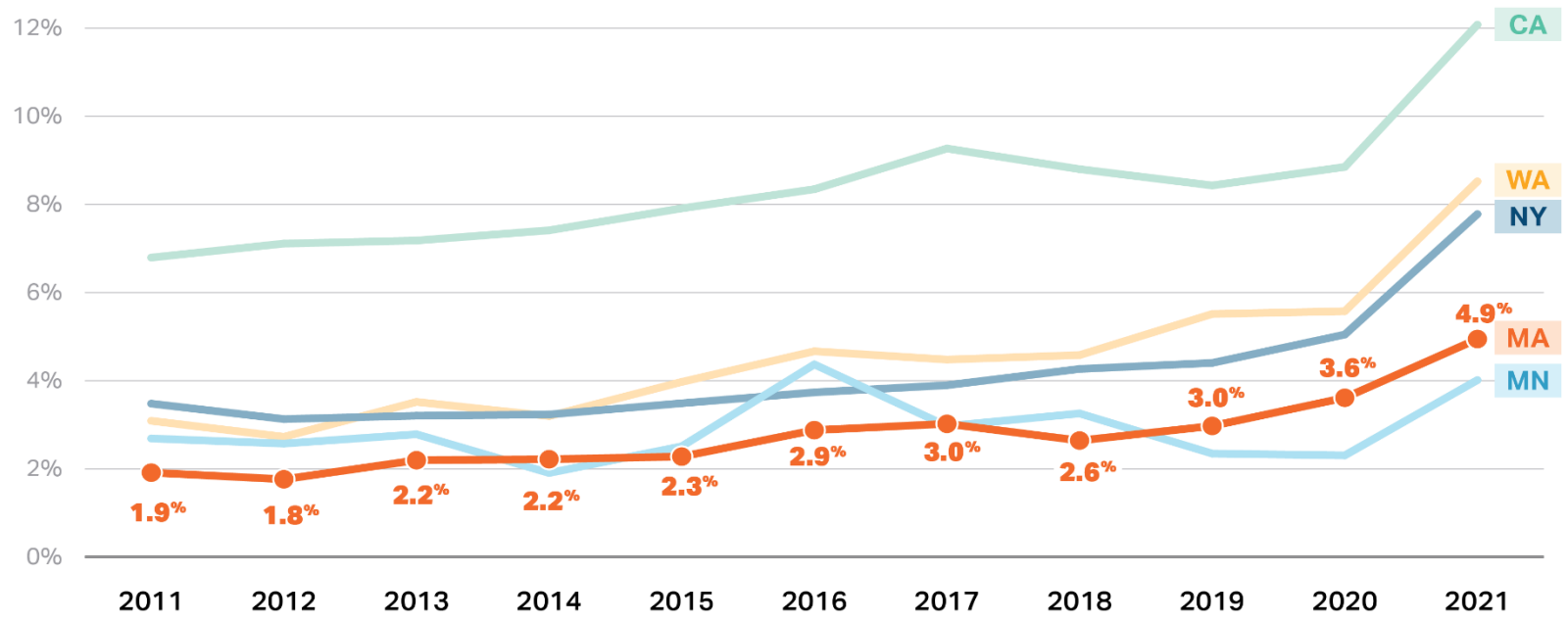
Number of patients awaiting discharge from acute hospitals by discharge setting, March – September 2022



Notes: LTACH/IRF = Long term acute care hospital/inpatient rehabilitation hospital. Includes a consistent cohort of hospitals that responded to the survey each month, therefore not all hospitals are represented.
Sources: Throughput Survey Report, Massachusetts Health and Hospital Association, September 2022.

Similar to other states, MA hospitals have increasingly relied on contract labor to fill workforce gaps, at a much higher cost.

Contract labor as a percentage of hospitals' total patient care labor cost, Massachusetts, 2011 - 2021



Contract labor represented about 5% of hospital patient care labor cost throughout the Commonwealth as of 2021, ranging from 3% to 9% across most hospitals.

Recent estimates indicate that contract labor spending was 154% higher in FY2022 than FY2021, rising to $1.5 billion.[1]

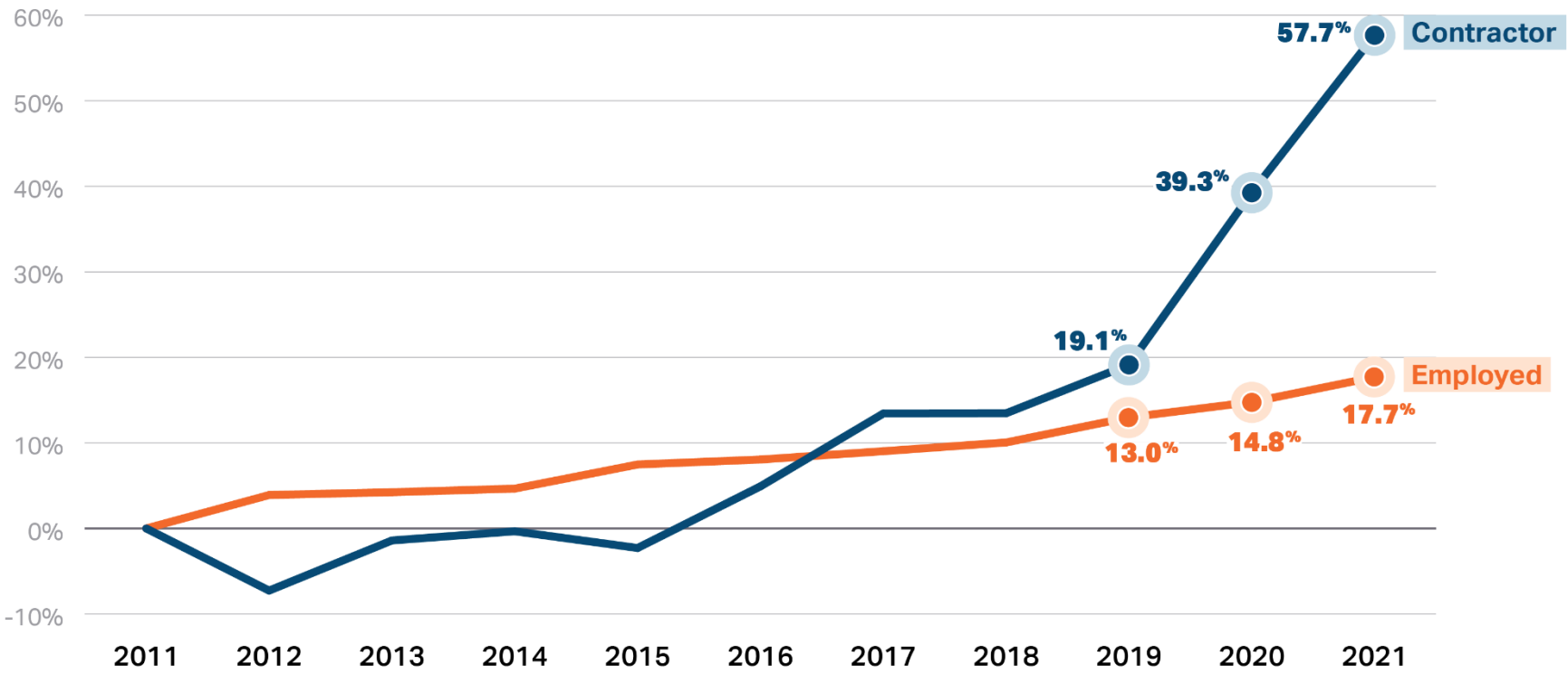
Notes: Years represent hospital fiscal years. CA = California; WA = Washington; NY = New York; MA = Massachusetts; MN = Minnesota. Direct patient care labor excludes other personnel not providing direct patient services, such as administration, maintenance, and other personnel not providing direct patient care. Labor costs include vacation, holiday sick leave, other paid time off, severance pay, bonus, and benefits. "Contractor" excludes physicians but includes all other contracted labor. 24 hospitals were dropped from this analysis due to missing or incomplete data.

1 Massachusetts Health & Hospital Association. Hospital Temporary Labor Costs: A Staggering $1.52 Billion in FY2022. March 13, 2023. Available at https://www.mhalink.org/MHA/MyMHA/Communications/PressReleases/Content/2023/Hospital_Temporary_Labor_Costs_2023.aspx

Exhibit source: National Academy for State Health Policy, Hospital Cost Tool Data, 2022.

Wages for contract workers spiked in 2020 and 2021, adding strain to hospital finances.

Change in average wages for patient care labor for contractor vs employed hospital staff, Massachusetts, 2011-2021



As of 2022, average wages for contract nurses in MA were 189% of average wages for employed nurses.[1]

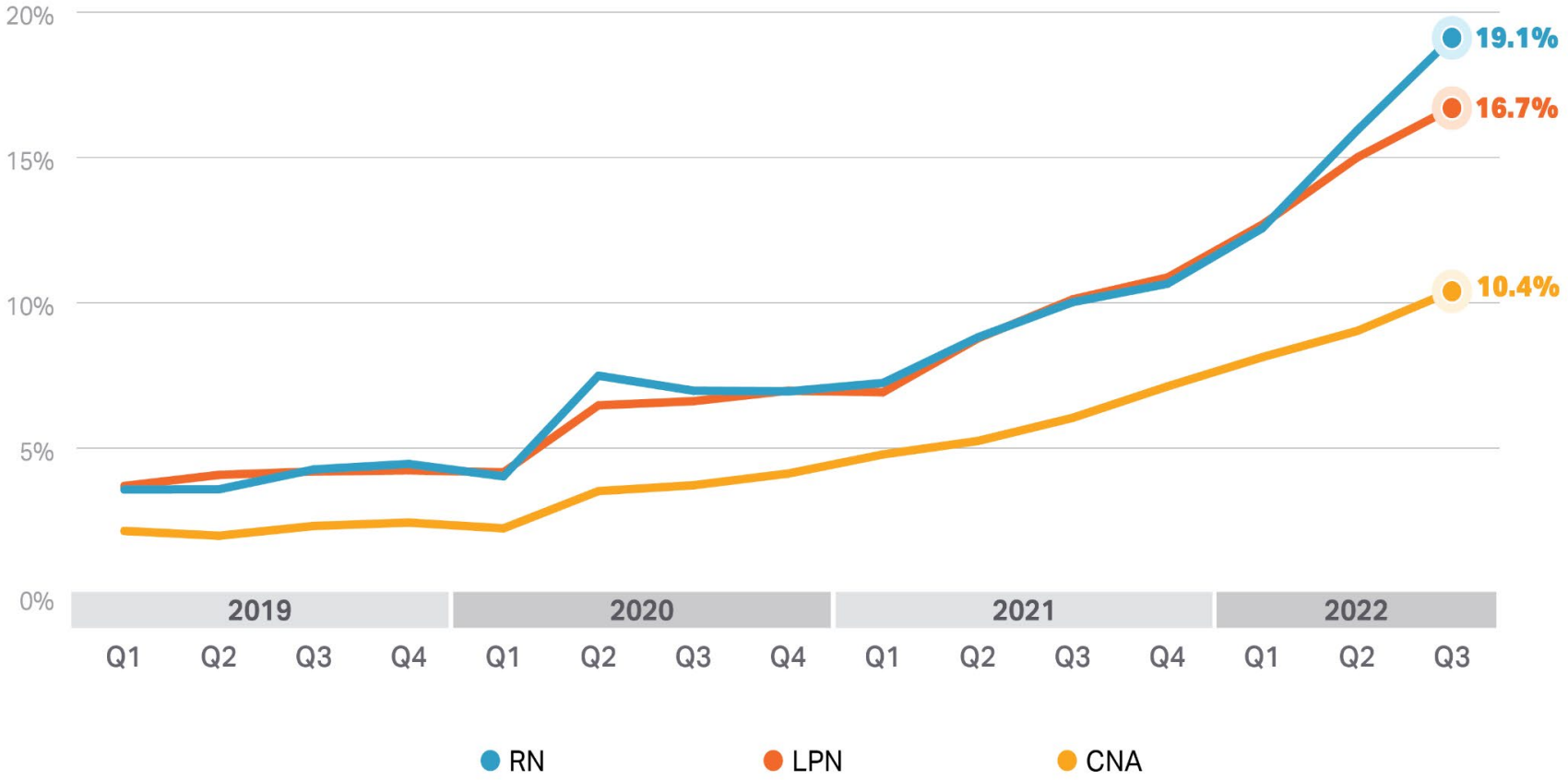
Notes: Years represent hospital fiscal years. Wages refer to average hourly rates. Direct patient care labor excludes other personnel not providing direct patient services, such as administration, maintenance, and other personnel not providing direct patient care. Labor costs also include vacation, holiday sick leave, other paid time off, severance pay, bonus, and benefits. Percent changes are relative to 2011. "Contractor" excludes physicians but includes all other contracted labor, including, but not limited to, nursing, diagnostic, therapeutic, and rehabilitative services. 24 hospitals were dropped from this analysis due to missing or incomplete data.

1 Robertson M. Average nurse pay vs. travel nurse pay for all 50 states. Becker's Hospital Review. December 15, 2022. Available at https://www.beckershospitalreview.com/compensation-issues/travel-nurse-vs-rn-pay-gap-for-all-50-states.html. Data are not necessarily specific to the hospital setting. Massachusetts has the 9th lowest ratio of contract to employed nurse pay of any U.S. state.

Exhibit sources: National Academy for State Health Policy, Hospital Cost Tool Data, 2022.

Long-term care facilities have also increasingly relied on contract workers to fill staffing gaps in multiple roles.

Contract hours as a percent of total hours for registered nurses (RNs), licensed practical nurses (LPNs), and certified nursing assistants (CNAs) in long-term care facilities, Massachusetts, Q1 2019 – Q3 2022

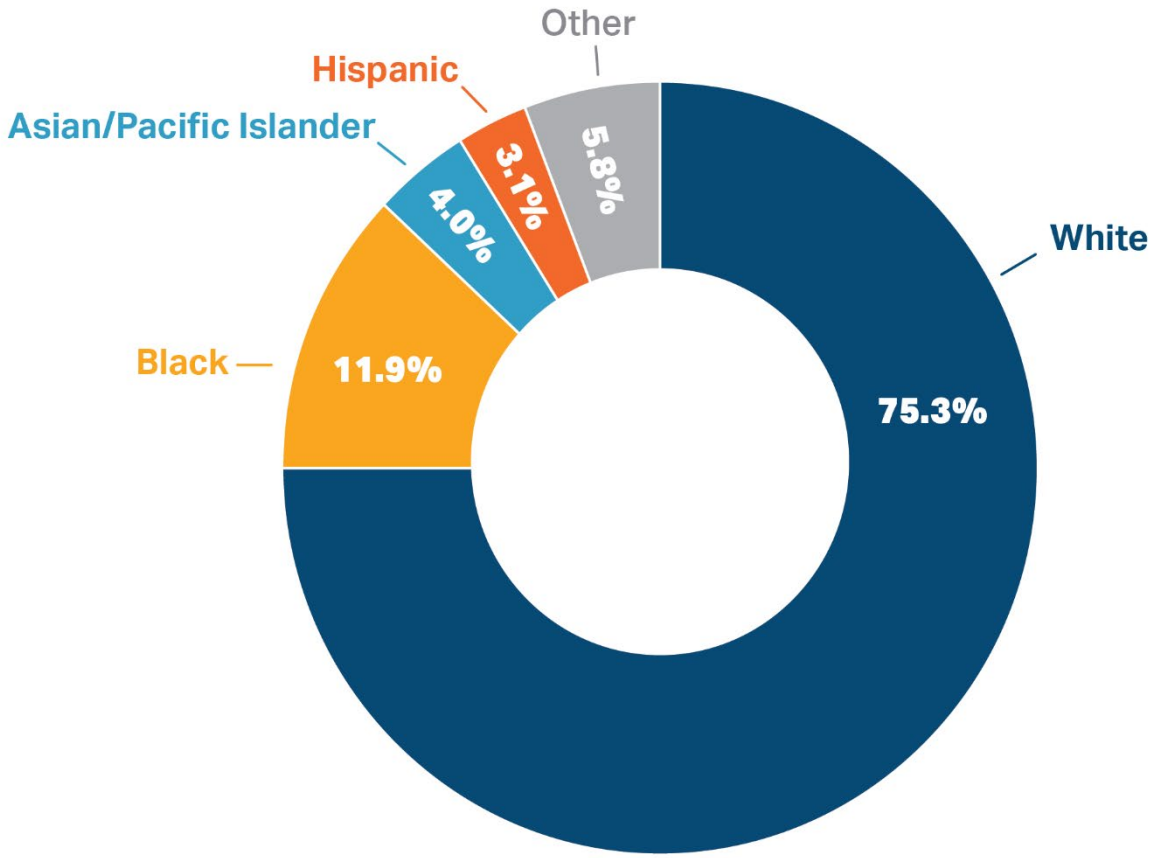


As of Q3 2022, **total RN hours** in long-term care facilities were **down 20.6%** relative to Q1 2019, and **employed (non-contracted)** RN hours were **down 33.4%**

Notes: Hours for workers with administrative duties and hours for directors of nursing were not included in this analysis.
Sources: Centers for Medicare and Medicaid Services, Payroll Based Journal Daily Nurse Staffing Data, Q1 2019 - Q3 2022.

As of 2021, nearly 90% of Massachusetts registered nurses were women, and 75% were white.

Massachusetts registered nurses by race and ethnicity, 2021



87% Female

$96,630 Median Annual Income

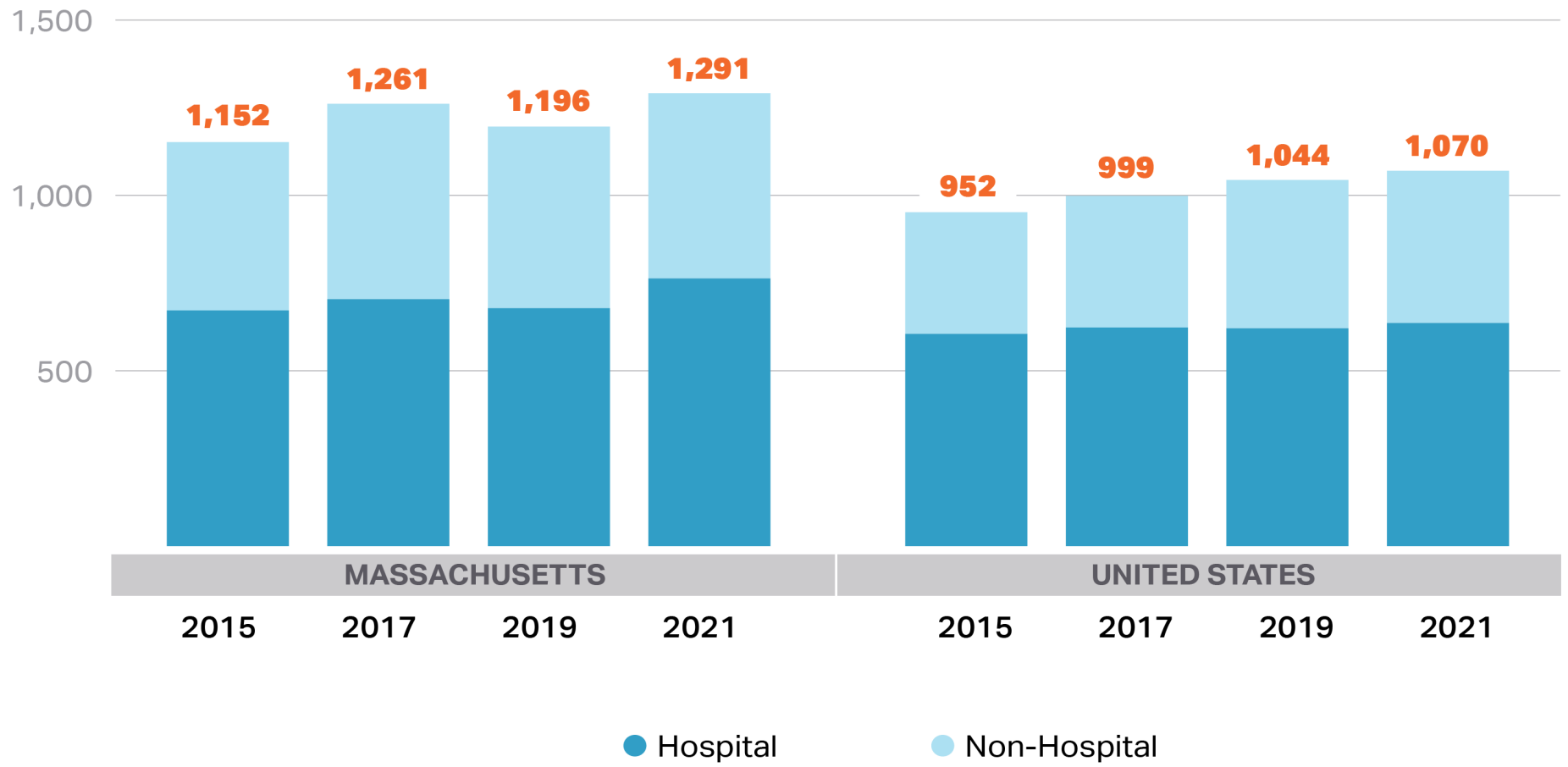
15% Immigrant

43 Median Age

Notes: Immigrants include naturalized citizens and non-citizens. Hispanic includes all races.
Sources: American Community Survey, 1-year Sample, 2021. Bureau of Labor Statistics, U.S. Department of Labor, Occupational Employment and Wage Statistics, 2021.

Nursing workforce challenges do not appear to stem from an overall decrease in the RN workforce. Massachusetts has more RNs per capita than the U.S. and has seen 12% per capita growth since 2015.

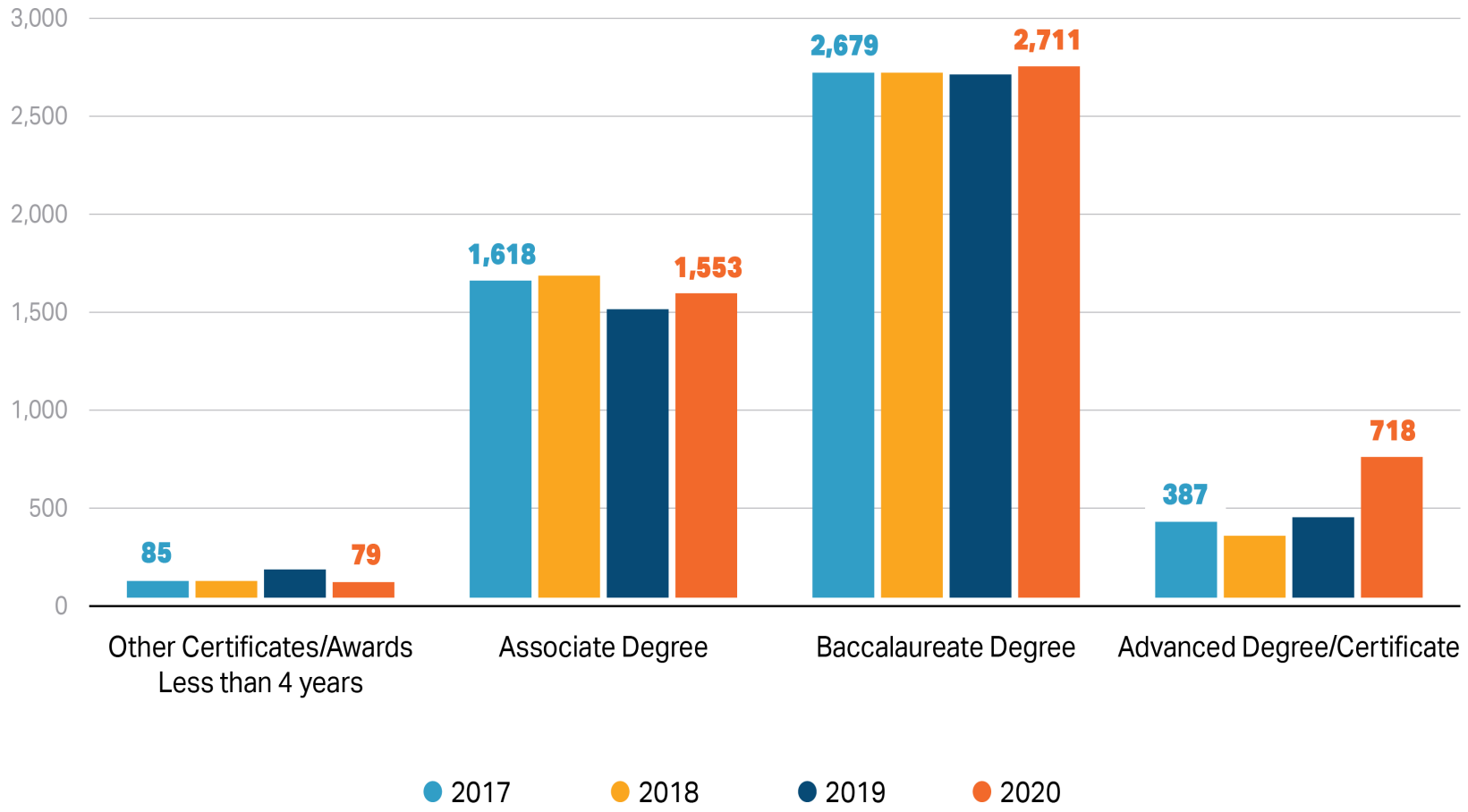
RN employment per 100,000 population by setting, Massachusetts vs United States, 2015 - 2021



Notes: Occupations and population weighted using the ACS person weight. Total growth in Massachusetts RN supply (not per capita) from 2015 to 2021 is 15%.
Sources: American Community Survey, 1-year Sample, 2021.

The total number of people completing nursing programs in Massachusetts has remained steady into the pandemic, suggesting a relatively steady pipeline.

Number of awards conferred by Massachusetts postsecondary institutions for registered nursing programs, 2017-2020

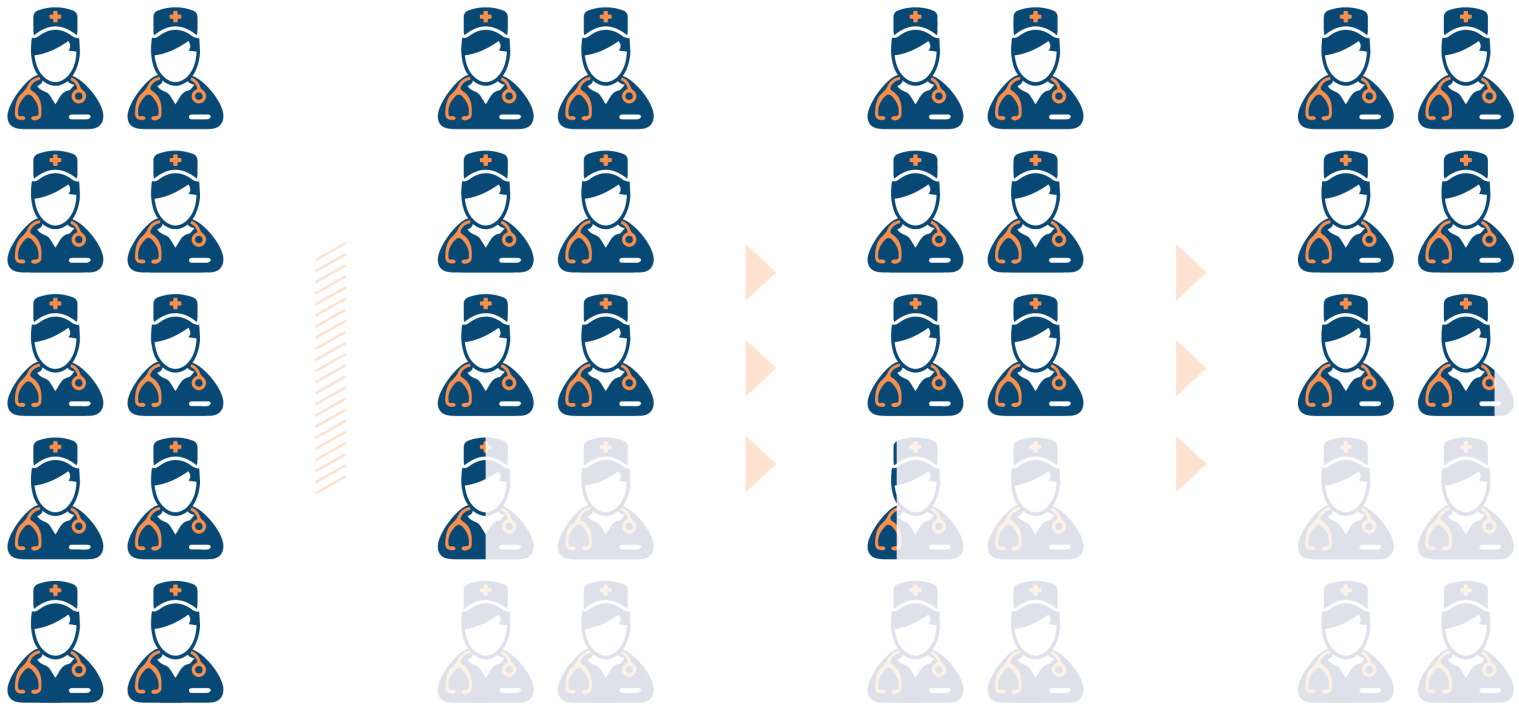


- The pandemic did not appear to affect the number of people completing nursing programs, and there was an **increase in advanced degrees in 2020.**
- The number of people who passed the NCLEX-RN licensing exam increased by 3% from 2019 to 2020, and declined 1% in 2021

Notes: "Advanced Degree/Certificate" group includes all degrees and certificates above the baccalaureate level.
Sources: Degrees and Certificates Conferred (Completions), U.S. Department of Education. Institute of Education Sciences, National Center for Education Statistics.

One third to half of RNs educated in Massachusetts ultimately move on to work in other states, limiting the return on investment in the nursing education pipeline.

Share of RNs who completed basic nursing education in Massachusetts and working in other states, by years since graduating, as of 2018



For **every 100 RNs** educated in MA...

Only about **65 remain in practice in MA** after 5 years

After 15 years, **even fewer remain** - about 63 nurses

After 25 years, **only 58 RNs remain**

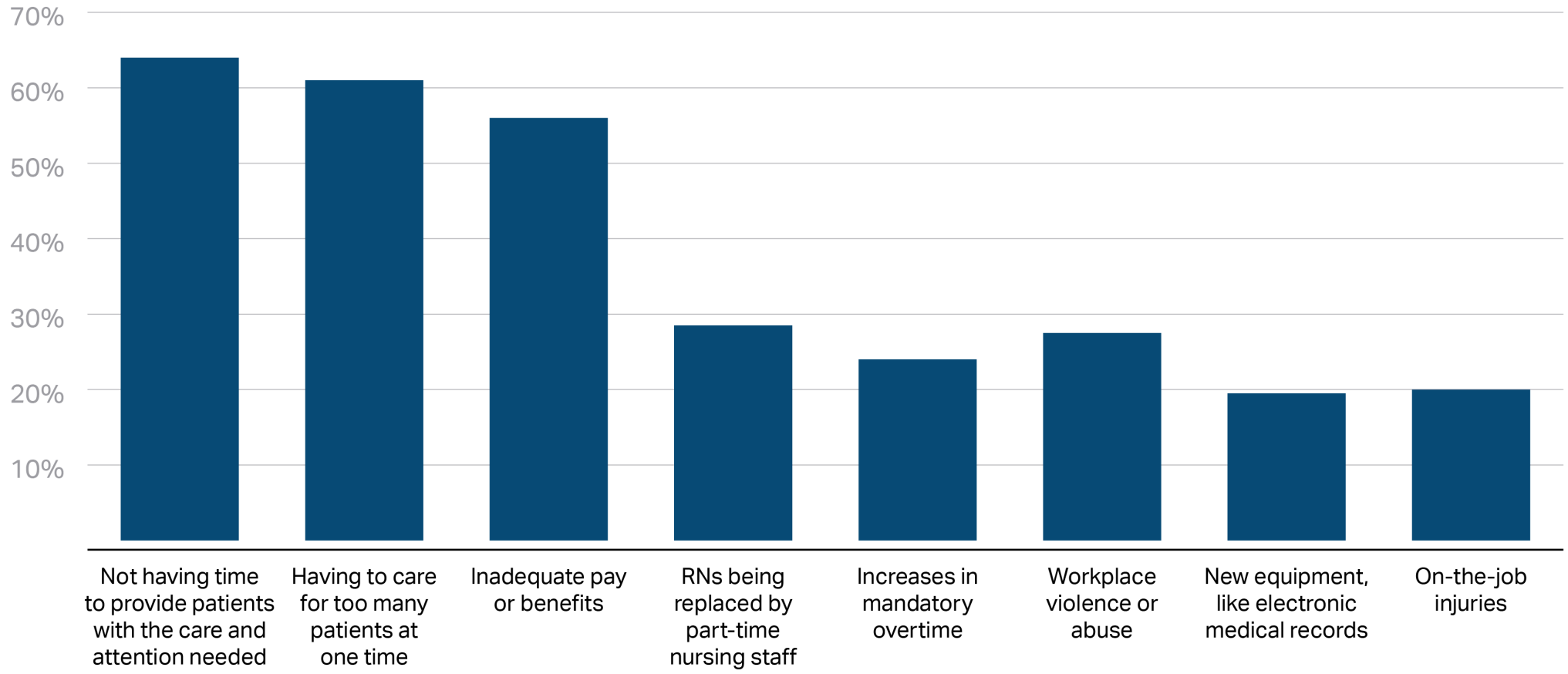
- Massachusetts has **a similar rate of attrition** as other states.
- Similarly, a third (33%) of RNs working in Massachusetts in 2018 obtained their nursing degrees in other states.

Notes: Exhibit reflects the unweighted NSSRN sample. MA total sample size is 452 RNs. 46% of all nurses educated in Massachusetts continued working in-state, compared to 52% in California, 53% in Maryland, and 37% in New York.

Sources: National Sample Survey of Registered Nurses, U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. 2018..

Nurses continued to report workplace challenges throughout the pandemic.

Average share of RN survey respondents identifying major challenges in nursing, Massachusetts, 2021-2022



Sources: A Survey of Massachusetts Registered Nurses, Beacon Research, 2021, 2022.

The experience with COVID-19 and the reliance on contract nurses have contributed to a cycle of turnover in many hospital nursing units.

A **unit of nurses** cares for their patients

COVID adds to already **difficult** work conditions, and nurses **leave** hospital employment or **retire** earlier than planned

Difficulty attracting experienced RNs leads the hospital to **backfill** with a combination of **recently graduated nurses** who need support and mentorship, and with **contract nurses** who may have less cohesion with other staff

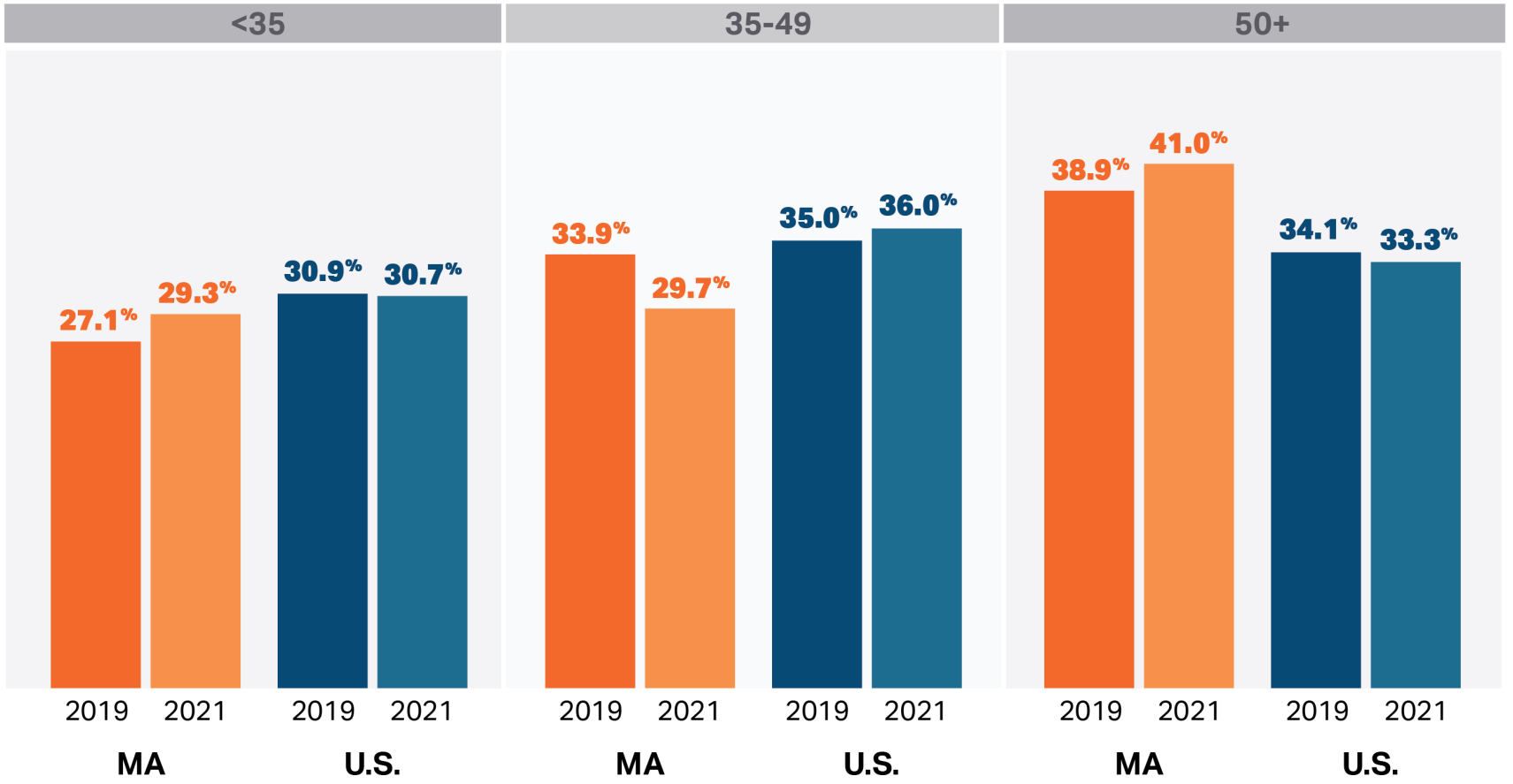
Another experienced nurse **leaves**, which, combined with **high turnover** among newer nurses, creates a **turbulent work environment**

RESULTING STAFFING SHORTAGE

More nurses leave in a **cycle of turnover** that creates a **challenging** work environment, **depletes** institutional knowledge, **raises** costs, and **worsens** continuity of patient care

Massachusetts has a relatively high proportion of RNs over 50 compared to the U.S. average, contributing to more frequent retirements and turnover.

Age Distribution of RNs, Massachusetts vs U.S. average, 2019-2021



Notes: Results are weighted using a full-time equivalent weight.
Sources: American Community Survey 1-year Sample, U.S. Census Bureau. 2021.

Challenges for the nursing workforce are concentrated around employment and retention.

Limited precepting capacity restricts the pipeline

Difficult working conditions contribute to turnover and attrition

Many nurses are seeking advanced degrees

Lower salaries for nursing faculty and the limited pool of preceptors for clinical education can limit the nursing education pipeline.

High levels of stress as a result of the pandemic

Fewer administrative support staff

Inflexible scheduling

Loss of institutional knowledge related to high turnover

Lack of capacity for mentoring new nurses

More experienced nurses retiring early

Newer nurses getting burned out

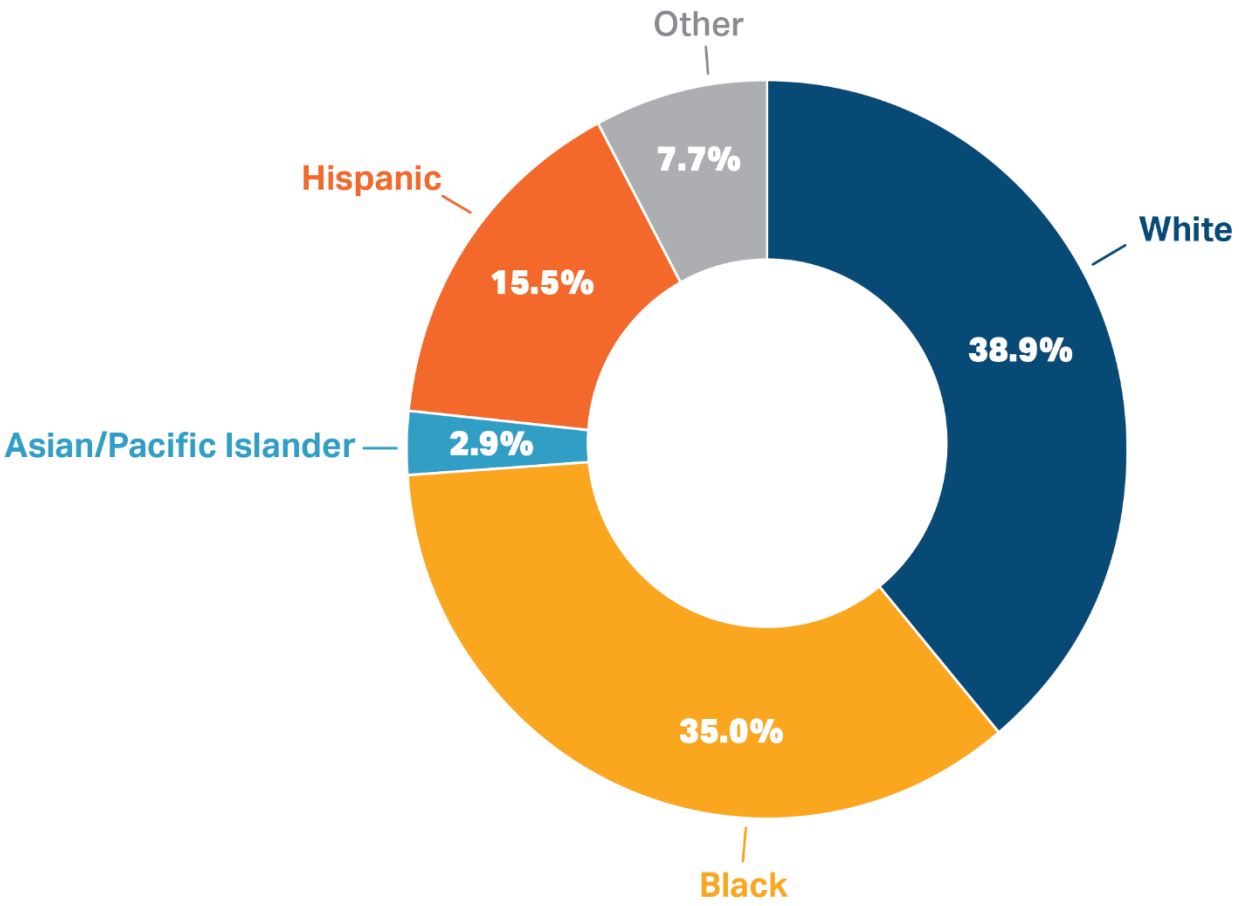
Nurses leaving employment for contract work

Nurses leaving patient care for other health care roles

Completion of APRN and other advanced degree programs is rising, which may be beneficial for access to care, but may also contribute to turnover as nurses leave the bedside to pursue further education

As of 2021, about 90% of Massachusetts direct care workers were women, 61% were people of color, and nearly half were immigrants.

Massachusetts direct care workers by race and ethnicity, 2021



89% Female

$37,015 Median Annual Income

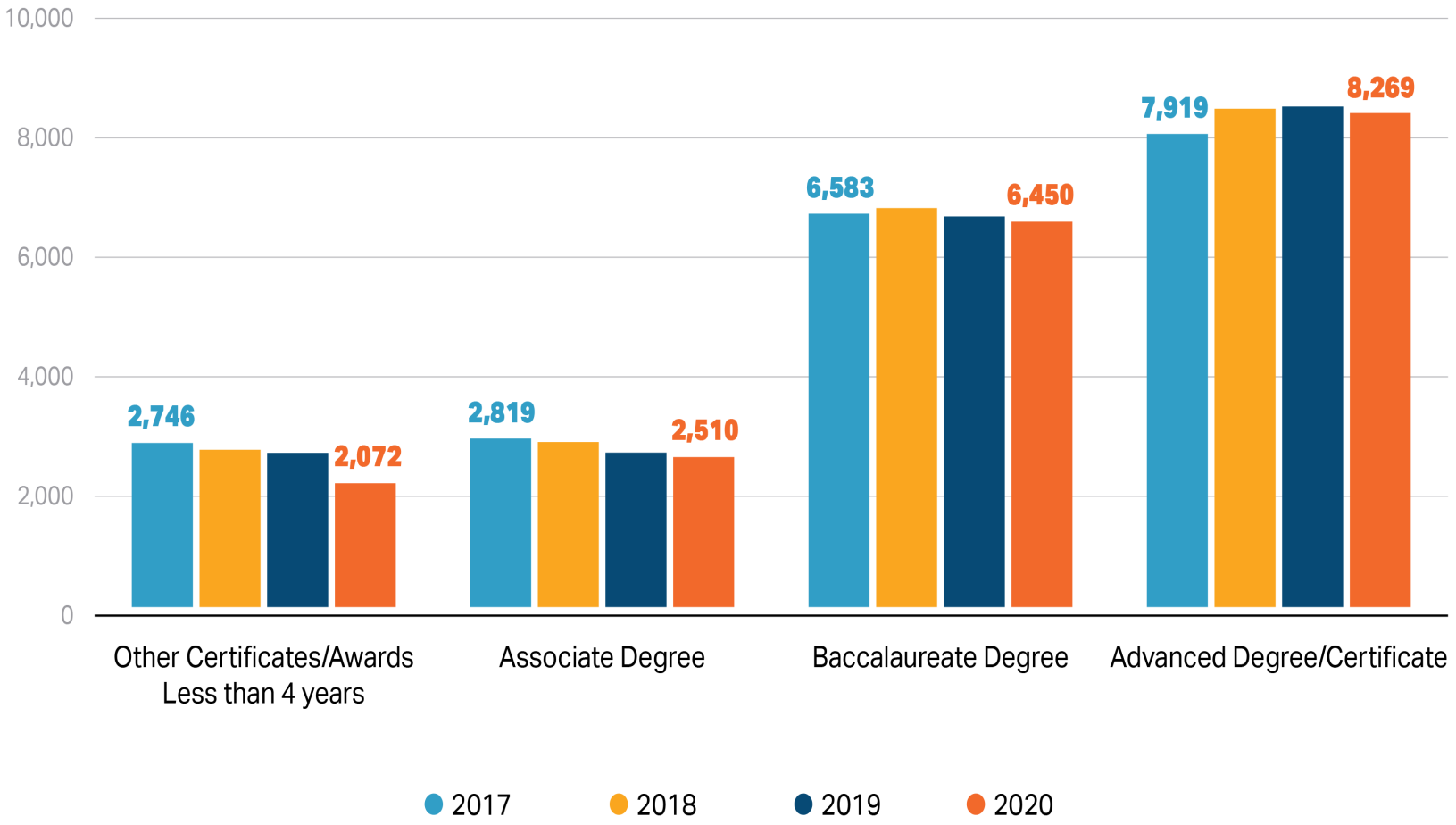
48% Immigrant

49 Median Age

Notes: Direct care workers include certified nursing assistants (CNAs), home health and personal care aides, psychiatric aides, and orderlies. Immigrants include naturalized citizens and non-citizens. Hispanic includes all races.
Sources: American Community Survey, 1-year Sample, 2021. Bureau of Labor Statistics, U.S. Department of Labor, Occupational Employment and Wage Statistics, 2021.

Completion of baccalaureate and advanced health profession degrees has been stable or rising in MA, but completion of shorter programs, including direct care certifications, has fallen.

Number of awards conferred by Massachusetts postsecondary institutions for all health professions and related clinical sciences, 2017-2020



Award totals over time:

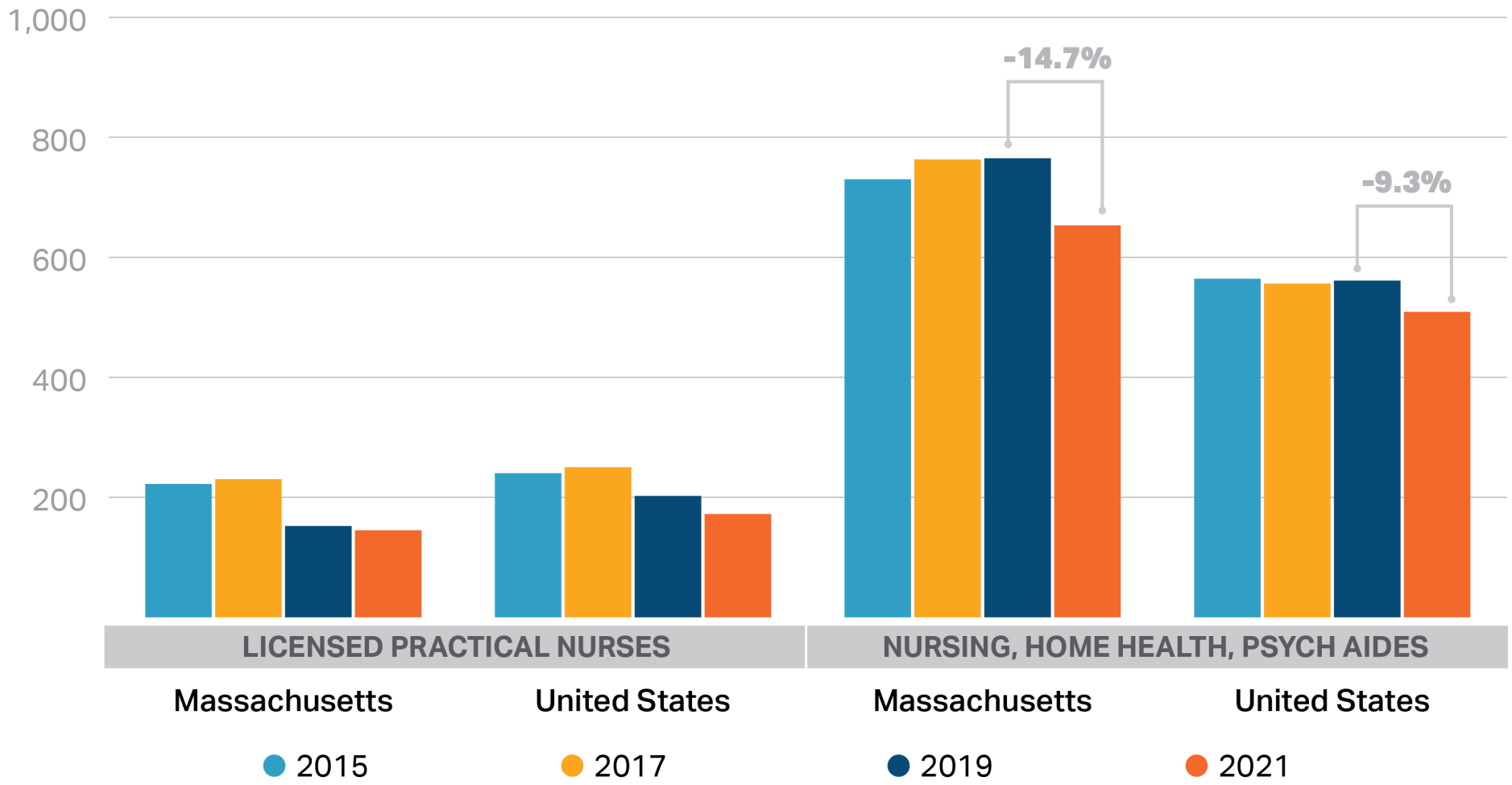
- **2017:** 20,067
- **2018:** 20,413
- **2019:** 20,080
- **2020:** 19,301

Notes: "Advanced Degree/Certificate" group includes all degrees and certificates above the baccalaureate level. Excludes dental and veterinarian degrees

Sources: Degrees and Certificates Conferred (Completions), U.S. Department of Education. Institute of Education Sciences, National Center for Education Statistics.

MA has more direct care workers per capita than the U.S. overall, but employment of these roles declined more quickly in MA from 2019-2021.

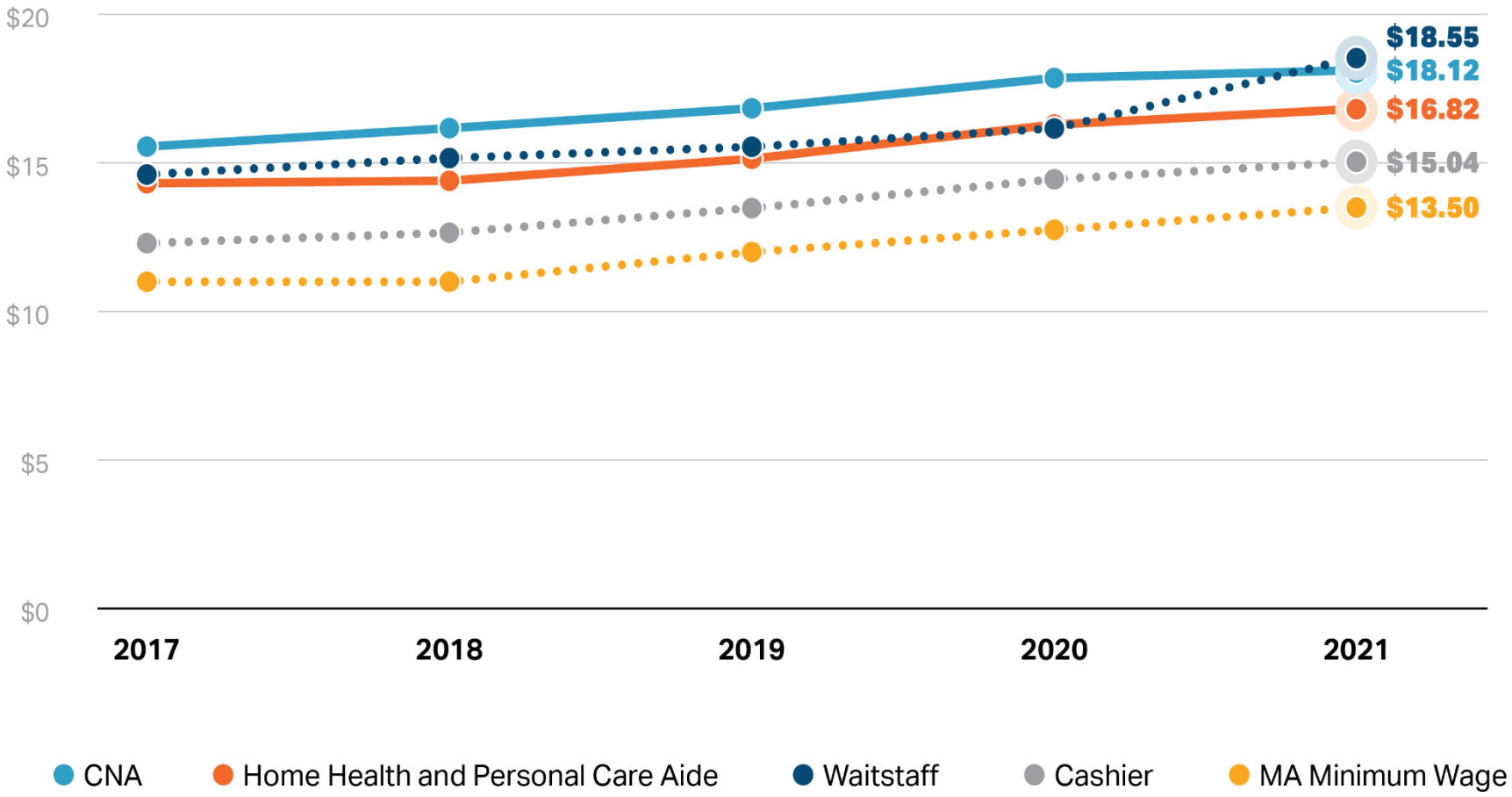
Employment in health care occupations per 100,000 population, Massachusetts vs United States, 2015 - 2021



Notes: Occupations and population weighted using a full-time equivalent (FTE) weight. Massachusetts had 765 FTE nursing, home health, and psychiatric aides per capita in 2019, which fell to 653 (percent change represented in bracket).
Sources: American Community Survey, 1-year Sample, 2021.

Lower-wage workers may leave health care occupations for alternatives with fast-growing wages in sectors such as retail or hospitality.

Minimum wage and average hourly wages for selected occupations, Massachusetts, 2017-2021



Notes: Waitstaff includes servers and bartenders. Cashier wages represent all employer sizes; however, large retailers may pay higher starting wages, e.g. Target raising its minimum wage to as much as $24 an hour.; see citation 2 below. The hourly wage for PCAs employed by MassHealth was $17.01 as of 2021.

1 Living Wage Calculation for Massachusetts, Massachusetts Institute of Technology. 2022. Available at https://livingwage.mit.edu/states/25.

2 Torchinsky R. Target is raising its minimum wage to as much as $24 an hour. WBUR. March 1, 2022. Available at https://www.wbur.org/npr/1083720431/target-minimum-wage

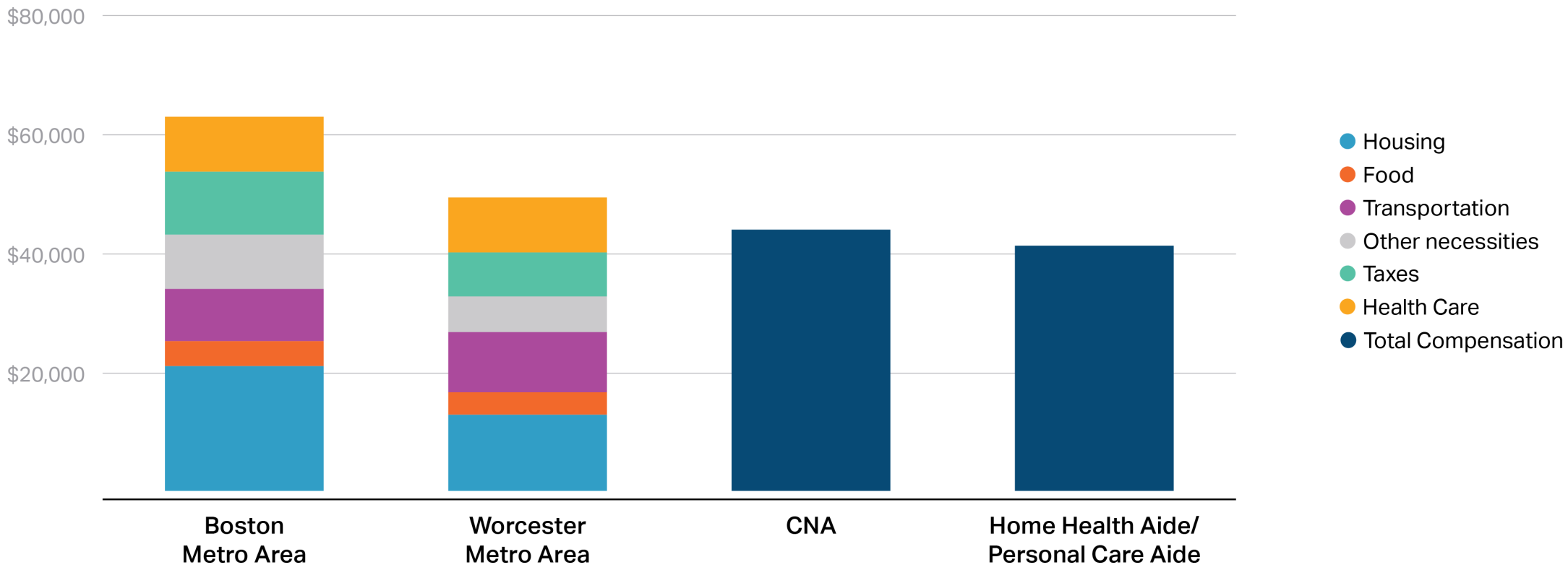
Exhibit sources: Bureau of Labor Statistics, U.S. Department of Labor, Occupational Employment and Wage Statistics, 2017-2021.

State Minimum Wage Rate for Massachusetts, U.S. Department of Labor, retrieved from Federal Reserve Bank of St. Louis (FRED). 2017-2021.

- The Massachusetts minimum wage as of January 2023 is $15 per hour.
- A living wage for a single adult with no children in Massachusetts is estimated to be $21.88 per hour.[1]
- Some large retailers offer starting wages as high as $24 per hour or more.[2]

The high cost of living in Massachusetts can be challenging for lower-wage health care workers, many of whom receive public assistance or have multiple jobs.

Total cost of living for a single adult and average compensation for selected occupations, Massachusetts, annual, 2021



Notes: Costs and compensation are in annual terms and for single adults with no children.

Sources: American Community Survey 1-year sample, U.S. Census Bureau. 2019-2021. Occupational Employment and Wage Statistics, Bureau of Labor Statistics. 2017-2021. State Minimum Wage Rate for Massachusetts, U.S. Departement of Labor, retrieved from Federal Reserve Bank of St. Louis (FRED). 2017-2021. Family Budget Calculator, Economic Policy Institute. Medical Expenditure Panel Survey. 2021.Taube, S, Lipson, R. COVID-19 and the Changing Massachusetts Healthcare Workforce. The Project on Workforce at Harvard & The Massachusetts Healthcare Collaborative. Available at: https://www.pw.hks.harvard.edu/post/ma-healthcare-workforce

Boston Indicators and Skillworks. Care work in Massachusetts: A call for racial and economic justice for a neglected sector. September 2022. Available at: https://www.bostonindicators.org/-/media/indicators/boston-indicators-reports/report-files/care_report_083122.pdf

For the direct care workforce, low wages are the crux of challenges at all stages.

Lack of clear opportunities for advancement contribute to attrition

Financial challenge of training

Low wages for high-responsibility work relate to turnover

The upfront cost of training for direct care roles may be burdensome for those paying out of pocket, and it may be difficult to lose wages while training

The prospect of low wages may limit the pipeline

Direct care roles are often not paid a living wage considering the high cost of living in MA

The MA minimum wage has grown more quickly than direct care wages in recent years

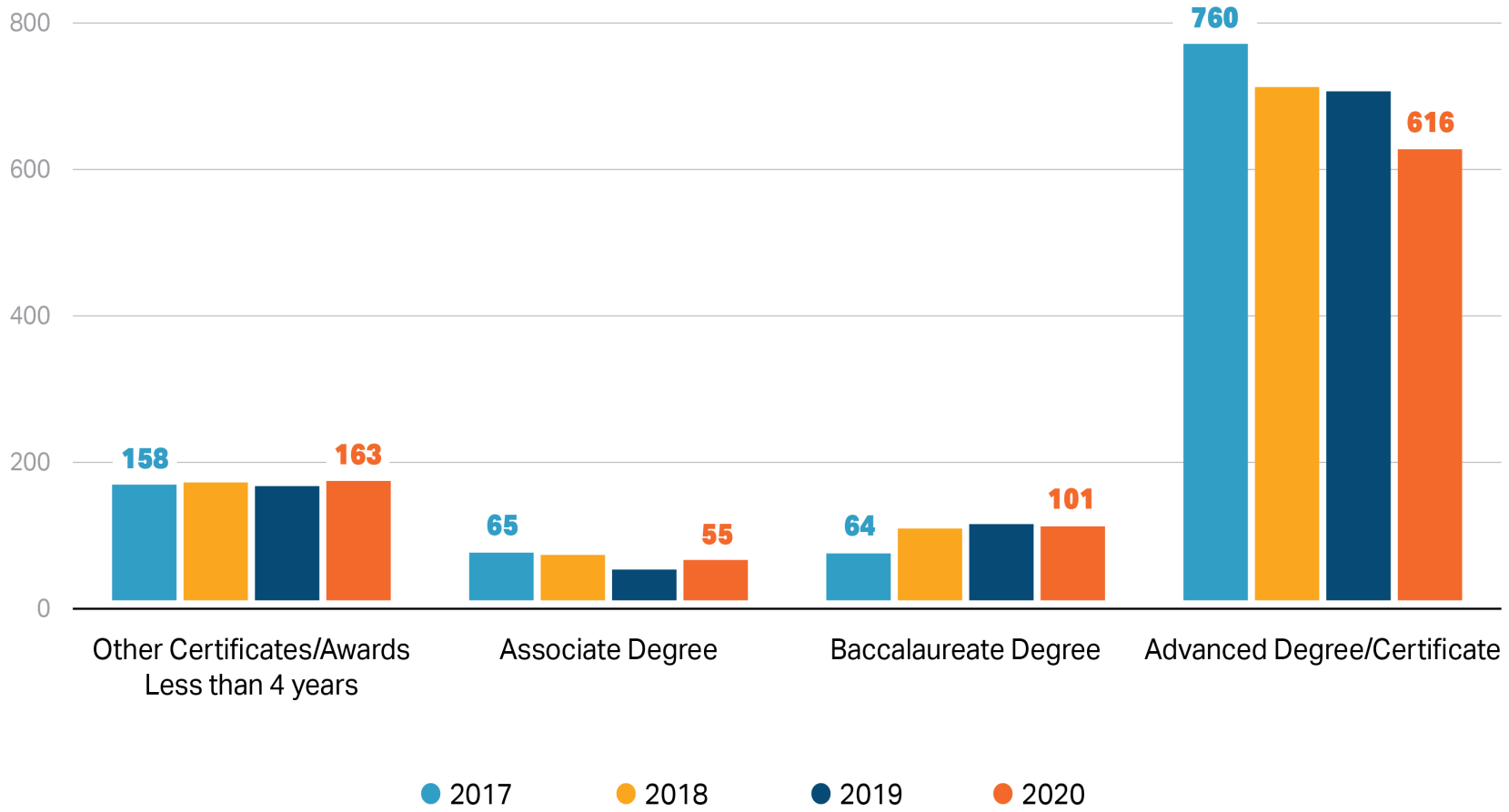
Turnover is especially high in lower-resourced settings, such as long-term care

Comparable wages for less stressful work are available outside of health care

Without clear opportunities and financial support for upskilling, direct care careers may be difficult to maintain

The overall number of mental and behavioral health degrees and certificates have declined, mostly due to declining completion of advanced degrees.

Number of awards conferred by Massachusetts postsecondary institutions for mental and behavioral health studies, 2017-2020



Notes: "Advanced Degree/Certificate" group includes all degrees and certificates above the baccalaureate level. Includes all CIP codes in the "Mental and Social Health Services and Allied Professions" category except for "Genetic Counseling." "Counseling" includes substance abuse, marriage and family, clinical pastoral, trauma, mental health. "Family services" includes infant and toddler mental health services, medical family therapy. Different roles in these professional areas are available based on level of education. Typically, counseling, clinical social work, and psychoanalysis/psychotherapy professions require master's or other advanced degrees. Psychiatric services technician roles can require a certificate or associate's degree in a relevant field.

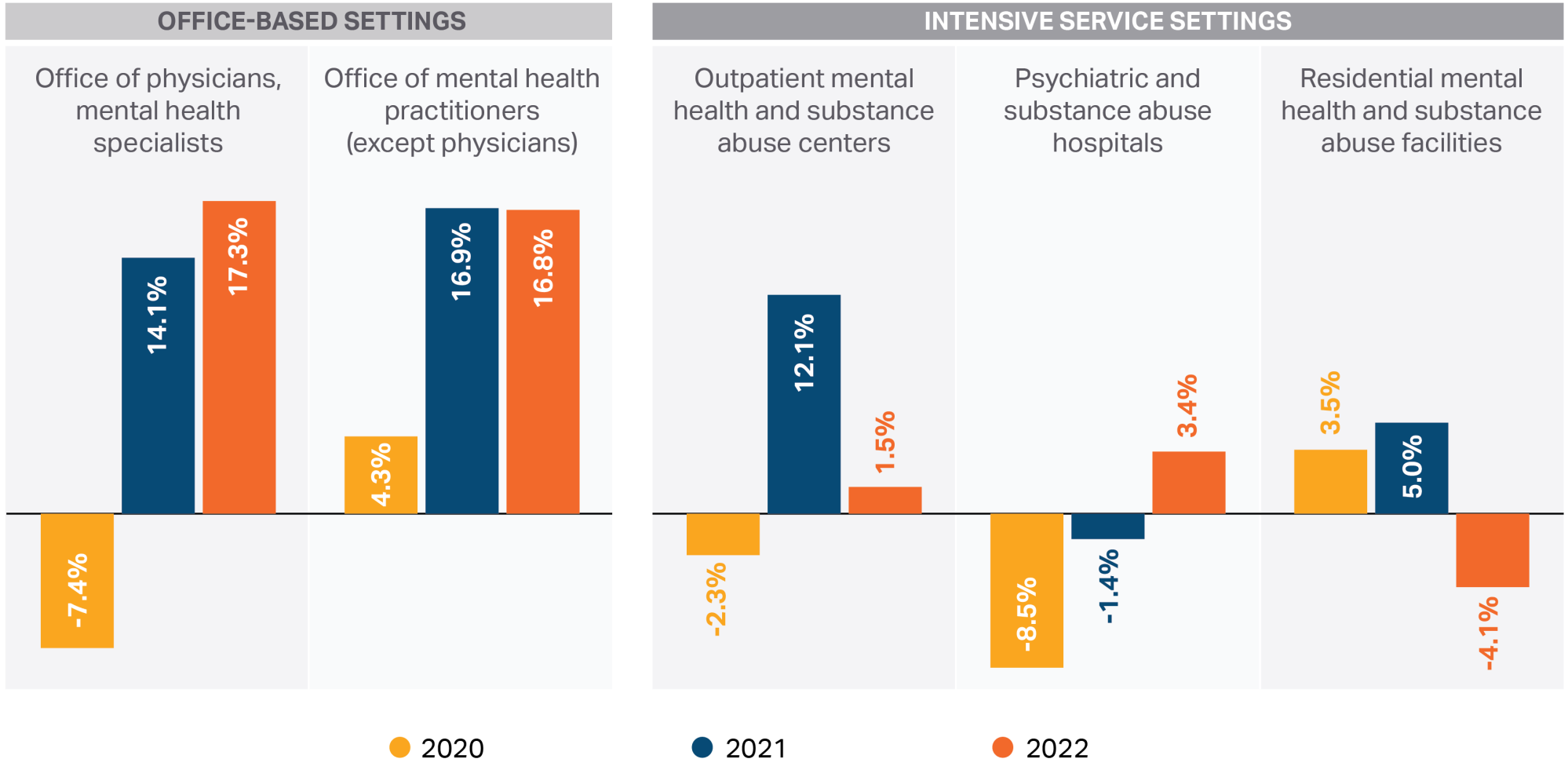
1 Bureau of Labor Statistics, U.S. Department of Labor, *Occupational Employment and Wage Statistics*, 2020-2021.

Exhibit source: Degrees and Certificates Conferred (Completions), U.S. Department of Education. Institute of Education Sciences. National Center for Education Statistics. CY 2017 - 2020

- **Employment has fallen in some roles requiring advanced degrees**: for example, employment of mental health and substance use social workers **fell in MA by 15.7%** from 2019-2021.[1]

Behavioral health employment trends vary by setting, with rapid employment growth in settings adaptable to telehealth, and slower growth or falling employment in intensive outpatient, inpatient, and residential settings.

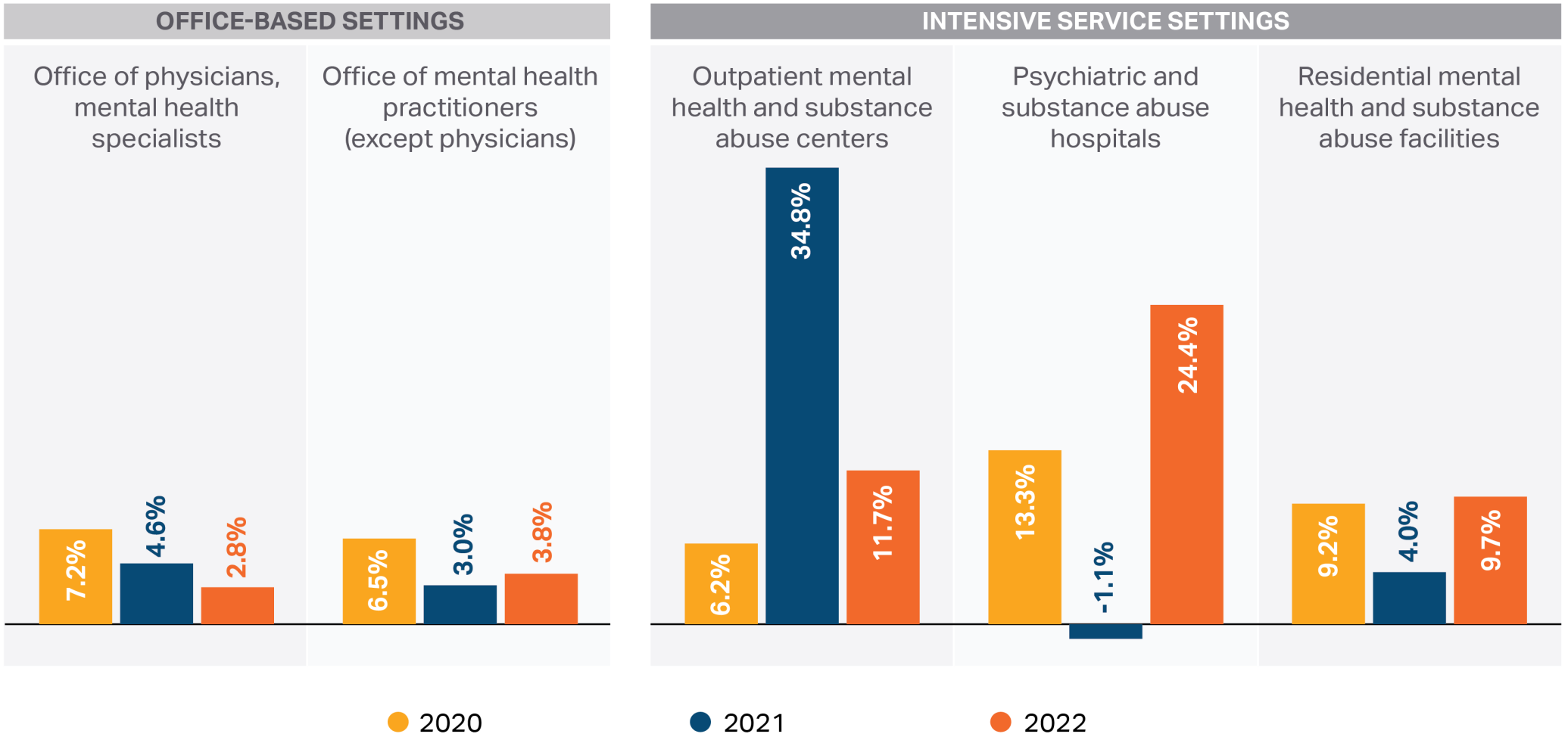
Year to year percent change in average monthly employment (Q1-Q2 average) in behavioral health settings, Massachusetts, 2020-2022



Sources: Bureau of Labor Statistics. Quarterly Census of Employment and Wags CY 2019-2022

Wages have grown rapidly in intensive outpatient and inpatient psychiatric settings, suggesting high demand for providers.

Year to year percent change in average weekly wages (Q1-Q2 average) in behavioral health settings, Massachusetts, 2020-2022



Notes: Average weekly wages are adjusted for quarterly variation.
Sources: Bureau of Labor Statistics. Quarterly Census of Employment and Wags CY 2019-2022

Challenges for the behavioral health workforce relate to the high cost of training and the division between in-person and telehealth care.

Expensive and lengthy training

Low wages can make recruitment and retention challenging

High turnover with varying trends by care setting

Lack of clear paths for advancement

Education and training for many behavioral health roles can be costly and time-consuming

Many roles require advanced degrees, and clinical training hours for students may be uncompensated

Compensation for many roles can be low, especially in outpatient settings

Low pay may be challenging for pre-licensure providers or those with student debt

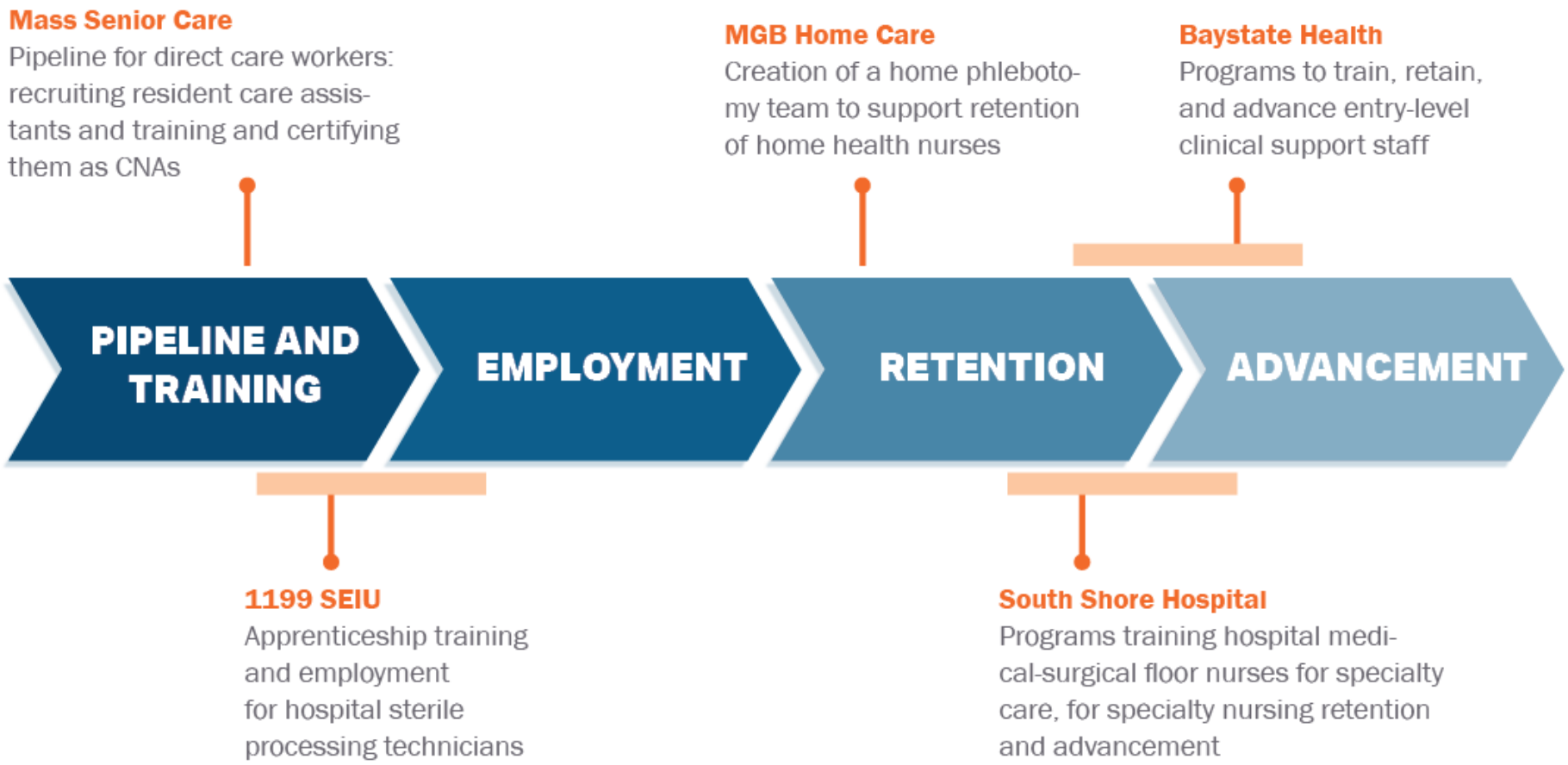
Care settings that are not adaptable to telehealth have lost workers

Turnover is high in both outpatient and inpatient care

There is a need for clearer career ladders for entry-level workers, including more mid-level roles, possibly involving financial support for training

The HPC explored five examples of current initiatives aiming to address health care workforce challenges across all stages of the workforce life cycle.

The workforce initiatives and policy review focus on each stage of the workforce life cycle.



Respondent Perspectives on Workforce Initiatives

- **Mass Senior Care RCA to CNA Program helped alleviate shortages**
  - "We have 30 people now that we wouldn't have otherwise…Given how challenging staffing is, I can only imagine what it would look like with 30 less people in the organization." – *Legacy Lifecare leadership*
- **1199 SEIU Sterile Processing Technician Apprenticeship facilitated career growth**
  - "If given the opportunity, yes, I think I would do it again because…it was a good situation, got me to accomplish the goals that I was hoping it would…this program in particular was a great example of how you learn." – *Program graduate and current sterile tech*
- **MGB Home Care Phlebotomy Team Program allowed nurses to focus on care requiring nursing expertise**
  - "They realized that how much time it freed up for us because drawing a lab is sometimes simple thing, but it's extremely time consuming." – *Case management nurse*
- **South Shore Hospital Transition to Practice Programs helped retain nurses while they pursued their goals**
  - "I'm grateful that the hospital has these programs…I would have had to leave the organization in order to…become an OR nurse if they didn't have it" – *Current OR Transition to Practice program OR nurse in training*
- **Baystate Health Inside-Up Initiatives benefited workers seeking new opportunities**
  - "There's plenty of people who want to do better and get better jobs, but for whatever reason, they just can't. Programs like this will be perfect for them." – *Pharm Tech Training Program graduate and current pharm Tech*

Several Common Themes Emerged Across Workforce Initiatives

- **Collaboration and planning across teams and organizations** is important for successfully launching, running, and expanding programs, and for retaining newly-trained workers.
- **Hands-on learning** is important for preparing trainees for their future roles and is often more engaging than the classroom component of training programs.
- **Training programs often strain existing staff** who serve as mentors, and who may already be stretched thin due to the workforce shortages the training programs seek to address – particularly because **mentors and preceptors are rarely compensated** for their mentorship work.
- Successful advancement initiatives create the **challenge of backfilling newly-vacated roles,** which are often lower-wage positions for which recruitment remains difficult.
- **Workforce initiatives are often expensive** for organizations to run, and funding support from the Commonwealth could ensure their sustainability or help expand them to less well-resourced organizations.
- **Educating organizations about health care apprenticeships** may support expansion of training programs into new roles and organizations.

Broad Takeaways

- Given relatively **tight labor markets** today and in the future, **rebalancing health care worker supply and demand** will require adjustments that ultimately **enhance the attractiveness** of health care positions for which there are workforce gaps.
- **Job attractiveness must be considered relative to alternatives.** For example, hospital RNs may leave for non-hospital or non-patient care positions, while direct care workers may exit health care entirely in favor of comparably or higher paid positions in other sectors. Behavioral health settings often lose employees to better-resourced settings of care.
- **Targeted government investments** can help in certain cases such as reducing entry bottlenecks, seeding innovations and initiatives, and enhancing wages for under-resourced sectors.
- **Health care delivery organizations should invest in their workforce and implement care delivery innovations** to provide attractive schedules, improved work environments, and career advancement opportunities.
- **Clear and accessible career ladders** may help to support **increased health care workforce diversity**.
- **Reducing the burden of avoidable care** requires a broad multi-sector approach including investments in primary care and behavioral health care, care transitions, and payment reform in accordance with value.

Recommendations: Registered Nurses

Massachusetts enjoys a relatively **steady nursing education pipeline and a nursing workforce that grew 15% in size from 2015 to 2021** and is **20% larger** (per capita) than in the US overall. Nevertheless, **high turnover,** especially in hospitals, has destabilized health care work environments.

HEALTH CARE DELIVERY ORGANIZATIONS

- Care delivery organization-based solutions to improve the stability of the RN workforce and reduce vacancy rates and turnover should **focus on job quality and retention,** including improvements in **mentoring and coaching for new nurses, support for preceptors, administrative support, effective use of paraprofessionals, compensation and schedule flexibility, and increased support around incidents of workplace violence.**[1]

THE COMMONWEALTH

- The Commonwealth could support further strengthening the supply of nurses by supporting nursing schools in **streamlining their clinical education requirements**, and by continuing to support and collaborate with the Nursing Council on Workforce Sustainability in their work on this issue.
- Changes that could help improve hospital staffing include joining the **Nurse Licensure Compact** to facilitate permanent hires from other states.

1 Specific examples of workforce innovations and programs along these lines can be found Massachusetts Health & Hospital Association. Innovations in Care: A Compendium of Care Innovations and Strategies. January 2023. Available at https://mhalink.informz.net/mhalink/data/images/MHA%20Innovations%20in%20Care%20Compendium%20-%20January%202023.pdf

Recommendations: Direct Care Workers

The direct care workforce in Massachusetts is characterized by an **acute worker shortage, including declining entry into educational programs, declining employment, and exit from patient care to non-health care sectors with increasingly competitive wages. Low wages without clear opportunities for advancement** contribute to recruitment and retention challenges, particularly given the high cost of living in MA.

HEALTH CARE DELIVERY ORGANIZATIONS

- Care delivery organization-based solutions should focus on **supporting workers in transitioning from training to employment** and offering opportunities for **professional development and advancement.**
- Given the demographics of the Commonwealth's direct care workforce, **clear and accessible career ladders for direct care workers will help increase the diversity of the Commonwealth's health care workforce, and help it better resemble the patients it serves.**

THE COMMONWEALTH

- The Commonwealth can reduce barriers to entry and support retention by expanding **upfront financial support for training and education** and with **policy changes to enhance wages,**[1] and could consider creating additional avenues for career advancement.[2]

1 For example, by setting a wage floor at a percentage or dollar amount above minimum wage, or by providing supplemental payments to facilities to increase workers' hourly wages commensurate with their tenure. See National Governors Association. Addressing Wages Of The Direct Care Workforce Through Medicaid Policies. Nov 1, 2022. Available at: https://www.nga.org/publications/addressing-wages-of-the-direct-care-workforce-through-medicaid-policies/

2 For example, by creating intermediate roles that involve skills training that is transferrable to licensed roles, e.g., the advanced aide role in NY. See New York State Education Department Office of the Professions. Advanced Home Health Aides General Information. Available at https://www.op.nysed.gov/professions/clinical-nurse-specialists/advanced-home-health-aides

Recommendations: Behavioral Health Workers

Even prior to the pandemic, **the supply of behavioral health care providers was insufficient** to meet patients' care needs. **Completion of behavioral health training and education programs has steadily declined** over time – especially completion of advanced degree programs – and there is high turnover and a shortage of care providers across settings of care, often related to wages. However, with the adaptability of office-based care to telehealth, **the need for behavioral health providers has become increasingly concentrated in higher-intensity, inpatient, and residential settings.**

HEALTH CARE DELIVERY ORGANIZATIONS

- Care delivery organization-based solutions should focus on **reducing turnover through higher wages and opportunities for professional development and advancement,** particularly for entry-level workers and in especially in higher-intensity settings.

THE COMMONWEALTH

- The Commonwealth should provide upfront support to alleviate the financial burden of education and training, including for advanced degrees and for the period between education and licensure for licensed roles, and should otherwise reduce barriers to entry.
- Upfront funding for education and training may also support increasing the diversity of the behavioral health workforce.

PANEL 1

REACTIONS FROM THE FRONTLINE: UNIQUE CHALLENGES AND SOLUTIONS ACROSS HEALTH CARE WORKFORCE SECTORS

MODERATOR: DR. MATILDE CASTIEL, HPC COMMISSIONER; WORCESTER CITY COMMISSIONER FOR HEALTH AND HUMAN SERVICES

ANDREA BRESNAHAN, EXECUTIVE DIRECTOR, NURSING COUNCIL ON WORKFORCE SUSTAINABILITY

DR. CARLOS CAPPAS, CHIEF BEHAVIORAL HEALTH OFFICER, LYNN COMMUNITY HEALTH CENTER

FILAINE DERONNETTE, VICE PRESIDENT AT LARGE, 1199SEIU

TARA GREGORIO, PRESIDENT AND CEO, MASS SENIOR CARE ASSOCIATION

JAKE KRILOVICH, EXECUTIVE DIRECTOR, HOME CARE ALLIANCE OF MASSACHUSETTS

SHARON STEMM, ASSOCIATE CHIEF NURSING OFFICER FOR PROFESSIONAL DEVELOPMENT, SOUTH SHORE HEALTH

MASSACHUSETTS
HEALTH POLICY COMMISSION

PANEL 2

WHAT DOES THE FUTURE HOLD FOR THE HEALTH CARE WORKFORCE? RECOMMENDATIONS FOR MASSACHUSETTS TO PROMOTE RESILIENCY AND INNOVATION

MODERATOR: TIMOTHY FOLEY, HPC COMMISSIONER; VICE PRESIDENT FOR 1199SEIU UNITED HEALTHCARE WORKERS EAST

LYDIA CONLEY, PRESIDENT AND CEO, ASSOCIATION FOR BEHAVIORAL HEALTHCARE

MICHAEL CURRY, PRESIDENT AND CEO, MASS LEAGUE OF COMMUNITY HEALTH CENTERS

JULIE PINKHAM, EXECUTIVE DIRECTOR, MASSACHUSETTS NURSES ASSOCIATION

DR. ELLANA STINSON, EMERGENCY MEDICINE PHYSICIAN, MASSACHUSETTS MEDICAL SOCIETY

STEVE WALSH, PRESIDENT AND CEO, MASSACHUSETTS HEALTH AND HOSPITAL ASSOCIATION

MASSACHUSETTS
HEALTH POLICY COMMISSION

THANK YOU

HEALTH CARE WORKFORCE TRENDS AND CHALLENGES IN THE ERA OF COVID-19: CURRENT OUTLOOK AND POLICY CONSIDERATIONS FOR MASSACHUSETTS

SPECIAL FOCUS ON REGISTERED NURSES, DIRECT CARE WORKERS, AND BEHAVIORAL HEALTH PROVIDERS

MASSACHUSETTS
HEALTH POLICY COMMISSION

MARCH 29, 2023