Implementing the Action Plan

A Guidance Document to Recruit, Train, and Retain a Resilient and Diverse Health Care Workforce for New Jersey

Q | NEW JERSEY HEALTH CARE QUALITY INSTITUTE

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INTRODUCTION

The New Jersey Health Care Quality Institute released *Emerging From COVID-19: An Action Plan for a Healthier State* in April 2021. The Action Plan included twenty-four consensus-driven recommendations, informed by the experiences of one hundred health care leaders during the pandemic, to strengthen our health care system. A key focus area of the Action Plan was the need to create and support a resilient and diverse health care workforce for the future. To deliver safe, equitable, person-centered care, New Jersey needs a health care workforce sufficient in size, life experience, diversity, and training to meet the needs of its diverse and aging population.

This guidance document outlines a path forward to build the data infrastructure and systems needed to create and sustain a resilient and diverse health care workforce. It also outlines the workforce issues that need to be addressed and shares current strategies that could be improved upon and other potential strategies to deploy.

To create the guidance document, Quality Institute staff interviewed over fifty stakeholders, including subject matter experts from a variety of health care professions, state government agencies, and academic institutions. These individuals provided input on how New Jersey could improve its efforts to recruit, train, and retain a more diverse health care workforce. To effectively undertake those efforts, however, New Jersey needs more information about the demographic makeup of its existing health care workforce, including its demographic diversity and experience.

The guidance document explains why New Jersey needs more publicly available demographic data on its health care workforce. It highlights three successful health care workforce development models that collect and use demographic data to identify state health care access and workforce needs. Finally, the document explores how a similar system could be created and deployed in New Jersey for all health care professionals.

ACKNOWLEDGEMENTS

DEFINING NEW JERSEY'S HEALTH CARE WORKFORCE NEEDS

A "Health care professional" is a person licensed or otherwise authorized pursuant to Title 45 or Title 52 of the New Jersey Revised Statutes to practice a health care profession that is regulated by the Division of Consumer Affairs or by one of the following boards:[1]

- State Board of Medical Examiners
- New Jersey Board of Nursing
- New Jersey State Board of Dentistry
- New Jersey State Board of Optometrists
- New Jersey State Board of Pharmacy
- State Board of Chiropractic Examiners
- Acupuncture Examining Board
- State Board of Physical Therapy
- State Board of Respiratory Care
- Orthotics and Prosthetics Board of Examiners
- State Board of Psychological Examiners
- State Board of Social Work Examiners
- State Board of Veterinary Medical Examiners
- State Board of Examiners of Ophthalmic Dispensers and Ophthalmic Technicians
- Audiology and Speech-Language Pathology Advisory Committee
- State Board of Marriage and Family Therapy Examiners
- Occupational Therapy Advisory Council
- Certified Psychoanalysts Advisory Committee

Collecting data about the health care workforce is essential to identify shortage areas, estimate workforce supply, create educational opportunities, increase diversity, shape policy decisions, and support financial investment strategies. This data should include race and ethnicity, gender, age, language(s) spoken, practice status, practice locations, the potential for retirement, education, and training background. Having comprehensive data about our current health care workforce is also needed to evaluate the effectiveness of existing programs and to plan for future needs.

New Jersey does not currently have a statewide health care workforce strategic plan, or a vehicle to create one, to bolster and diversify the health care workforce. To create a strategic plan, the state must first have access to comprehensive health care workforce data from its professional licensing boards. Most health care professionals are licensed or certified by boards within the Division of Consumer Affairs. In addition, some allied professionals, such as certified nursing assistants (CNAs) are currently regulated by the Department of Health. There is, however, a legislative proposal to move the licensure of CNAs from the Department of Health to the Board of Nursing in the Division of Consumer Affairs.[2]

Current licensure and certification applications in New Jersey do not ask questions about race and ethnicity, languages spoken, or practice characteristics. To apply for a license, individuals must register with the Division of Consumer Affairs for an "e-gov" account. The initial registration asks applicants to voluntarily submit their ethnicity. Some applications ask for proficiency in written and spoken English. Knowing the percentage of health care professionals who speak certain languages relative to the population in New Jersey would provide critical data necessary to recruit enough native speaking health care workers to provide appropriate care. For example, right now it is exceedingly difficult for older patients, and their caregivers, to find bilingual home health aides.

Some of the health care licensing boards do collect additional information through a separate survey administered when professionals renew their license every two years. The Board of Medical Examiners and the Board of Nursing currently survey physicians, nurses, and home health aides. The survey for physicians is **mandatory** and asks about race and ethnicity, other languages spoken, and practice characteristics such as primary practice site and hours of operation. The survey for nurses is **voluntary** and asks about race and ethnicity, level of education achieved, current employment status, primary employment, position, setting and retirement intentions, and additional states where they may be licensed and practice. The survey for home health aides is also **voluntary** and asks about race and ethnicity, level of education achieved, languages spoken, employment status, employment setting, and retirement. Voluntary survey participation for nurses and home health aides may result in gaps in reporting. Information collected by the Board of Medical Examiners is not publicly reported and therefore is not widely used to support workforce development. The lack of complete and public New Jersey physician demographic data hampers investment and

strategic planning efforts to create a diverse workforce and one that can meet the growing needs of our aging and diverse population. More information is needed from every health care professional licensed or certified by the state and should be made publicly available to inform a statewide health care workforce strategy.

The need to better understand and problem solve health care workforce issues has never been more critical. The COVID-19 pandemic stressed an already strained health care workforce, especially in certain sectors and positions. Throughout the pandemic, health care workers experienced post-traumatic stress, and some have left the health care workforce altogether. The U.S. Bureau of Labor Statistics estimates that the health care sector lost nearly half a million workers since February 2020. Morning Consult, a survey research company, reported that that 18 percent of all health care workers have quit since the pandemic began.[3]

Many advocacy organizations and government agencies have long predicted health care workforce shortages. In 2017, the U.S. Health Resources and Services Administration (HRSA) predicted that New Jersey would face the third largest nursing shortage in the nation by 2030, with a projected shortfall of 11,400 registered nurses.[4] In addition to workforce shortages there is also an insufficient number of physicians from underrepresented groups practicing across the nation. With one of the most diverse populations in the country in New Jersey, this is particularly concerning. We need a physician workforce that represents the communities we serve. National accrediting organizations and HRSA recognize the benefits of supporting measures that create or expand increased diversity of historically marginalized individuals in health careers and medicine.[5] The pandemic's impact on health care workforce shortages and disproportionate impact on minority communities must be addressed.

Moreover, many health care workforce reports fail to recognize there are even greater shortages among allied health professionals, which then further strain the entire health care system. Allied health care workers make-up about 60 percent of the U.S. health care workforce. Mercer's 2021 External Healthcare Labor Market Analysis report examined health care labor statistics for the next five to 10 years in every state and at county, state, regional and national levels. One of the main findings is that there will be a labor shortage for lower-wage jobs, limiting access to home care. About 9.7 million individuals currently work in lower-wage health care positions with the need in the next five years rising to 10.7 million.[6] Allied health professionals include respiratory therapists, dental hygienists, dental assistants, certain mental health providers, certified nursing assistants, medical assistants, and home health aides, among many others. This group of professionals are among the lowest paid in the health care system and often experience barriers that prevent them from pursuing further education or training that would allow them to advance professionally.

With more publicly available health care workforce demographic data, New Jersey would be in a stronger position to understand and quantify the pandemic's impact on the current health care workforce, better able to address the underlying factors that contribute to workforce shortages, and better positioned to execute a workforce development strategy that also improves diversity.

MODELS FOR USING DATA TO DRIVE DECISION MAKING

There are many successful models for health care workforce data collection and analysis across the country. Here we examine three models that can each contribute essential elements to standing up a Health Care Workforce Reporting Program in New Jersey.

The Center for Health Workforce Studies (CHWS) in New York is one of nine health workforce research centers in the United States sponsored by the Health Resources and Services Administration (HRSA) and dedicated to providing health care workforce data and information to support decision making. Its work has supported the need for health workforce policy changes in New York and serves as an example of what New Jersey could do if supported with better data to implement workforce reforms. HRSA recently released a notice of funding opportunity for states to join the Health Workforce Research Center Cooperative Agreement Program.[7] This application window has closed, but New Jersey could consider applying for a future opportunity to create a HRSA-funded health workforce research center.

New York also recently signed into law the Health Professionals Practice Information Bill (A.3050/S.3543).[8] The law requires the State Education Department to collect information from certain licensed health professionals about themselves and their practice. The intent of the law is to strengthen the state's health workforce by generating new information about where and how New York's health care professionals' practice. The New York State Department of Health and the Center for Health Workforce Studies will use this information to evaluate workforce capacity and access to needed health care services. New Jersey would benefit from similar data collection.

The New Jersey Collaborating Center for Nursing (NJCCN) was established by law in 2002[9] to develop a strategic plan for the continued development of an adequate nursing workforce, in number, education, and training, to meet the needs of New Jersey residents. NJCCN receives the New Jersey Board of Nursing (NJBON) Nursys® license renewal survey information and analyzes it each year in its Workforce Supply Data Reports. Current data response rates reported by NJCCN are between 68-81%, which underscores the need for a mandatory survey process that is publicly reported for broader use.

NJCCN uses the data it receives from the NJBON survey as well as supply and demand data

based on nationally researched tools[10] to focus on workforce deficits, faculty shortages, health, and well-being of nurses. NJCCN's data driven work has enabled it to provide more information to policymakers, the public, and the health care industry about the nursing profession. NJCCNs data has been used to support policy changes, funding proposals, and multi-stakeholder advocacy efforts through the New Jersey Action Coalition.[11]

NJCCN recently released the Home Health Aide Data and Analysis,[12] which shows that home health is an area in dire need of attention and support in New Jersey. From 2017 to now, the home health aide workforce in New Jersey has seen a 16.5% reduction. There are now 10,000 fewer home health aides than there were in 2017 to provide direct patient care related to activities of daily living for older adults and individuals with disabilities, chronic illnesses, or cognitive impairment. Further analysis reveals that New Jersey home health aides are primarily female, Black/African American, and have a high school diploma or general equivalency degree. Sixteen percent of respondents to the survey indicated they had two or more jobs to support themselves and their families. This data helps to quantify the home health aide shortage in New Jersey and is an example of the value of having data and using it in strategic planning, policymaking, and investment decisions.

Expanding the NJCCN model of data collection, analysis, and advocacy to include all health care professions in New Jersey would support future workforce development. However, replicating this structure for every health care profession may be cost-prohibitive and inefficient. We envision a statewide strategy to create a health care workforce reporting program for all health care professions that works in tandem with

NJCCN and has the benefit of learning from a successful model that already exists in New Jersey.

The **Oregon Health Care Workforce Reporting Program (HCWRP)** is a model for creating and updating a statewide health care workforce strategy. Before pursuing its strategy, Oregon experienced a health care workforce environment much like New Jersey — one with little data to understand the health care workforce makeup and no process to have industry experts analyze the landscape and make recommendations for improvement. Now, Oregon has data to better understand its health care workforce, to adjust its incentive programs, and to meet its needs.

In 2009, Oregon passed house bill 2009,[13] which created the Oregon Health Authority[14] (OHA). OHA oversees most of Oregon's health-related programs including behavioral health, public health, Oregon State Hospital, and the state's Medicaid program. Its policy work is overseen by a nine-member Oregon Health Policy Board.[15]

Among many provisions included in house bill 2009, the law tasked OHA with creating the Health Care Workforce Reporting Program (HCWRP).[16] The HCWRP collects information through OHA's health care workforce regulatory boards from applicants during the licensure and licensure renewal process. Health care professionals including physicians, physician assistants, nurses, dentists, dental hygienists, physical therapists, pharmacists, and licensed dieticians all provide this information. This information includes demographics, including race and ethnicity, practice status, education and training background, population growth, economic indicators, and incentives to attract qualified individuals, especially those from historically underrepresented or underserved groups to health care education.

Part of the HCWRP includes a multi-stakeholder group of industry volunteers called the Oregon Health Care Workforce Committee ("Committee").[17] The Committee meets every other month to review the data from the HCWRP and make recommendations to the Health Policy Board. The recommendations and action plans created by the Committee help the Health Policy Board implement necessary changes to train, recruit and retain a dynamic health care work force that is scaled to meet the needs of new and evolving systems of care. Current members include physicians, nurses, dentists, academics, behavioral health experts, and human resource professionals. There is also a non-voting member who is a medical student in training. The Committee focuses on identifying resources, needs, and supply gaps, and ensuring a culturally competent workforce that is reflective of Oregon's increasingly diverse population.

The Committee's statutory responsibilities include biennial evaluations of the effectiveness of health care provider incentives in Oregon, health care workforce needs assessments, and profiles of Oregon's current health care workforce. The Committee also provides strategies around creating career ladders, clinician burnout rates, clinician and patient satisfaction, and education and training capacity of health professionals.

In 2020, the Committee released a report and companion dashboards on The Diversity of Oregon's Licensed Health Care Workforce.[18] This report utilized newly collected data from the HCWRP to explore the race, ethnicity, gender, and language makeup of Oregon's licensed health care professionals compared with that of the state. The report raised an important discussion about whether the workforce is culturally and linguistically representative of the population that it serves. Without data from the HCWRP, this report would not have been possible.

We propose a program in New Jersey that includes essential elements from each of these three models. Critical to all of them is the concept that more robust data should be collected from every licensed health care professional and analyzed to support long-term workforce development strategies. In addition, the New Jersey Health Care Workforce Reporting Program should imitate New York's strategy to pursue Federal funding to achieve the goals of the program. The program should also incorporate NJCCN's strategy to collect data and analyze it in concert with supply and demand data to educate policymakers and the public about workforce needs. Finally, the program should include Oregon's strategy to collect data from every health care profession and utilize the guidance of a multi-stakeholder committee to create a statewide health care workforce strategic plan that addresses development and diversity.

HOW NEW JERSEY COULD BENEFIT FROM DATA COLLECTION AND ANALYSIS

New Jersey could benefit from each of these data collection and analysis models by creating a strategy with robust health care workforce data and a multistakeholder strategic planning committee. With this approach, New Jersey would be in a better position to address the critical issues outlined below to create a more resilient and diverse health care workforce.

A. Targeted Outreach and Recruitment

Recruiting a health care workforce for the future starts with early exposure for young people to learn about and experience careers in health care. There are many existing health care career and technical education programs offered in New Jersey. These programs would benefit from a central repository for promotion and outreach to targeted audiences, including middle school and high school students. Some of the programs are being administered by the New Jersey Department of Education Office of Career Readiness[19]; medical schools such as Cooper Medical School of Rowan University[20]; non-profit organizations such as Jobs for America's Graduates New Jersey;[21] county vocational-technical schools[22]; and by many of the state's eighteen community colleges.

The health care industry also has a role to play in outreach and recruitment. Facilities, organizations, and associations can contribute to the information being shared with young people about pursuing careers in health care. The Health Care Association of New Jersey (HCANJ),[23] which represents many of New Jersey's long term care facilities, is creating a video that highlights the career pathways in long-term care and features testimonials from nursing home workers. The video will be a tool for HCANJ and its members to encourage young people to consider a career in long-term care.

Collecting comprehensive health care workforce data could support further development, promotion, and targeted outreach for these programs to ensure they benefit the people, places, and specific health care professions in the greatest need of workforce development.

Through a partnership between the Winthrop Rockefeller Institute and the Rural Health Association of Arkansas, health care stakeholders attended yearly summits and participated in workgroups from 2017-2020 to address issues such as critical workforce shortages. One of these workgroups was tasked with addressing student exposure to health care experiences and careers. In their 2019 Rural Health Summit Workgroup Summary Report,[24] much like New Jersey, the group identified many distinct groups across the state already working to expose students to careers in health care. The report laid out next steps to increase awareness and expand the health career programs and resources that were already available across the state. The group "created and curated an exhaustive list of all the available health education programs and their administrators in a sizable resource guide. Over two thousand physical copies of that guide were printed and distributed at school-related conferences, state health offices, and in the hands of Summit attendees."[25]

i. Improve Access to Targeted Health Care Career and Technical Education Programs

A multi-stakeholder health care workforce Committee could work with the state, academic institutions, health care providers, and non-profit organizations to produce an online resource guide and site of currently available career preparatory programs in New Jersey. This guide and site could include information from the New Jersey Department of Labor about the health care professions with the greatest demand. The Center for Health Workforce Studies in New York maintains a similar online resource guide with information and resources for individuals interested in health care careers.[26]

In addition to expanding the information available about health care career and technical education programs, New Jersey should use workforce data to support expanding proven training programs. A pending bill in the New Jersey Legislature, A1311,[27] would establish a four-year health care careers pilot program to encourage institutions of higher education and proprietary institutions to partner with

the Jobs for America's Graduates (JAG) program. JAG is a nationwide dropout prevention program that helps young people build professional skills, earn credentials, gain employment, and enter postsecondary education. Students are placed on pathways to academic and economic success through classroom learning, coaching, leadership development, and job placement. The New Jersey Health Care JAG pilot would help create programs that encourage students in high schools in underserved areas to pursue career opportunities in the health care field.

Since the graduating class of 2013, JAG NJ seniors have graduated at a rate of 97%-100%. Research conducted by Drexel University comparing JAG students to the normal population has shown JAG graduates were 2.8 times more likely to be employed fulltime.[28] A Health Care Workforce Committee could identify similarly successful programs, like JAG NJ, to serve as vehicles for greater investment in health care workforce development and diversification opportunities. The Committee could also align similar programs together to encourage the sharing of best practices and to avoid any redundancies.

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B. Training

Preparing our health care workforce for the future requires having enough academic faculty to teach, clinicians to mentor and train, and health care facilities to provide a training environment. On the heels of the pandemic, with an exhausted health care system and workforce shortages, we have an even greater need to expand our education and training system.

The state, in partnership with New Jersey's Community Colleges and the New Jersey Business and Industry Association, has invested in NJ Pathways to Career Opportunities.[29] This collaborative effort aims to provide students and workers with the career pathways they need to find new careers and jobs, and to ensure that employers have access to a highly skilled workforce to meet critical labor market needs. Health Services Collaborative is one of four Pathways Collaboratives that hosts several Centers of Workforce Innovation that will build pathways in critical shortage areas of patient care and health care technology and administration. This effort is a major step forward in expanding the training available to people interested in careers in health care and ensuring that there is broad access and information about viable career development opportunities across the state.

Having comprehensive health care workforce data and convening the Committee would add to the work of the Pathways program by informing program leaders of the current supply of health care workers and tracking annually which professions are in need. Obtaining information about future retirement plans would also help to better understand future potential shortage areas. Having these data would foster productive deliberations and policy decisions to combat health care workforce shortages.

i. Track Educational Pipeline to Inform Supply and Demand

In addition to better understanding our current health care workforce and how workers intend to practice through the Health Care Workforce Reporting Program, we need to know how many academic training programs are being offered, how many people are entering these programs, and who is completing them. Tracking our educational pipeline is critical to understanding the health care workforce supply and demand.

The Center for Health Workforce Studies (CHWS) publishes the NY Health Workforce Planning Data Guide and updates it every two years.[30] The Data Guide includes information about the health status of the population, the current health workforce, and the educational pipeline. The Data Guide is meant to assist regional stakeholders in identifying the most pressing health workforce needs and match the educational pipeline with those needs. CHWS also publishes the New York Graduate Medical Education (GME) Data Dashboard.[31] The dashboard includes data collected from GME programs around the state on graduates' demographics, education debt, job market experiences, and expected income. These data sets are important tools for policy decision making and could be replicated by the Committee and other stakeholders.

ii. Address Academic Faculty Shortages

According to the American Association of Colleges of Nursing (AACN) 2019-2020 Enrollment and Graduations in Baccalaureate and Graduate Programs in Nursing report, U.S. nursing schools turned away 80,407 qualified applicants from baccalaureate and graduate nursing programs in 2019 due to insufficient number of faculty, clinical sites, classroom space, and clinical preceptors, as well as budget constraints.[32] Nurses may not be pursuing careers as faculty members due to insufficient wages. A survey by the American Association of Nurse Practitioners (AANP) shows the median salary of a nurse practitioner, across settings and specialties, is $110,000, but the average salary for master's-prepared assistant professors in nursing schools was just under $80,000.[33]

The New Jersey Higher Education Student Assistance Authority (HESAA) runs the Nursing Faculty Loan Redemption Program[34] to address the current and projected critical shortage of nurse faculty. The program offers up to $50,000 of student loan redemption in exchange for full-time faculty employment at a school of nursing in the State of New Jersey for a five-year period following completion of the approved graduate degree program. The program is currently allocated just $375,000 in state funding. In fiscal year 2019-20, only five Nursing Faculty participants received loan redemption through the program.[35] While insufficient wages are likely the driving factor in nurse faculty shortages, the Nursing Faculty Loan Redemption program could be a valuable recruitment tool for nursing schools. $50,000 of loan redemption is too small for the required five-year commitment as compared to the Primary Care Practitioner Loan Redemption Program, also run by HESAA, that provides $120,000 of loan redemption for a two-year minimum commitment. There is also an eligibility requirement that says employment must begin within one year of completing approved graduate program. Most nursing school graduates aim to practice as a nurse and gain experience before pursuing a faculty position. These, and other issues, should be reevaluated to improve the use of the Nursing Faculty Loan Redemption Program as a recruitment tool.

Other states are making more significant investments to combat faculty shortages. The Maryland Higher Education Commission administers the Nurse Support Program II. NSP II focuses on expanding the capacity to educate nurses through nursing education programs at Maryland institutions.[36] NSP II recently awarded $29.3 million in grants for 29 proposals at 14 nursing schools to promote new and creative options for their nursing professionals.[37] One of the awarded proposals was for continuing the Faculty Academy and Mentoring Initiative (FAMI) at Salisbury University to include advanced curriculums and expanded partners at schools and hospitals across the state to prepare 500 clinical instructors. FAMI prepares experienced Bachelor or higher degree prepared registered nurses for new roles as clinical nursing faculty members.

The Committee, informed by more comprehensive workforce data, could work with HESAA to study, and recommend investment strategies, like those employed by Maryland, to address barriers to faculty recruitment, training, and retention in New Jersey.

iii. Expand Residency Slots and Clinical Placement Sites for Critical Shortage Areas

Once health care workers finish their formal educational training, many professions require additional on-the-job training, such as a residency for physicians or clinical placement sites for other professionals, such as midwives. Clinical training is required for many health care workers pursuing a license to practice. If there are not enough residency slots or clinical placement sites for prospective health care workers to train, a bottleneck in the process of adding professionally trained health care workers to the workforce will form.

Graduate medical education (GME), the residency and fellowship training where physicians differentiate into specialties, is required for any physician pursuing a license to practice medicine. GME is funded by federal, state, and private dollars, with Medicare paying the lion's share. The Balanced Budget Act of 1997 capped the number of residents that would be paid for under Medicare, creating a "match squeeze," whereby some medical students could not find a residency slot match. In 2021, CMS passed a rule that will fund 1,000 new Medicare-funded physician residency slots to qualifying hospitals, phasing in two hundred slots per year over five years. These slots will be prioritized by Health Professional Shortage Areas (HPSAs), which can be geographically underserved areas, rural areas, state mental hospitals, federally qualified health centers and others. New Jersey currently has just thirty-seven designated HPSAs, whereas a larger and more rural state like California has 652.

One area affected by the lack of residency slots is mental health care. Access to mental health care is at a crisis point, due, in part, to the pandemic. According to Jennifer Thompson, executive director of the National Association of Social Workers' New Jersey chapter, those seeking mental health help are seeing a 30-to-60-day wait for a private practice counselor — if they can get in at all — and a three- to five-month wait to see an agency therapist."[38] To expand the number of residency slots available to prospective physicians, the state can play a supporting role. In Governor Murphy's FY22 and FY23 budgets, $4 million was allocated to the Psychiatry Residency Expansion Program for ten new four-year residency slots that supplement existing psychiatry resident training slots.[39] These ten new slots will support providers treating individuals with mental health and substance use disorders and individuals dually diagnosed with mental health conditions and intellectual and developmental disabilities.

Another area affected by lack of access to clinical training is midwifery. With support from the Burke Foundation, the Quality Institute recently released _Delivering Better Care: Midwifery Practice in New Jersey_,[40] a report that outlines how we can strengthen and support midwifery in New Jersey.[40] The report identified that clinical placement spots for midwifery students in New Jersey are extremely limited, that there is a great deal of competition across programs to gain placement, and that privately funded universities may have access to endowment funds that can factor into which programs get placement spots. Additionally, clinical preceptors are not typically reimbursed for the considerable time and resources spent when serving in this role, which can deter participation and result in even fewer placements for midwifery students. Having greater access to practice information such as how many licensed providers are practicing, and where, would allow the state to make critical investment decisions about how many more residency slots and clinical placement sites are needed. Collecting additional survey data year over year could also help identify other high need areas that need state support.

C. Retention

Ongoing staff turnover is costly. Increased pay for temporary staff, time spent recruiting, interviewing, and onboarding can have a negative impact on care delivery. Health care worker retention is not a new problem but has been exacerbated by the pandemic. Some of the more effective interventions include paying a living wage, providing benefits that improve quality of life, and offering career growth opportunities.[41]

Having access to more information about the health care workforce, including race and ethnicity, languages spoken, and current employment status can help New Jersey better understand the workforce and its socioeconomic needs. Employers' retention strategies should be informed by knowing the real-life challenges that workers must overcome to be employed and the necessary incentives to retain them.

i. Inform Retention Strategies for Employers

Sixty percent of the health care workforce is in direct care. Eighty-six percent are female, fifty-nine percent are people of color, twenty-six percent are immigrants, and fifteen percent live below the federal poverty level.

This includes home health aides, personal care attendants, and certified nursing assistants, among others. These workers provide services such as helping people bathe, cleaning their homes and preparing meals, managing medication regimens, and providing companionship. Some are drawn to the field because of their experiences caring for family members and by the low barrier to entry; unlike some other entry-level careers in health care, direct care workers may not need training or certifications before finding work.[42]

A low barrier to entry is what attracts people to the direct care field, but one strategy to keep them there are opportunities for advancement. The investment made by the state to create the Pathways to Career Opportunities program will be critical in this effort. Health care organizations can also play a role in career development opportunities for their prospective employees. Parker Health Group, a not-for-profit, New Jersey-based aging services organization that provides nursing care, assisted living, memory care, post-acute rehab, and adult day services was facing a certified nursing assistant shortage during the pandemic. As a certified CNA school, Parker initiated a class in 2021 to recruit new CNAs to train. Parker recruited staff from their own dining and recreation programs, paid for their training onsite, allowed them to continue to work, and had existing nursing staff mentor them as they sought out a new career path. With more data, the state and private businesses can work together to target programs, like the CNA school at Parker, to support the professions with the greatest need and tailor programs to meet the needs of the people applying for them.

Other factors that impact retention include the need to make a living wage and increased competition for low-wage workers.

According to the Massachusetts Institute of Technology living wage calculator,[43] a single adult living in New Jersey needs to make $18.22 per hour to earn a "living wage." With one child, they would need to make $38.05 per hour. A living wage is considered income to meet minimum standards given the local cost of living. According to Indeed, a widely used job website, the average base salary for a home health aide in New Jersey is $15.02 per hour, certified medical assistants make $17.77 per hour, and certified nursing assistants make on average $20.04 per hour.

PHI, a national nonprofit dedicated to transforming eldercare and disability services, reported in 2019 that 39% of all direct care workers in New Jersey are living at 200% of the Federal poverty level.[44] Other states, like Colorado and Michigan, have committed additional resources to ensure that direct care workers make a living wage through wage reform and hazard pay.[45]

Added pressure comes from competition for these low-wage health care workers from major retailers, like Amazon, paying higher hourly wages, offering sign-on bonuses, and other attractive benefits. The average starting pay for an entry-level position at Amazon warehouses in New Jersey is more than $18 an hour, with the possibility of as much as $22.50 an hour,[46] and a $3,000 signing bonus, depending on location and shift. Full-time jobs with the company come with health benefits, 401(k)s and parental leave.[47] In 2020, ROI-NJ reported that Amazon surpassed health care systems RWJBarnabas Health and Hackensack Meridian Health as the largest employer in New Jersey, with over 40,000 jobs.[48]

Another example of pandemic driven market competition is the proliferation of travel nursing agencies. According to a report from the New Jersey Hospital Association, Healthcare Employers in Dire Need of an Expanded Workforce Pipeline, hospitals spent approximately $222 million for agency and traveler staff in 2020 and are projected to have spent more than three times that amount – $670 million – in 2021. This represents an increase of 202 percent in just 12 months.[49] Travel nurses now can be paid between $5,000 and $10,000 per week."[50]

Childcare responsibilities are another barrier in retaining a majority female workforce. In 2019, the U.S. Census Bureau found that women hold 76% of all health care jobs.[51] Women typically perform most childcare duties, and at the height of the pandemic that became far more difficult with children attending school from home and daycares being closed. Many hospitals across the country have invested in onsite childcare for staff as a retention tool and are starting to see returns on their investment.[52]

Most of the current data available to help us understand the makeup of the health care workforce comes from national publications. If employers had access to New Jersey specific data, with guidance from a committee, they could make better educated decisions about what retention strategies will resonate with the workforce they employ.

ii. Inform State Incentive Strategies

The cost of going to medical school varies and increases by about 2% to 3% every year. According to the AAMC, in 2018-2019 the average cost of public medical school in the United States was $36,755 per year for in-state students and $60,802 for out-of-state students.[53] Medical students can graduate with upwards of $200,000 in debt and many choose to leave New Jersey and practice elsewhere. New Jersey has the seventh highest attrition rate for medical residents. According to the AAMC, in 2021, 2,684 (52.3% of all medical residents in New Jersey) are practicing in another state after finishing their residency here. The cost of medical school combined with our prohibitive cost of living can deter people from pursuing careers in health care in New Jersey and deters students from pursuing primary care fields which are lower paid than most specialties. Pursuing attractive financial incentive strategies, which are targeted to the State's needs, will improve our ability to compete for the best medical talent to train and practice in New Jersey.

The New Jersey Higher Education Student Assistance Authority (HESAA) provides students and families with financial and informational resources for students to pursue their education beyond high school. HESAA administers financial aid programs, scholarships, college savings plans, and a loan redemption program. Specific to health care, HESAA runs the Primary Care Practitioner Loan Redemption Program.[54]This program provides for the redemption of eligible primary care practitioners' student loan expenses in exchange for specified periods of service in medically underserved areas. Eligible clinicians include physicians, dentists, physician assistants, certified nurse practitioners, and certified nurse midwives. The program provides up to $120,000 in student loan redemption for two to four years of service as a primary care practitioner in areas ranked by the New Jersey Department of Health as experiencing a health professional shortage. In fiscal year 2019-20, forty-five primary care practitioners received loan redemption through the program. There is currently a waiting list to access these funds. Much like the Nursing Faculty Loan Redemption Program, this program should be reevaluated to better understand the return on investment to the state and whether additional funds should be allocated.

Using comprehensive workforce data, the newly formed Committee could also work with HESAA to study the areas of greatest need in the state and offer practical feedback about ways to attract more health care workers to pursue loan redemption through the Primary Care Practitioner Loan Redemption Program.

Pursuing attractive financial incentive strategies, which are targeted to the State's needs, will improve our ability to compete for the best medical talent to train and practice in New Jersey.

THE IMPLEMENTATION JOURNEY

The health care worker shortages we experienced during the pandemic clearly revealed that New Jersey needs more health care workers now. As described, there are many initiatives underway to bolster the current health care workforce in New Jersey. In addition to improving health care career pathways through the NJ Pathways to Career Opportunities program and expanding the number of residency slots for critical shortage areas, there are also industry specific coalitions forming to address the very nuanced issues facing health care professionals. Coalitions of mental health professionals, direct care professionals, and midwives for example are needed to address underlying issues that could be barriers to improving workforce development. The role of the Health Care Workforce Reporting Program and Committee will be to supply long-term workforce data and analysis that supports the great work already being done by these groups to provide immediate workforce shortage relief.

New Jersey will be in a stronger position to maintain adequate staffing levels during a health care emergency if a program, like those highlighted from New York, NJCCN, and Oregon, is established. By benefitting from the experience of successful models, applying existing resources and data collection activities, and leveraging available federal recovery funding, the time is now, and the pace can be accelerated.

New York, NJCCN, and Oregon all began collecting additional licensure information through state legislation. New Jersey could take similar action and empower the Division of Consumer Affairs to create and oversee these programs.

Any proposal should include:

- A requirement that all health care professionals be administered a mandatory survey upon licensure and renewal. This approach can be phased in with a limited number of boards implementing the program each year. Current surveys administered by the Board of Medical Examiners and Board of Nursing should be evaluated to ensure consistency.
- An educational campaign for current and prospective health care professionals to illustrate the need for the information and its intended use.
- Dedicated project management and data analytics staff for the Division of Consumer Affairs to accomplish the goals of the program.
- Funding for a sophisticated data dashboard to publicly display the results of the data collected. Oregon makes its data dictionary of information fields public[55] and includes links to each survey administered. The survey data collected by its professional boards is made public in an online data dashboard[56] that offers supply by occupation, supply by county, and demographics and practice information. The dashboard shows how the data has changed over the time that they have been collecting it and uses heat maps and tables to illustrate geographic disparities in direct patient care.
- A data dictionary is necessary and should include fields such as demographics, including race and ethnicity, gender, age, language(s) spoken, practice status, office/practice geo locations, the potential for retirement, education, and training background.
- A process by which multi-stakeholder members of a Health Care Workforce Committee are identified, appointed, and staffed or externally supported for strategic planning.

A. Funding

The Oregon Health Authority promulgated regulations[57] to establish a per-license fee to cover the cost of collecting and reporting health care workforce information. The fee is calculated by adding the costs necessary to compile, maintain, and analyze the health care workforce information and dividing that cost by the approximate number of individuals licensed in Oregon. The fee may not exceed $4.00 per individual licensed for two years and $2.00 per individual licensed for one year. NJCCN is also funded through existing nurse licensure fees collected by the Division of Consumer Affairs.

The Division of Consumer Affairs collects fees from all applicants for licensure and licensure renewal. The amount of the fee varies by type of license. According to the proposed FY23 state budget, $38.5 million of the fees collected from several State professional boards, advisory boards, and committees located in the Department of Law and Public Safety are unspent and appropriated to the state general fund.[58] Pages C-5 and C-6 of the budget includes actual figures for what each board collects. In 2021, the health care related boards collected $959,630 in total licensure fees. That number may vary each year depending on the number of applicants and licensure renewal schedule. Rather than increasing the fees paid by applicants, the Division of Consumer Affairs should allocate some of the unspent funds to increased staffing, technology upgrades, and program costs to support the Health Care Workforce Reporting Program. This approach could be offset by one-time American Rescue Plan Act (ARPA) funds for infrastructure, governance, and development work.

CONCLUSION

Supported with data about our health care workforce, a workforce Committee of industry experts, and input from a broad array of stakeholders, New Jersey could develop strategies to combat some of these critical issues that exacerbate staffing shortages and could create a diverse pipeline of health care workers for the future. Investing in a Health Care Workforce Reporting Program and Committee now would prevent future critical health care workforce shortages in an emergency. The COVID-19 pandemic caused unprecedented disruption to our health care system and our everyday lives. But it will not be the last health care emergency. We can and should be better prepared for the reality that our population is growing, aging, and becoming increasingly diverse. We need a strategy to build and support a health care workforce that not only meets, but exceeds, the needs of our patient population.

APPENDIX A – INTERVIEWEES

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APPENDIX B – GLOSSARY

- **American Association of Colleges of Nursing (AACN)** – is the national voice for academic nursing. AACN works to establish quality standards for nursing education; assists schools in implementing those standards; influences the nursing profession to improve health care; and promotes public support for professional nursing education, research, and practice.
- **American Association of Nurse Practitioners (AANP)** - is a North American for profit, membership organization formed in 2013 because of a merger between the American Academy of Nurse Practitioners (founded in 1985) and the American College of Nurse Practitioners (founded in 1995) to provide nurse practitioners with a unified way to

network and advocate their issues. The American Academy of Nurse Practitioners was the first organization created for nurse practitioners of all specialties in the United States of America, and AANP remains the largest national membership organization for nurse practitioners in the United States.

- **Association of American Medical Colleges (AAMC)** - is a nonprofit organization based in Washington, D.C. that was established in 1876. It represents medical schools, teaching hospitals, and academic and scientific societies while providing services to its member institutions that include data from medical, education, and health studies, as well as consulting.

- **American Rescue Plan Act (ARPA) of 2021** - also called the COVID-19 Stimulus Package or American Rescue Plan is a US$1.9 trillion economic stimulus bill passed by the 117th United States Congress and signed into law by President Joe Biden on March 11, 2021, to speed up the country's recovery from the economic and health effects of the COVID-19 pandemic and the ongoing recession.

- **Center for Health Workforce Studies (CHWS) New York** - is one of nine health workforce research centers in the United States sponsored by the Health Resources and Services Administration (HRSA) and dedicated to providing health care workforce data and information to inform decision-making.

- **Centers for Medicare & Medicaid Services (CMS)** - is a federal agency within the United States Department of Health and Human Services (HHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid, the Children's Health Insurance Program (CHIP), and health insurance portability standards. In addition to these programs, CMS has other responsibilities, including the administrative simplification standards from the Health Insurance Portability and Accountability Act of 1996 (HIPAA), quality standards in long-term care facilities (more commonly referred to as nursing homes) through its survey and certification process, clinical laboratory quality standards under the Clinical Laboratory Improvement Amendments, and oversight of HealthCare.gov.

- **Certified Nursing Assistant (CNA)** - is an entry-level member of a patient's healthcare team, performing important patient-centered tasks under the supervision of licensed nursing staff.

- **Coronavirus disease (COVID-19)** - is an infectious disease caused by the SARS-CoV-2 virus.

- **Faculty Academy and Mentoring Initiative (FAMI)** - prepares experienced Bachelor or higher degree prepared registered nurses for new roles as clinical nursing faculty members. Funded through the Maryland Higher Education Commission Nurse Support II program

- **Graduate Medical Education (GME)** - refers to any type of formal medical education, usually hospital-sponsored or hospital-based training, pursued after receipt of the M.D. or D.O. degree in the United States This education includes internship, residency, subspecialty, and fellowship programs, and leads to state licensure and board certification

- **Health Care Workforce Committee (Committee) of Oregon** - The Committee is a multi-stakeholder group of industry volunteers that meets every other month to review the data from the Health Care Workforce Reporting Program and make recommendations to the Health Policy Board. The recommendations and action plans created by the Committee help the Health Policy Board implement necessary changes to train, recruit and retain a dynamic health care work force that is scaled to meet the needs of new and evolving systems of care.

- **Health Care Workforce Reporting Program (HCWRP)** - was created in 2009 with the

passage of HB 2009, which required the Oregon Health Authority to collaborate with seven health profession licensing boards to collect health care workforce data via their licensing renewal process. In 2015, SB 230 added ten additional health licensing boards to the program.

- **Health Professional Shortage Areas (HPSA)** – are designated geographic areas or subgroups of the populations or specific facilities within them as lacking professionals in primary care, mental health, or dental care.
- **Health Resources and Services Administration (HRSA)** - is an agency of the U.S. Department of Health and Human Services. It is the primary federal agency for improving access to health care services for people who are uninsured, isolated, or medically vulnerable.
- *Higher Education Student Assistance Authority (HESAA)* - is the only New Jersey state agency with the sole mission of providing students and families with financial and informational resources for students to pursue their education beyond high school.
- **Jobs for America's Graduates (JAG) program** - is a state-based national non-profit organization dedicated to supporting young people of great promise. JAG is delivering the best results in its 40-year history, while serving youth who face significant challenges, to help them reach economic and academic success
- **New Jersey Board of Nursing (NJBON)** – licenses registered nurses and practical nurses and regulates the nursing profession in New Jersey. The board certifies advanced practice nurses, sexual assault forensic nurses, and certified homemaker-home health aides. The board accredits nursing schools and approves clinical affiliates.
- **New Jersey Collaborating Center for Nursing (NJCCN)** - established by law in 2002 to develop a strategic plan for the continued development of an adequate nursing workforce, in number, education, and training, to meet the needs of New Jersey residents.
- **Nurse Support Program (NSP)** – was created to increase the number of nurses in Maryland hospitals. NSP I is hospital centered while NSP II focuses on expanding the capacity to educate nurses through nursing education programs at Maryland institutions.
- **Oregon Health Authority (OHA)** - is a government agency in the U.S. state of Oregon. It was established by the passage of Oregon House Bill 2009 by the 75th Oregon Legislative Assembly, and split off from Oregon Department of Human Services, OHA oversees most of Oregon's health-related programs including behavioral health (addictions and mental health), public health, Oregon State Hospital for individuals requiring secure residential psychiatric care, and the state's Medicaid program called the Oregon Health Plan. Its policy work is overseen by the nine member Oregon Health Policy Board.

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