



HEALTH CARE

VOL. 4, NO. 2 | FALL 2023
aft.org/hc

A BIENNIAL JOURNAL ON HEALTH AND COMMUNITY WELL-BEING



SOLVING THE STAFFING CRISIS

Our Code Red campaigns are winning protections for patients—and the people who care for them. [page 3](#)



Also in this issue:

- ✦ **A nurse in crisis** [page 11](#)
- ✦ **Moral injury in healthcare** [page 17](#)
- ✦ **Holistic mental health** [page 24](#)
- ✦ **Health equity** [page 30](#)
- ✦ **Housing and health** [page 39](#)




CODE RED

Understaffing = Patient Care Crisis 

American hospitals are on the critical list. All across the country, a staffing crisis is jeopardizing quality care. Frontline caregivers are burned out, exhausted from the moral injury of being forced to provide inadequate care—and they are leaving hospital employment in record numbers. But we can turn things around!

The AFT and our healthcare affiliates around the country are leading efforts to secure safe patient limits and other crucial protections to improve the quality of care our patients receive.

+ aft.org/CodeRed



AFT Health Care is dedicated to ensuring that everyone has the freedom to thrive. It's about healthcare as a human right, systemic changes to put people above profits, and the social, economic, and environmental factors that affect individuals' and communities' health and well-being.

APPLY TO BECOME A PEER REVIEWER

To publish the most relevant, trustworthy, and useful articles, we need to draw on your experience and expertise—so we're developing a peer review board. Please visit aft.org/hc/peer-review to learn more about becoming a reviewer and submit your application today.

SUBMIT A MANUSCRIPT

Are you struggling with unsafe staffing and/or workplace violence? Is your employer trying to address these crises or making them worse? We are interested in learning about your experiences. For details on submitting your manuscript, visit aft.org/hc/article-submission-guidelines.



Real Solutions: We're Fighting for—and Winning—Safe Staffing

RANDI WEINGARTEN, AFT PRESIDENT

AMERICAN HEALTHCARE has become a “medical-industrial complex,” raking in billions a year by denying needed medical care, overcharging patients (especially those without insurance), and reducing staff to dangerous levels. Patient care is increasingly controlled by hospital monopolies (some backed by private equity), along with insurance and pharmaceutical companies. We're up against corporatizers and extremists who won't support safe staffing, healthcare for all, or even reducing prescription drug costs for Medicare.

Understaffing is a dire problem. A 2022 survey by New Jersey's Health Professionals and Allied Employees (HPAE) found that 95 percent of nurses with five years' experience or less wanted to leave the bedside, due largely to the stress of understaffing.

Enough is enough.

In February 2023, the AFT and our affiliates launched the Code Red campaign, a nationwide initiative to secure safe staffing levels and other crucial protections—such as workplace violence prevention—for patients and clinicians. More than 100 AFT affiliates have jumped into this campaign to offer real solutions to fix our broken healthcare system. The contrast between the profiteers and the problem solvers couldn't be clearer.

While hospitals work clinicians to the bone, and understaffing and endless overtime endanger patients, we're working to pass safe staffing legislation and curb mandatory overtime. In this issue, you'll read about the amazing victories our affiliates in Connecticut (page 4), Oregon (page 7), and Washington (page 10) have already achieved. All

three have new laws that give healthcare workers a strong voice in staffing—and our affiliates are already figuring out how to ensure employers follow those laws.

When they drive people away from the profession, we help them stay. The New York State Public Employees Federation's Code Red campaign (see page 6) focuses on healing the healers. Their retention plan includes the impressive salary gains, professional development bonuses, and improved paid parental leave they've already won, plus new preceptor and mentoring programs.

While they deploy an army of healthcare lobbyists, we're urging legislators to protect patients. Healthcare lobbyist spending has skyrocketed: \$713.6 million in 2020 alone. So our unions are showing legislators that reform is a make-or-break issue. HPAE has long worked to pass nurse staffing standards for hospitals and ambulatory surgery facilities. Now, as every seat in the state legislature is up this year, the union is endorsing only candidates who pledge to support safe staffing legislation (see page 8).

While hospitals evade staffing reforms, we hold them accountable. Washington State Nurses Association members found that hospital management made a sham of state-mandated staffing committees. The union mobilized thousands of members and, in April 2023, won a new staffing law in which CEOs no longer have veto power on staffing plans, staffing committees are 50 percent union-represented workers, and state agencies will have the power to force noncompliant hospitals to close down units or implement staffing ratios (see page 10).

When they try to silence healthcare professionals, we organize and empower them. While hospitals have a long history of union busting, it's not working. The AFT has organized 28 new healthcare unions so far this year, with more than 5,000 members nationwide in a range of professions, from imaging technicians to resident physicians. Our Oregon affiliates alone organized over 1,000 new members in the last year. And AFT locals are using the power of collective bargaining alongside legislative advocacy. For example, nurses at the Ohio State University Wexner Medical Center have bargained some of the strongest staffing provisions in the country. Now they're pushing for mid-contract improvements, including additional protections from workplace violence, like metal detectors and more security personnel (see page 5).

One reason our Code Red campaigns are succeeding is that we are working in coalition with other unions, patient advocates, and our communities. Please keep reaching out to your colleagues and communities to engage people on these issues and urge them to support elected leaders and candidates who will choose patients—and the people who care for them—over profits.

It's time for all of us to show where we stand. At the AFT, we stand for a better life for all. Better healthcare outcomes. Better access to good jobs with decent wages. Better opportunities for our kids. We stand for real solutions that mandate safe staffing and, ultimately, heal our healers. Real solutions for kids and communities. +



More than 100 AFT affiliates have jumped into this campaign to fix our broken healthcare system.

3 Solving the Staffing Crisis

Our nation's hospitals have failed in their most basic responsibility: providing a safe place for patients to receive care from healthcare professionals. But AFT Code Red campaigns are winning protections for patients—and the people who care for them.

11 We Are Not OK

A Nurse Shares Her Journey to Moral Injury and Her Struggle to Return to the Bedside

BY TAMIE CLINE

17 Clinicians in Distress

Addressing Moral Injury in Healthcare

BY WENDY DEAN

24 Caring for the Whole Person

A Model for Treating Mental Health and Substance Use

BY REBECCA FARLEY DAVID AND CONNOR MCKAY

30 Achieving Health Equity

The Invaluable Role of Nurses

BY JANICE PHILLIPS

39 Tearing Down Invisible Walls

Ending Economic Housing Discrimination

BY RICHARD D. KAHLBERG



Download this issue for free at aft.org/hc.



Our Mission

The **American Federation of Teachers** is a union of professionals that champions fairness; democracy; economic opportunity; and high-quality public education, healthcare and public services for our students, their families and our communities. We are committed to advancing these principles through community engagement, organizing, collective bargaining and political activism, and especially through the work our members do.

RANDI WEINGARTEN
President

FEDRICK C. INGRAM
Secretary-Treasurer

EVELYN DEJESUS
Executive Vice President

LISA HANSEL
Chief Publications Editor

SHARONE CARMONA
Managing Editor

LESLEY R. GONZALEZ
Assistant Editor

LUKE STEELE
Editorial Coordinator

SEAN LISHANSKY
Copyeditor

JENNIFER CHANG
Art Director

JENNIFER BERNEY
Graphic Designer

RACHEL ANDERSON
Junior Graphic Designer

AFT HEALTH CARE (ISSN 1063-7710 print / ISSN 1562-6865 online) is published semiannually by the American Federation of Teachers, 555 New Jersey Ave. NW, Washington, DC 20001-2079. 202-879-4400, aft.org

Letters to the editor may be sent to the address above or to hc@aft.org.

AFT HEALTH CARE cannot assume responsibility for unsolicited manuscripts.

Please allow a minimum of four weeks for copyright permission requests.

Signed articles do not necessarily represent the viewpoints or policies of the AFT.

AFT HEALTH CARE is mailed to AFT nurses and health professionals, and members in related fields, as a benefit of membership. Subscriptions represent \$2.50 of annual dues. Non-AFT members may subscribe by mailing \$10 per year by check or money order to the address below.

MEMBERS: To change your address or subscription, notify your local union treasurer or visit aft.org/members.

POSTMASTER: Send address changes to AFT Health Care, 555 New Jersey Ave. NW, Washington, DC 20001-2079.

© 2023 AMERICAN FEDERATION OF TEACHERS, AFL-CIO

Cover photos:
AFT

Solving the Staffing Crisis

In Code Red Campaigns Across the Country, Healthcare Workers Are Fighting for Safe Staffing

Nurses and other healthcare professionals are leaving their jobs in droves. They are exhausted, burned out, and disillusioned. COVID-19 worsened a staffing crisis that had been building for years—yet healthcare executives continue to place profits over patient care and worker safety. That's why in February 2023 the AFT launched Code Red, a national multiyear campaign to fight for legislation requiring safe patient limits, to enact enforceable workplace violence standards, and to bargain contracts that help recruit and retain frontline caregivers. (For more details, see aft.org/CodeRed.)

Several months into year one, we spoke with affiliates in seven states about their Code Red campaigns. Read on to learn more about their initiatives, their amazing victories so far, and their determination to solve the staffing crisis. —EDITORS



Winning Landmark Legislation for Connecticut Nurses



By John Brady

John Brady, RN, is the vice president of AFT Connecticut, an executive board member of the Connecticut AFL-CIO, and the former president of the Backus Federation of Nurses. He retired from Backus Hospital after 16 years as an emergency department nurse.

In Connecticut, we've been fighting for safer healthcare workplaces for decades. We've had some successes, but AFT Connecticut members continue to face working conditions that threaten their safety and the safety of their patients. The staffing legislation we've had in place in the state since 2009—which was updated in 2015—was insufficient to address the problem. It called for staffing committees and a collaborative process to *develop* staffing plans, but it didn't require those committees to *approve* the plan. Management showed a plan to the committees and claimed collaboration. And some of our hospitals were still mandating overtime despite Connecticut's law against it, using a loophole to require nurses to work past their assigned shifts. As consolidation has increased in our state, staffing shortages that were already dire have only gotten worse.

We needed to create real change in our members' workplace conditions, so we established six goals for our multiyear Code Red campaign:

- Pass legislation on staffing and mandatory overtime
- Fight for staffing and safety concerns through collective bargaining agreements
- Build internal organizing power and structures for member and community engagement
- Increase AFT Connecticut's impact as a leader on Connecticut healthcare issues
- Be the union that nonunionized healthcare workers look to when they're ready to fight for change
- Continue our work with other unions and affiliates across the country

We began with our legislative goal: statewide staffing ratios and strengthened protection against mandatory overtime. We wrote a bill using the federal Nurse Staffing Standards for Hospital Patient Safety and Quality Care Act as a template, then proposed it to the chairs of the public health committee in our state legislature. Forty AFT Connecticut members testified at the public hearing on the bill, and many others submitted written testimony. After some pushback on the ratios, the bill died in the judicial committee. But, in a major victory, an adjusted version was passed after it was added to the budget implementer bill.

Getting the staffing bill into the budget implementer bill took bipartisan support. A group that included our lobbyists, one of our field reps, and the Connecticut Nurses Association met with Republican and Democratic leaders of the public health committee, a few state agencies, and the governor's office. We discussed the problems some committee members had with the bill and hammered out a version that both houses of the legislature agreed on.

One of our Republican state senators helped strengthen the legislation in a big way. To replace the ratios, we proposed staffing committees in which half of the members were bedside nurses. Foreseeing potential ties between staff and management, this senator insisted that the number of bedside nurses be 50 percent plus one. So what passed in the end is a game changer for recruitment and retention. Now, the law effectively addresses mandatory overtime, the majority vote on our staffing committees will always belong to bedside nurses, and staffing committees will approve any staffing plans. In union hospitals, the union picks the nurses on the committee, so if we do this right, we should be able to write our hospitals' staffing plans, including the ratios, which will be enforced by the Department of Public Health with fines.

In time, others will see the power of that union difference. It's going to take a lot of work to make sure that this legislation and our staffing committees are effective. Over the next months, we'll be educating our members about the new bill and training new staffing committee members. Those chosen to be on staffing committees are going to be very important; they need to know how to be strong (so they don't get pushed over by management) and how to vote as a caucus. Our goal is to roll out the training before the new bill goes into effect in October.

We achieved our legislative goal much faster than expected, and the internal and external organizing and coalition building we've engaged in over the last decade were the foundation for this victory. Currently, 24 of our 36 state senators are Democrats; of those, 9 are union members and 2 are AFT members, including our state federation president, Jan Hochadel. That's the result of years of door knocking, getting people out to vote, encouraging participation in member organizing institutes, and other strategies. All of these efforts compound over time.

We've made great progress on all of our campaign goals. And we'll keep reevaluating and collaborating with our local leaders and affiliates to make sure we're all going in the right direction, sharing resources and lessons learned so that our successes build off each other. We have high hopes that through our examples, hospitals nationwide will be compelled to do right by their workforces.

Building a Statewide Movement in Ohio

By Rick Lucas

Rick Lucas, RN, has been a critical care nurse for 20 years and a rapid response nurse at the Ohio State University Wexner Medical Center for 10 years. He is the president of the Ohio State University Nurses Organization and first vice president of the Ohio Nurses Association.

At the Ohio State University (OSU) Wexner Medical Center, we've had some of the strongest staffing provisions in the country, with specified ratios for each unit, since 2019. But those provisions alone can't solve the staffing crisis. We have more than 1,100 full-time nursing vacancies in the hospital. Most days, the hospital has to close more than 100 beds, which has a bottleneck effect in the emergency department. That translates to 30 or 40 boarders and 60 people waiting in the emergency room for care. Administrators don't want to take meaningful action on staffing—but they're opening a new \$2 billion inpatient hospital tower early in 2026. Who's going to staff it? It feels like they're trying to normalize these conditions to save money rather than investing in safe, sustainable patient care.

Most hospitals in Ohio don't even have the protections we've bargained with OSU. So one of the major goals of the Ohio Nurses Association's (ONA's) Code Red campaign is to establish greater consistency across the state through legislation, collective bargaining, and organizing as we work toward safe staffing for all Ohio nurses and health professionals.

ONA started our campaign by surveying registered nurses statewide about staffing and workplace safety—and we got more than 11,000 responses from every county in the state. We developed a white paper based on the results (available at ohnurses.org later this year), and we're using it to support other elements of our campaign, including our legislation that was introduced in fall 2023. The bill addresses safe staffing and mandatory overtime, protects whistleblowers, and establishes recruitment and retention initiatives like a student debt forgiveness program. Our goal is to pass it by the end of 2026.

In the meantime, we're focusing on coordinating messaging and strategy across the state, using the Ohio State University Nurses Organization's (OSUNO's) staffing contract language as a model. Throughout the pandemic, we were able to maintain safe ratios at OSU. Our critical care units didn't flex above two patients per nurse. In some instances, acute care and other lower acuity areas had to flex up more, but we were able to hold the hospital to not flexing above five patients per nurse in the med-surg unit.

ONA's goal is to take that from precedent to standard, helping locals build the OSUNO language into collective bargaining campaigns that connect with larger statewide initiatives. That way, when the Ohio Hospital Association claims that ratios are dangerous for patients or will bankrupt them and harm our com-

munity, we can point to the 20 hospitals that have this structure in place and the patient care outcomes that prove it works.

We're also helping locals develop their own Code Red campaigns, following OSUNO's lead. OSUNO is pushing for some mid-contract improvements, including enhanced incentives to fill open shifts, reopen beds, and safely care for patients. We're also looking for additional protections from workplace violence, like metal detectors, more security personnel, and better training and post-incident support.

To support those goals, we're working to build sustained public awareness of and support for safe staffing. We started with a small group of nurses standing in front of the hospital for an hour every morning with a banner that read "Understaffing = patient care crisis." We're also collecting member testimonials to share on social media and use in paid advertisements. We want our community and legislators to understand what understaffing conditions mean in our hospital and how tired and burned out nurses are—and we hope what we're doing at OSU will help tell the story statewide.

Instead of reinventing the wheel at each local, we'll adjust the OSUNO model for each ONA hospital's needs. We're putting together a toolkit for pictures and quotes, graphics, button templates, and more that locals can use.



COURTESY OF ONA

We've been sounding the alarm for a long time, especially during COVID-19, and healthcare workers in Ohio have taken notice. We've had a lot of interest in new organizing because people can see what we stand for: we're responsive to what's happening with our members, we want to protect patients, and we have our priorities in the right place. Code Red is a continuation of that, and it's especially important right now as ONA is in a period of transition. We've ended our affiliation with the American Nurses Association and are revamping our constitution and bylaws to become a fully fledged union. Our Code Red campaign will help us continue to grow union density and healthcare worker power in our facilities and across the state. We plan to keep sounding the alarm louder and louder until we get the results we need to safely care for our patients.

Healing the Healers in New York

By Amy Lee Pacholk

Amy Lee Pacholk, MSN, AGNP, APRN, is a critical care nurse in a surgical trauma ICU, an executive board member for the New York State Public Employees Federation (PEF), the council leader for PEF Division 225, and the chair of PEF's Statewide Nurses Committee. She is also an adult geriatric nurse practitioner, a professor of adult health and obstetrics, and a lecturer on neurotrauma.

The nurses of the New York State Public Employees Federation (PEF) are nurse practitioners, doctors of nursing practice, associate nurses, and registered nurses; we work in public hospitals, psychiatric facilities, prisons, clinics, drug and rehab facilities, and home settings. Our Code Red campaign targets the staffing and retention issues our nurses are experiencing in their various regions and agencies. For example, nurses leave SUNY Downstate University Hospital in Brooklyn because they can make \$20,000 more at the city hospital across the street or at nearby private hospitals. At SUNY Upstate, in Syracuse, 30 percent or more of some units are staffed by travelers, so there's a lack of institutional knowledge.

These issues fuel nurse burnout, trauma, and moral injury. Some nurses even take their own lives.* We need sustainability in public nursing so we don't keep losing people to the private sector—and so we can better care for the mental and emotional health of our nurses.

We have some longer-term legislative goals, like making sure language in staffing laws applies to nurses in nonhospital settings, but our primary Code Red campaign goal is to heal the healers. We do that by using our collective power in bargaining, committee work, and advocacy to get state agencies to invest in nurses. Like so many other issues, that comes down to staffing: we need to recruit and retain enough nurses on the floor so we can do our jobs safely.

In PEF's recent contract negotiations, nurses won a 10 to 22 percent increase in base salary. We secured an additional \$600 per year for nurses who hold advanced degrees or certifications, which is a good start that we hope to build on. We also now get paid for licensing and renewals, up to \$1,600 a year to attend professional conferences and workshops, and 12 weeks of paid parental leave when having, adopting, or fostering a child. This all came from Code Red.

Those are big wins, but we can't stop there. We desperately need better training and support structures for nurses, so now we're focusing on developing preceptor and mentoring programs. Within six months of starting their jobs, our new nurses are questioning what they're doing here. Sometimes they're pulled off orientation early, which sets them up to fail despite their best intentions. Other times, their preceptor hasn't been



there long enough to know how to do the job well themselves, let alone teach it.

We're establishing our own preceptor standards for state facilities so that nurses who orient new staff have enough experience and appropriate skills. We found a terrific training program used by Massachusetts General Hospital in Boston under the guidance of the Norman Knight Nursing Center for Clinical and Professional Development. We're working to get approval to adapt it for nurses in New York state. Our long-term goal is for both the training and the precepting to be appropriately compensated as part of the job; we've developed a bill to pay preceptors trained through our program that we expect to be introduced this fall.

We're also working on a mentorship program for nurses who are new or changing fields. A precepting program builds your career and professionalism, but a mentoring program builds your spirit: Do you see yourself here for five years? Becoming a nurse practitioner? Going into education? Do you see that this isn't for you? Having a trusted person to talk to can quell anxiety and help people realize it's OK to not be perfect. We're still working on identifying the right mentor training program, so we may begin more informally. But we'll know a lot more about what works and what doesn't once we get started.

An important part of developing both programs is internal coalition building—getting nurses from agencies across the state to come together on our shared goals. In September, members of the statewide nurses committee had a training with a leadership and mentoring expert so we could learn to set up and facilitate these programs. We're also taking advantage of the resources of the AFT. We're creating a webpage for people to learn about the preceptor program, and we're getting social media training so we can create more effective campaigns. We hope to use these tools to begin to connect our more- and less-experienced members and build a statewide movement.

Having better support programs can give public nursing an edge over private facilities. But we also want to establish these programs because we know nurses and health professionals need to be valued as human beings. We hope that with these supports in place, more people will stay.

*To learn more, see "Deaths by Suicide Among Nurses: A Rapid Response Call" by Kathryn Lee and Christopher Friese in the *Journal of Psychosocial Nursing and Mental Health Services*: go.aft.org/3p8. For suicide prevention help, dial 988.

Historic Staffing Win for Oregon Health Professionals

By Tamie Cline and Shane Burley

Tamie Cline, RN, is the president of the Oregon Nurses Association and a bargaining unit leader at Good Shepherd Medical Center in Hermiston, Oregon. Shane Burley is the communications organizer for the Oregon Federation of Nurses and Health Professionals, a union of more than 6,000 nurses and health professionals in Oregon and Southwest Washington.

Our Code Red campaign focuses on the key problem our members face: unsafe staffing. Oregon hospitals' decades of "lean to mean" understaffing to increase profit set us up for catastrophe well before the pandemic. Once COVID-19 began, healthcare workers left their jobs in record numbers, unwilling to work under those conditions—and since then, the problems have only gotten worse for staff and patients.

We've heard of patients being kept under anesthesia longer than is medically safe because there weren't enough nurses and techs in the post-anesthesia care unit to receive them. Some patients haven't been treated quickly enough for cardiac episodes and others have had cancer diagnoses delayed because of the shortage of cardiothoracic, ultrasound, and sonography techs, causing disease progression that could've been prevented. In the ED and other areas, patient outcomes are declining severely because we lack tech workers to move patients through the system.

Still, hospital administrators have refused to invest in their workforce, leaving staffing at a critical minimum—and exposing staff to increased risk of workplace violence, particularly at night. The domino effect cascades across the whole healthcare system. But recruiting staff is challenging when prospective lab technicians or certified nursing assistants (CNAs) can make as much money working at McDonald's, with less stress on the mind and body. Hospitals don't value our nurses or our technical and professional support staff the way they value money. It's catastrophic for our communities, our patients, and our families—and it has to stop.

That's why the Oregon Nurses Association (ONA) and Oregon Federation of Nurses and Health Professionals (OFNHP) part-

nered to take the fight to the state legislature—and we won. HB 2697, which passed in July, is the first bill in US history to establish specific nurse-to-patient ratios, CNA-to-patient ratios, and ratios for specific units. The bill also creates staffing committees for care providers, technicians, and support professionals who did not previously have them, bringing more of the people who are integral to patient care to the table. And it has a more powerful enforcement mechanism than our previous staffing bill, including fines for violations, so that administrators can no longer manipulate the law for their benefit.

In September, ONA and OFNHP met with the Oregon Health Authority and hospital administrators on guidelines to implement this law. But its true power will be seen hospital to hospital, so one of our main efforts is ensuring effective implementation and training our members on its implications. We want workers to know how to engage in their staffing committees and how to file complaints through the new process we're developing to ensure the legal standards are enforced.

This is a bill of hope that gives healthcare workers back some of our power—but it won't go into effect for two years, and our healthcare professionals need help now. So we continue fighting to make our voices heard. In July, OFNHP picketed at PeaceHealth Southwest Medical Center in Vancouver (Washington), where we're trying to rectify historically low wages for about 350 tech workers as well as the lab professionals at a nearby hospital. Kaiser workers joined them on the picket line because they know this contract affects them too. The Alliance of Health Care Unions, which our Kaiser members are in, recently released a survey showing critical understaffing in over 50 percent of represented work sites, affecting most metro regions in the country. So everything we bargain for in Kaiser's next contract in 2025 will relate to staffing.

We are also aggressively organizing new units—gaining over 1,000 new members in the last year—because staffing connects all healthcare workers and our results show that collective action works. We can't keep up with the number of organizing requests we're receiving as workers see how powerful we can be together.

Long term, we'll continue building community support for safe staffing. We want our community—our patients—to see safe staffing as critical to their healthcare. We're using rallies, pickets, and events to educate others, and we're sharing patient-focused messages on social media, in town halls, and in community newsletters.

OFNHP and ONA will continue our strong partnership, building off our respective strengths to bring more light, power, and knowledge to all our members. We see a shift in power right now, in Oregon and nationwide, as more and more workers are demanding to be heard. We're building on that solidarity to make our workplaces and the healthcare system better.



We Won't Stop Until We Win Safe Staffing in New Jersey

By **Debbie White** and **Barbara Rosen**

Debbie White, RN, is the president of the Health Professionals and Allied Employees (HPAE), an AFT vice president, and a long-serving medical-surgical nurse. Barbara Rosen, RN, is the vice president of HPAE, a nurse educator, and a former critical care nurse.

For the Health Professionals and Allied Employees (HPAE), Code Red started with a survey. In the summer of 2022, we asked New Jersey's frontline caregivers about the state of hospital bedside nursing. We received many more responses than we anticipated—all from nurses—with much more alarming results than we expected (see go.aft.org/oo3). Thirty percent of nurses had left the bedside. Of the 70 percent who had stayed, another 72 percent wanted to leave within the next year. Most alarming was the statistic about new nurses: 95 percent of nurses with five years' experience or less wanted to leave the bedside. The top two reasons nurses left or wanted to leave? Stress and stress due to staffing.

The stories nurses related through the survey highlight how much staffing and stress are intertwined. These nurses shared being given untenable patient loads and multiple patient support roles outside their job duties because of staff shortages. They shared stories of understaffed emergency departments with patients waiting in line for days to be seen or patients lying on ED floors because of a lack of beds. They also spoke of training dozens of new nurses only to watch them leave months later—or see them be pulled from orientation and given workloads they were never trained to handle. Nurses described the strain of watching patients becoming angrier and more prone to violence the longer they went untreated, colleagues in tears during their shifts from being overwhelmed, and many more stressful, unsafe working conditions causing them to fear their nursing licenses were in jeopardy.

Only half of the 140,000 licensed nurses in New Jersey are currently practicing. Our survey results tell us loud and clear that

we don't have a shortage of nurses; we have a shortage of nurses willing to stay at the bedside. The issue is retention, and it cannot be solved with simple recruitment efforts. What we need is effective, enforceable staffing ratio legislation to keep patients safe, keep us safe, and stop the bleed of nurses leaving the profession at alarming rates.

HPAE has been pushing for safe staffing legislation for 22 years. Staffing regulations in New Jersey, which only cover ICU and critical care units, have not been updated since 1987. Meanwhile, the terrible working conditions we wrote about in a 2001 white paper to advocate for updated legislation have only worsened.

Now, we're fighting to pass bill S304, which establishes minimum nurse staffing standards for hospitals and ambulatory surgery facilities, and building a broad coalition to increase public support for safe staffing. In March 2023, we released another white paper (see go.aft.org/4su). We also held a lobby day, traveling to the state house in Trenton to call on legislators to pass the bill, and worked hard to secure the bill's endorsement by the New Jersey State Nurses Association (NJSNA). In May, we organized a rally at the state house and bused in members of every healthcare union in New Jersey. Hundreds of people attended, and the crowd was a sea of union colors, all standing together to highlight the need for safe staffing.

We are also focused on getting our state legislators on board with the bill. This year, every seat in our Assembly and Senate is up for reelection, and we are only endorsing candidates who support safe staffing legislation. In a short questionnaire, we asked all legislators, "Would you pass safe staffing legislation?" Those who responded "No" or "Maybe" or who didn't return the questionnaire weren't endorsed. This tactic helped force important conversations about our priorities with candidates who want our support. We're using that endorsement list to plan for further lobbying on safe staffing throughout the year.

We're working with our bill sponsors and other unions and organizations like NJSNA to develop enforcement guidelines and language. We'll continue building both internal and public support, but we also want to help our members find staffing solutions now at the bargaining table. Our October Professional Issues Conference will focus on internal organizing and mobilizing members to become advocates for safe staffing legislation. And we have several contracts up in 2024, so we're preparing our locals to use staffing as a pressure point for bargaining.

We've never seen nurses' stress levels this intense. Short staffing has inflicted unprecedented moral injury on the healthcare workforce, and we're tired of trying to convince administrators to change. That strategy is like tossing pebbles to stem a flood, and it hasn't worked. Nurses across the country are now throwing boulders. We'll do whatever it takes to make our workplaces safer for our patients and ourselves. We won't stop until we win.



COURTESY OF HPAE

Prizing the Frontline, Not the Bottom Line, in Wisconsin

By **Connie Smith and Jamie Lucas**

Connie Smith is the president of the Wisconsin Federation of Nurses and Health Professionals (WFNHP) and has worked in healthcare for more than 20 years, currently as a charge capture coordinator at St. Francis Hospital in Milwaukee. Jamie Lucas is the executive director of WFNHP.

The goal of the Wisconsin Federation of Nurses and Health Professionals (WFNHP) Code Red campaign is to engage healthcare workers in healing our healthcare system and making it sustainable again—which our members and our patients desperately need. The corporate model of healthcare prizes the bottom line over the frontlines and over patient safety. It has driven healthcare workers to the breaking point. The pandemic lit healthcare on fire, laying bare its structural issues and demonstrating just how unsafe and unsustainable corporate healthcare’s “do more with less” approach is.

For years, our members have worked under grueling conditions, increasingly unable to care for their patients in the way they signed up to do. We’ve heard stories of those who left the bedside because workplace stress threatened their health. Commonly, members work 12-hour shifts without being able to take bathroom or meal breaks. And some have been unable to refuse unsafe assignments for fear of discipline or termination. The extent to which healthcare workers, and nurses specifically, are asked to absorb more responsibilities and forgo a personal life or work-life balance is frightening. Administrators claim it’s necessary because of a pandemic-driven staffing shortage—but in truth, the shortage is a direct result of years of corporate decisions made to increase profit.

In December 2022, the *New York Times* investigated one of our employers, Ascension, which operates St. Francis Hospital in Milwaukee.* Ascension has been cutting staff since taking over the hospital in 2017—cutting our bargaining unit in half by 2020 and closing labor and delivery services in late 2022—and awarding millions in executive bonuses for keeping labor costs low. St. Francis serves primarily Black and Latinx communities, and these decisions just worsen the acute inequities that exist in Milwaukee, where segregation and inequality are rampant.

Now that the worst of the pandemic is past, healthcare workers also have a decision to make. Do we normalize the deterioration of our working conditions? Or do we fight to make healthcare the way it ought to be?

WFNHP decided to fight.

Wisconsin has no meaningful staffing regulations in place to keep healthcare workers safe. So this fall, we introduced legislation that establishes enforceable staffing ratios created by nurses and direct care staff. It includes a penalty for employers that violate their staffing plans, which will be established in accordance with a committee of direct care providers who work in the hospi-

tals. And it doesn’t allow employers to use overtime as a tool to avoid staffing ratios—the bill bans mandatory overtime for nurses and asserts nurses’ right to refuse unsafe assignments.

Now, we’re advocating for the bill and persuading legislators to give it a hearing. That decision is controlled by the committee chairs, who generally work along party lines. But we believe this bill deserves bipartisan support. The Senate Health Committee chair, a Republican nurse practitioner, has a clinic outside of the insurance industry and well understands the problems with corporate healthcare. So we hope she’s responsive to the work we’re doing to demonstrate the need for safe staffing legislation.



COURTESY OF WFNHP

In addition to this legislative push, we’re fighting to make quality care widely available to all people and to actively involve community members in decisions about the services offered in their areas. We have partnered with local groups in a coalition to restore needed surgical and labor and delivery services to Milwaukee, which Ascension closed in 2018 and 2022, and we’re continuing this coalition building to ensure that our communities can access the care they need.

We’re also taking advantage of organizing opportunities throughout Wisconsin, as more nurses and healthcare workers are looking to seize their power and take back control within their hospitals to be able to do their jobs safely. Our message is really resonating with people because the problems with the healthcare system are now clearer than ever. Instead of just complaining that healthcare is broken, we’re fighting for solutions that center patients’ and healthcare workers’ well-being.

It’s healthcare workers, not administrators, who go home at the end of each day wondering whether we did everything we could for our patients. So we are infinitely more qualified than hospital CEOs to fix what’s wrong at the bedside, on our floors, in our labs, and in the system more broadly. We are in a moment of incredible optimism and opportunity, and we’re making the most of it: we’re pushing forward in hope and leading with a vision of the way healthcare can—and should—be.

*To read this investigation, visit go.aft.org/agm.

Winning Staffing Legislation in Washington Is Just the First Step

By David Keepnews and Katharine Weiss

David Keepnews, PhD, JD, RN, FAAN, is the executive director of the Washington State Nurses Association (WSNA). He has devoted more than three decades to advancing the nursing profession in nursing education and health policy and previously worked as a staff nurse in inpatient psychiatry, psychiatric emergency, and community mental health settings. Katharine Weiss, MPA, is the director of government affairs at WSNA. She has also worked as a policy, research, and politics expert for the Washington State Labor Council, Washington State Health Care Authority, and Community Health Plan of Washington.

The Washington State Nurses Association (WSNA) has been fighting for safe staffing for decades. Our 2008 staffing law, updated in 2017, required staffing committees so that nurses and administrators could create safe staffing plans together. But hospital CEOs had veto power, so we ended up with a lot of unilateral decision-making by hospital leaders who claimed they couldn't afford to follow the committees' staffing plans.

The results have been deadly. We've had sentinel events, where patients died because short staffing forced workers to make impossible choices about how to allocate care. Hospitals claim staffing ratios will mean rationing care, but the reality is that nurses are already making those decisions every day without resources or support—and the staffing committees where they hoped to collaborate on solutions for tough issues are a sham. Nurses were supposed to have a voice, but instead hospital leaders overruled them, keeping staffing dangerously low and leaving nurses frustrated as the spirit of the committee was not being honored. As a result, nurses are traumatized, demoralized, and exhausted.

The first goal of WSNA's Code Red campaign was to win staffing legislation that mandates nurse-patient ratios and increases enforcement and accountability for hospitals. We'd begun working more closely with fellow healthcare unions SEIU Healthcare 1199NW and UFCW 3000 in 2019, when we passed a bill requiring meal and rest breaks for healthcare workers. Together, in 2022, we formed the WA Safe + Healthy coalition. While our legislation wasn't successful in 2022, this year one of the main legislators

who had stood in our way came to us and to the hospital association seeking a compromise. So we worked with them and our champion legislators to develop new legislative language that closes gaps from prior legislation.

At the same time, WSNA nurses embarked on an all-out advocacy campaign. On our lobby day, 50 nurses met with their state representatives; others testified in the legislature; thousands



more sent emails, made calls, and wrote letters to the editors of their local newspapers. Legislators heard us loud and clear. While they wouldn't agree to ratios, they pushed hospitals to meet our needs in many other areas, and our staffing bill was passed and signed into law in April 2023.

Under the new staffing law, healthcare workers have more power on staffing committees. Any staffing plan must be passed by a 50 percent plus one vote, so it needs healthcare worker support—and CEOs no longer have veto power. The proportion of union-represented workers to hospital appointees is still 50-50, but now CNAs and LPNs can participate alongside RNs, and everyone is paid for their time.

The new law significantly strengthens accountability mechanisms for hospitals. In addition to paying fines, hospitals are now responsible for tracking their staffing, and their compliance reports will have to be signed off on by staffing committee co-chairs, one of whom is a direct care provider. If hospitals are not in at least 80 percent compliance, the Labor and Industries Department and Department of Health will determine a corrective action plan that could include closing down units or requiring hospitals to implement staffing ratios. So in a roundabout way, we may be able to get ratios for noncompliant hospitals. In addition, the complaint process is now easier, and hospitals will have to monitor and follow up on complaints.

Additionally, the law establishes a statewide advisory committee that includes six union representatives, six hospital representatives, and some state officials. This advisory committee, which began work in September, focuses on implementation issues, like how to define a staffing complaint as resolved or unresolved and how to address the staffing problems faced by smaller rural hospitals. It gives our members a voice at the state level, working with the departments and agencies that care about the issues we face.

The rest of the bill will be implemented on a rolling timeline. By January 2024, hospital staffing committees will have to be reestablished to include CNAs, and they'll have to submit new staffing plans by July 2024. After that, the state can begin checking for compliance.

Many people think that legislative work is finished when you get a bill passed, but that's not reality. This bill is a major victory for us, but we have a long way to go before our members feel like they have the resources and staff to give patients their best care. We're going to keep fighting and working to keep the public and our legislators fighting alongside us until that happens. We're celebrating our successes, but we're also continuing to hold hospitals accountable. +





We Are Not OK

A Nurse Shares Her Journey to Moral Injury and Her Struggle to Return to the Bedside

I've been a nurse for over 20 years, and I've spent most of my career at Good Shepherd Medical Center (GSMC), a 25-bed acute care hospital in Hermiston, Oregon. I was a supervisor in the medical-surgical unit before I transferred to general surgery, where I spent almost 15 years. Now, I work as an IV therapy and wound care nurse in the treatment center. I love being a nurse. I love my colleagues. I absolutely love caring for my patients. But every week, just the thought of coming in for my shift gives me mind-numbing anxiety: unrelenting headaches, an upset stomach and tight chest, a constant feeling of impending doom. I dread even driving down the road leading to my hospital, let alone opening the front doors and walking in.

How did I get here?

I have always loved taking care of people. When my children were younger, our house was known in the neighborhood as Cline's House of Wayward Children. I can't tell you how many kids spent the night or even lived with us for a time because they were in bad situations. Once my children were in junior high, it made sense for me to return to school for my nursing degree so I could use my caregiving skills in a professional

role. Plus, as a cattle ranching family, we'd had our share of financial struggles, and I knew nursing was a good path to stability and a better life. So I became an RN at 40 years old and joined GSMC in 2001.

I have also always been proudly pro-union and an outspoken advocate for those whose voices need to be heard. I suppose I inherited some of this from my father, a pipe fitter and a union member until the day he died. When I was a teenager, his union went out on strike for months, which eventually meant we had no food in the house. But my father was passionate and never wavered in his conviction that what they were asking for was nothing more than what they deserved as humans. So when I was approached on my first day at GSMC and given paperwork to join the Oregon Nurses Association (ONA), I signed without hesitation.

It seems that I have been fighting for the respect and conditions needed to take care of my patients, my nurses, and myself nearly ever since.

Patients First, Nurses Last

I quickly learned that the life of a nurse is hard. We take care of our patients first before anyone else, even when that means putting our own lives on the line.

By Tamie Cline

Tamie Cline, RN, is the president of the Oregon Nurses Association (ONA) and a bargaining unit leader at Good Shepherd Medical Center in Hermiston, Oregon. She has served on the ONA Professional Nursing Care Committee since 2020 and has been a delegate to the AFT's convention since 2018. She is currently an IV therapy and wound care nurse in the Good Shepherd Treatment Center.



I didn't realize at the beginning of the pandemic that stress, anger, and loss of compassion are signs of burnout.

Many of us take on every aspect of the caregiver role thinking no one else can, and our dedication is easily taken advantage of and unappreciated.

This became especially clear to me in 2009, when ONA entered contract negotiations with GSMC. We were told that all nurses do is stand around and draw paychecks, and that we could be replaced immediately. We'd asked for help—we needed more nurses because we were overworked. Instead, we were laughed at and told we weren't working hard enough. Administrators later brought in productivity "experts" to tell us how many full-time nurses we actually needed, based on a calculation of patient load and how many hours a nurse is at the bedside. Their expert calculators didn't account for patient acuity or nurse skill level. They didn't account for what we'd already been saying for years: the system we had in place wasn't working, and we weren't able to take care of our patients properly.

I became the bargaining unit leader after those negotiations because I could no longer just pay my union dues and stand by quietly. I needed to step up and fight for nurses. And while we were able to win some marginal improvements to our workplace conditions over the next few years—Oregon strengthened its safe staffing law in 2015, for instance—management continued gaslighting nurses while repeatedly telling us how lucky we were to have our jobs. In one memorable round of negotiations, we fought for lower interest rates on employee hospital bills because the hospital was charging 11 percent interest and referring to collections when staff members couldn't pay. The finance manager rejected this, saying that a car loan was more secure than a nurse's hospital loan—and proceeded to offer us credit cards at 26 percent interest.

By 2019, I was working in the surgery unit and had become ONA's treasurer. But we were still regularly being asked to do more with fewer resources and not enough nurses, and we were exhausted. For years, we would be on call for 24 weekday hours plus a weekend that started at 3 p.m. Friday and ended at 6:30 a.m.

on Monday. We would sometimes work over 24 hours straight, and when the 3 p.m. call time came, there was no one to give us a break because we did not have enough staff. There were times I would clock out from my shift, drive home, fall asleep in my truck in the driveway, and wake up with no memory of getting there. Other times, I would just barely get home and in the door before I was summoned right back to work. And although the staffing law offered nurses some measure of protection, other colleagues, like scrub techs and our certified registered nurse anesthetists (CRNAs), weren't protected—so there were times that they'd have to put in even longer hours.

We were losing nurses, nurse assistants, and CRNAs because of these working conditions, and we kept telling management that we needed more help. They kept answering that we had no more staff and, besides, the productivity numbers didn't support what we were seeing on the floor. We were asked to do more and more work. We'd have to pick up all the cases for nurses who called in sick. We were required to volunteer in the afternoons after our shift ended. Management just started signing us up for late shifts if no one was scheduled—so a shift that was supposed to end at 3 p.m. would be extended to 7:30 p.m. We had no say, no choice. When we tried to push back, we were told, "This is what you signed up for. It's part of the job description."

As the workload changed for the worse, so did the workplace. We had gone through multiple managers in the surgery unit, and by the end of 2019, things had become toxic. The assistant manager was pitting nurses and scrub techs against each other, leading to coworker bullying—particularly of younger or less experienced nurses. I stood up for myself in the few instances that coworkers tried to bully me, and I also stood up for the nurses I worked with. So many nurses in my department were being bullied and had no voice; they were afraid to speak up because of the consequences—including receiving the worst shift assignments and being demeaned by their peers. Where did our humanity and our compassion for each other go?

I was constantly advocating and standing up for my nurse colleagues—on the floor, as part of our union's staffing committee, and as a member of our union's program and policy council. I refused to allow them to be mistreated. I also fought to get a better call schedule implemented at GSMC so that my nurses weren't working shifts longer than 24 hours. But the stressors and exhaustion of short staffing, our relentless schedule, and constantly fighting for the conditions we deserved wore on me. I also changed, and not for the better.

I used to be the colleague who always had a smile for everyone and walked the halls with pep in my step. But I had become dissatisfied with my job, and increasingly, I was no longer a happy person, but an angry person. At home, I was mean to my husband, shutting him out when he tried to understand what

was happening with me. At work, I would still smile, and my patient care never suffered, but I was dismissive and short with my colleagues. I was no longer as compassionate with them. I was emotionally shutting down. And a few coworkers who were closest to me saw it. Once, in the middle of a shift, a nurse told me, “I don’t even recognize you anymore. Where’s the Tamie you used to be?”

“I don’t know,” I said. “I don’t know who that Tamie is anymore.”

By the end of 2019, I’d had enough. I asked to transfer out of my unit and into the hospital’s treatment center.

Then COVID-19 hit, and everything became much, much worse.

From Desperate to Unimaginable

I didn’t realize at the beginning of the pandemic that the stress, anger, and loss of compassion I was experiencing were signs of burnout. I just thought I needed a change of pace. So I moved to the treatment center on April 1, 2020, just weeks after the country went into lockdown. I’d barely gotten used to my new unit when it seemed the entire medical profession was turned upside down.

In May, GSMC laid off more than 20 nurses because departments were closing due to the extended lockdown. By that time, I was the chair of our bargaining unit and I was on the ONA board of directors; although I was not laid off, I felt it wasn’t right to still be working while my nurses couldn’t. I volunteered to take a layoff because the only way I knew how to support them was to show them that they weren’t alone. The layoff lasted for a month. And just weeks after we all returned to work, our region became the epicenter of COVID-19 in the state.

COVID-19 ran rampant through our community and hit our hospital extremely hard. We had no beds. Some days, there were no beds anywhere in the region, so we had to send patients to other states for care. We shut down the hospital to outside visitors. Nurses became unable to touch our patients or colleagues. Ours is a compassionate, nurturing profession, and touch is one of our key assessment tools. But our patients were dying, and we were putting gloves filled with warm water in their hands so that they would feel some kind of touch. We were calling families over iPads to say goodbye as their loved ones died, because they weren’t allowed to come in and hug them. Our colleagues were in pain, and we could only give them air hugs in the hallways.

In the treatment center, we were administering monoclonal antibody infusions in addition to IV therapy and wound care. We were one of the only hospitals in the area where patients could get the infusions, so they came from all over. We had been short on resources and staff before the pandemic—now, we were drowning. Simply surviving each shift became our priority.

Just like everybody in our hospital and throughout the nation, I was also picking up extra shifts. On my few days off, I volunteered to come in and just do infusions so that my nurses didn’t have to. I didn’t want to volunteer, but I couldn’t say no. Nurses are conditioned to feel like we’re letting our coworkers, communities, and families down if we don’t run ourselves ragged. And some supervisors are happy to use that to ask us to work beyond our capacity: “We really, really need you. Can’t you do it just this once?” But it’s never just once.

For months on end, we cared for our patients at the expense of ourselves, doing all we could to protect our families from exposure to the virus. Nurses were parking in their garages and sleeping in tents to make sure their families weren’t exposed. I kept a shoebox in my truck to store my work shoes so I didn’t have to bring them in the house with me after a shift. My grandchildren live close by, and I didn’t want to take any chances. I wouldn’t let them hug me when I came through the door. I’d go straight to the bathroom, throw my clothes in the washer—I can’t even estimate how much bleach I used on my scrubs—and hit the shower first, all before I was able to relax or hug my grandkids.

We were doing everything in our power to get through the pandemic, but the hospital did little to support us or keep us safe. They would occasionally throw a pizza party or bring in cookies, but they never gave us what we really needed. We were told to wear the same gowns from patient to patient and use masks for 12 hours a day and then re-sterilize them. When we asked for proper protective equipment and hotel rooms when we were on shifts so that we didn’t have to worry about exposing our families, we were accused of trying to profit from the pandemic. And if all that were not enough, while COVID-19 was still spreading rapidly, the then-CEO changed GSMC’s policy on contact tracing so that we were not told if we had been potentially exposed to the virus.

So much of what we experienced went against our professional ethics and changed our whole perspective of nursing. No longer were we there to take care of patients to our best ability. Instead, we were told to keep quiet and do our jobs. One manager even emailed the nurses on the med-surg floor, telling them that they were privileged to work through the pandemic and experience something they would never see again in their careers.

In truth, we were being pushed past our capacity, guilted into coming in for “just one more shift” with administrations shoving money at us to keep showing up. And nurses were committing suicide because they couldn’t—and they had nowhere else to go.¹ Our lives didn’t seem to matter.

Meanwhile, our patients were still dying. During one shift, I was called to a room to give an IV for a patient who was very sick. Just a few hours later, a nurse asked for another IV and sent me to the same room.

We're conditioned to feel like we're letting our coworkers, communities, and families down if we don't run ourselves ragged.

*If we don't
take care of
ourselves, we can't
take care of
our patients.*

I asked, "Did the patient pull it out?"

She said, "No, it's a new patient."

The patient had not made it. I went into the bathroom, and I let myself cry for five minutes. Then I wiped my tears, put on my mask, and walked back out into the hall like nothing was wrong.

But something was very wrong. Nurses felt it during the worst of the pandemic, when it was all we could do to survive. And we were still feeling it two years later, when the tide had seemingly turned. When one of my nurse colleagues was injured by a patient who had become violent, management asked what the nurse did wrong. Our request for extra security was refused because in management's view, the nurse could have done something different to avoid the attack. By asking to be safe, we were asking for too much.

Dying Inside

For two years, I acted like everything was normal, but internally I was angrier than I'd ever been. I was the chair of the hospital bargaining team, and I had run for and become ONA president so that I could fight for the rights of our nurses. But every day that I stepped into that hospital, I was dying inside.

I had stopped most self-care. I would wash my hair in the bathroom sink before work but sometimes went a month without taking a bath because I just didn't want to. I used to exercise all the time, but now I no longer had the energy. All I would do was go to work, come home, sit in my chair, and read. I gained 50 pounds. I didn't sleep. My blood pressure was out of control. For a solid six months, I had a headache that no medicine could take away. I was an emotional wreck.

In early October 2022, I saw my primary care physician in the hallway and spontaneously said, "I think I'm experiencing some burnout."

He looked right at me. "Tamie, I know you are. Do you need time off?"

"No, I've got this," I said. "I just feel that way."

He told me, "Well, when you hit your brick wall, come see me."

A couple of weeks later, I did. One morning I clocked in for my shift at 7:30 a.m., and by 8:30 a.m. I wanted to walk out the door. I told my boss, "I can't do this. I can't be here." I finished my shift that day, and then I took the rest of the week off. I saw my doctor again on November 1. When he walked into his office and saw me waiting, he said, "You hit your brick wall, didn't you?"

I started crying.

He suggested I take a month off to start, and while I agreed, I couldn't imagine ever coming back. Yet, as I took the elevator up two floors to my manager's office with my paperwork in hand, I felt so sick to my stomach that I wanted to throw up. I almost turned around and changed my mind about the whole thing. But I walked into my manager's office and handed her the paperwork. She told me to take all the time I needed.

Another nurse was sitting in the office when my manager stepped out to print my leave paperwork. "Have a great vacation," she told me.

I don't think she meant it the way it sounded, but it made me feel worthless. Why was I taking time off for myself when I still had a job to do and there was so much need? My coworkers and community were counting on me to keep showing up. How could I let them all down?

I looked at that nurse and said, "I will." And I left.

It's OK to Not Be OK

I was off work for five months, and much of that time is a blur because of how numb and traumatized I was. I couldn't even think of going back to work. Just turning down the road that led to the hospital on my way into town sent me into a panic attack. My headaches returned, and my anxiety went through the roof. So, I stopped taking that road. I found another way to town or left the area altogether—my family's cabin in the mountains became my safe place.

I began counseling, grateful that it was offered through my employer. As I started talking over my feelings and experiences with my counselor, I became angry all over again that my nurses and I—and nurses all over the country—endure mistreatment, disrespect, violence, and more in order to care for our patients. I was furious that it's the culture of nursing to put ourselves last and feel guilty for taking any time at all to care for ourselves.

As I talked with my counselor and started using the education resources offered by the AFT, I started learning more about what I was going through. The AFT offers training classes on burnout, moral injury, and posttraumatic stress disorder (PTSD), and I attended a session during the AFT Nurses and Health Professionals' Professional Issues Conference in Chicago. As the trainer discussed the signs of PTSD, my experiences and emotions of the last three years made sense. I stood up and said, "I think I have PTSD. I know I have burnout. You are describing me."

That was the beginning of my journey in understanding moral injury, which the trainer introduced as what happens when I'm made to do something that violates my ethics.* Listening to examples of situations that can cause it—like not being able to give my patients the care they need and deserve because of short staffing—I realized that not only did I have moral injury, but that many of my nurses and colleagues did, too. And like me, they had no idea that there is a name and help for what they're experiencing.

*To learn more about the causes of moral injury and what it will take to protect healthcare workers and enable them to heal, see "Clinicians in Distress: Addressing Moral Injury in Healthcare" on page 17 and "Moral Injury: From Understanding to Action" in the Spring 2021 issue of *AFT Health Care*: aft.org/hc/spring2021/pittman.

Shortly afterward, I contacted ONA and told them we need to do more to get the word out. I recorded a podcast (available at oregonrn.org later this year) to share what led to my breakdown and how I learned to recognize moral injury, PTSD, and burnout. I talked about suicide. I explained that while I never really thought about committing suicide, I did wonder who would miss me if I weren't around, whether anyone would show up for my funeral. It was a dark place to be.

Most importantly, I acknowledged that I wasn't OK. It's a hard thing to admit. And it took a lot of time and counseling for me to believe that nothing is wrong with me. I'm not defective. It's OK to not be OK.

That's the message that I needed years ago, and that nurses across the nation need now more than ever.

I returned to work at the end of April, when my short-term disability ran out. I certainly did not want to come back, and emotionally, I wasn't ready. But I'm a nurse who still wants to care for my patients. To keep my license, I need a certain number of hours at the bedside. Still, what primarily drove my decision was that my job security was in question. If I didn't come back after my leave of absence ended, I would have lost my seniority at GSMC. So, while there is no timeline for healing from burnout, PTSD, and moral injury, my time was up. I had to return to the bedside to protect my job.

I didn't sleep the night before my first shift back. The next morning, my anxiety, pounding headache, upset stomach, and chest tightness returned like old friends. I had to convince myself to walk through the hospital doors.

I was nervous to see my coworkers again. I thought I had let them all down. But my crew was amazing. Everyone was excited to see me and glad that I had taken care of myself. I worked three days in a row because I knew if I didn't, I would never return. After the third day, I left as soon as I could get out of the hospital. I decided to work just one day a week for a while. Because I'm per diem, I can work when I want to. Having some control of my schedule gives me back a little bit of the power and identity that I lost because I was running on empty for so long and pretending I was OK.

Many coworkers and other nurses who have heard my story contact me because they are also experiencing burnout, moral injury, and/or PTSD. They want to know how I got through this. I tell them the truth: I'm not through it. I'm still not OK, still not back to the happy person I used to be years ago. I don't know if I'll ever be. I'm still seeing a counselor, and even though I've returned to work, things are really, really hard right now.

I don't know how long I'll struggle with anxiety and fear. I'm hoping that by returning and learning to work through it, I'll get some measure of healing. I've been lucky to have this time away from work because it was a viable financial option for me; many others don't have the option of taking an extended leave for self-care.



Things have to change. Too many of us are hurting. We cannot continue in the way that we are, or our healthcare system will implode.

That's why I continue fighting. I recorded the podcast and am transparent with my nurses and anyone who will listen about what I'm experiencing and how they can get help. And I fought to pass a landmark bill this summer, HB 2697, that strengthens Oregon's safe staffing legislation. This bill will help save lives, reduce hospital admissions and readmissions, and change our profession for the better.[†]

I don't know if our profession—or even our generation—will ever fully recover from the trauma of the last few years. The pandemic and increasing corporatization of healthcare, in which hospitals put profits over patients and staff, have changed nursing. In many ways, they've changed who we are.

So where do we go from here?

If we are going to see change in our healthcare system for ourselves and our patients, we need to start with taking better care of our nurses and healthcare workers. But this requires changing the culture of nursing.

Caring for Ourselves

So much is wrong with the current, corporate model of healthcare,[‡] not the least of which is that it is dehumanizing and keeps nurses from really caring for our patients in the ways they deserve. But another failure of the corporate model is that it teaches nurses that caring for ourselves is not important to patient care—when the reality is that if we don't take care of ourselves, we can't take care of our patients.

*Together,
we can lead a
movement to
change nursing
and rehumanize
healthcare.*

[†]To learn more about this legislation and how we won passage, see "Historic Staffing Win for Oregon Health Professionals" on page 7.

[‡]For details, see "Bedside Medicine to Corporate Medicine" in the Spring 2023 issue of *AFT Health Care*: aft.org/hc/spring2023/derlet.

Resources

- Learn more about the mental health challenges nurses face and get help: oregonrn.org/page/mentalhealthresources.
- Read materials on PTSD, burnout, moral injury, and building coping skills and resilience from the AFT Nurses and Health Professionals' Professional Issues Conference: go.aft.org/2eb and go.aft.org/1ue.
- Share your story with researchers studying moral injury among nurses at George Washington University: gwhwi.org/moralinjury.html.

Do not hesitate: if you or someone you know may be considering suicide, call or text the 988 Suicide & Crisis Lifeline at 988 (in English or Spanish). TTY users can dial 711, then 988. Another option is to contact the Crisis Text Line by texting HOME to 741741.

—T. C.

For months during the pandemic, I asked that we stop scheduling patients for every minute of the day so that nurses could have a break. But my request was ignored. Every week, the ward clerk would send out an all-department message outlining everything that needed to be done for the week and information on any new patients we had. One week, the ward clerk wrote at the top of the outline in bold letters, “I know Tamie wants her breaks, but patient care comes first.”

I immediately looked at her and said, “You’re wrong. The law comes first. And the law tells me I am entitled to a break.”

We can’t put patients first if we haven’t eaten or had a moment to breathe or use the bathroom. But that’s the culture that has been created because of corporatization. In this culture, everything is a numbers game, and the end goal is money. So we check boxes on computer screens to speed up our assessments and notes. But nursing is not checking a box and calling it productivity. And it’s not sacrificing ourselves and calling it “patient care.”

Taking care of ourselves starts with admitting that we’re not OK and then seeking help. But I don’t think we push hard enough to get our members and all nurses the education and resources they so desperately need to improve their mental health and well-being. We need to reach out through every avenue available, including through commercials and on social media, because no one is talking about why nurses are experiencing burnout. No one’s saying, “It’s OK to leave the bedside if you need to.” In my experience, most nurses leave when they hit their brick wall, like I did, or when something traumatic happens in their care that they blame themselves about. And we lose nurses to suicide when they can no longer sit in their pain and they don’t have the physical or mental ability to find help. So, we need to let them know that it’s OK to start taking care of themselves long before they reach that point. It’s OK to take a day off whenever they need to reset. It’s OK to get help.

We also need to normalize counseling. It’s not the culture to talk to someone unless we’re in crisis. But nurses in every hospital and every care setting need regular access to behavioral health counseling. Dropping in to see a counselor, whether one-on-one or in groups, should be as common a practice as getting a meal in the cafeteria. It is a vital self-care tool that we shouldn’t have to beg for or pay for out of our own pockets.

I have heard from nurses throughout Oregon that while some hospitals offered counseling and other well-being supports during the height of the pandemic, most withdrew them when the worst was over—right when many people were realizing they needed help. Nurses throughout this nation are desperate right now.² The crisis point of COVID-19 may have passed, but the mental health crisis is just beginning. And we’re not OK. We need to acknowledge it now, because I can’t stand the thought of losing even one more nurse when help is out there.

Caring for Each Other

To change our system and nursing culture, we also need to change how we treat each other. We need more respect and kindness for our coworkers. Nurses aren’t trained to be bullies. Bullying stems from being under pressure; when we are unable to control a situation, we project our anger onto someone more vulnerable. The problem is those vulnerable nurses—usually our new grads or younger nurses who are still trying to learn the profession—have no way of protecting or defending themselves, and no voice to speak up for themselves.

We need to speak out against bullying and start teaching in nursing schools, hospitals, and all health-care settings that bullying culture is unacceptable. If we don’t push our new nurses out of the profession, they will be caring for us someday. They should be mentored and supported, not isolated and harassed.

One of the many lessons of the pandemic is that nursing has to completely change. But a safe staffing law alone won’t accomplish that. Counseling and education alone won’t accomplish it. It will take all of us fighting together for each other and for this profession that we love.

To nurses and other healthcare workers who are experiencing PTSD, burnout, and moral injury: Please know that you are not alone, and you haven’t let your families, coworkers, or communities down. Maybe one day, we will all be OK. But until then—and long after—we’ll fight for and support each other because we are stronger together. We are in a special moment now: our voice is strong, and we have the power to make a difference like never before. Together, we can lead a movement to change nursing and rehumanize healthcare. Together, we can be healthy again. ✦

For the endnotes, see aft.org/hc/fall2023/cline.

Clinicians in Distress

Addressing Moral Injury in Healthcare



Late in the summer of 2020, Dr. Rita Gallardo saw Mrs. Alvarez (both names are changed) in her oncology clinic. Mrs. Alvarez was tired, bruised, and aching, and a lab test pointed to a rare blood cancer, one Rita had seen only once before. The prospect of treating it made her uneasy. Her instinct, because all the doctors in her system were similarly unfamiliar with this rare blood cancer, was to send Mrs. Alvarez to a more specialized center, which happened to be part of another health system.

Rita knew the perfect person to see her patient: her mentor from her oncology fellowship, an expert in rare blood cancers who had treated hundreds of similar cases and worked at an academic center just 75 miles away. He was also a gentle, kind man who would take the time to make sure Mrs. Alvarez understood what he was doing and why.

But Rita also knew her health system expected employed doctors to refer patients to doctors within their own system to prevent patient revenue “leakage” to competitors. She knew administrators were tracking her referrals, and her supervisor hinted at serious consequences if she failed to meet those expectations. But Rita made the referral anyway and waited for repercussions.

Just a few weeks later, her supervisor admonished her for making more outside referrals than was the

norm. It is illegal to threaten or reward physicians for their referral habits, so organizations use a variety of other tactics to steer referrals where they want them to go, such as strongly worded reminders to physicians that internal referrals improve continuity of care, communication, tracking to ensure follow-up, and patient satisfaction. Rita didn’t buy any of those rationales, but she heard her supervisor’s indirect message clearly: her job was on the line if her patients’ needs, rather than those of her hospital, remained her priority.

For the second time in five years, Rita, a US Army veteran who had deployed to Iraq and cared for combat-shattered young service members, recognized her experience of moral injury. Looking for a healthier practice that prioritized patients, she left a job whose organizational values did not align with her professional obligations to her patients. She prioritized the promise she made to her patients, at significant personal cost.¹



In 2017, my husband suffered a critical illness. He is also a physician, and during the course of his short stay at our local hospital, the doctors caring for him—his colleagues—were distant and impassive in the face of his extremis. They delayed his transfer, despite my urgent requests, until his next option for treatment was extracorporeal membrane oxygenation, a therapy not

By Wendy Dean

Wendy Dean, MD, is a psychiatrist, author, and cofounder of Moral Injury of Healthcare, which addresses clinician distress and its impact on patient care. She has overseen research funding for the US Department of Defense and supported military medical research at the Henry M. Jackson Foundation for the Advancement of Military Medicine.

offered at the small facility. They were caring people and not reckless physicians, so their stonewalling and what felt like brinkmanship with my husband's life seemed out of character. But their inaction stuck with me because of how unsettling and inexplicable it was, given what I knew of them, and of medicine. If asked what was wrong, they might have said they were burned out, because there was no other language for their experience at the time. But to me, their struggle seemed different. It seemed like their hands were tied, as though without accurate language, they were resigned to a situation they couldn't articulate and therefore could not solve.

+++

Countless earnest efforts to address clinician distress over more than three decades have fallen short.

Recently, when I was a patient, my physician shrugged off a long-delayed diagnosis as the cost of working with a poorly designed electronic medical record (EMR). He found it too hard to locate notes from outside clinicians, and after offering feedback on the EMR that was ignored for months, he stopped looking for the notes. He also didn't respond to questions sent through the patient portal, relegating that to other staff; they deferred the answers until my weeks-later follow-up appointment. My physician knew what needed to happen, and he had asked for it repeatedly. His choices were to leave or strike out on his own—but other hospitals in the area were just as bad, and he knew that reestablishing a practice elsewhere would take much longer than the few years left before he retired. So he stayed, frustrated but without viable alternatives, knowing his patients would do better with simpler care coordination. The upshot was delayed communication, a delayed diagnosis, and, ultimately, a compromised outcome. All because a physician's tool, selected by a committee of nonclinicians, was built to optimize revenue cycles instead of patient care.

+++

And, finally, as a psychiatrist, I struggled to find a business model that allowed me to practice in a way that was best for patients. Teaching hospitals stressed productivity and medication management. In pri-

vate practice, I could choose the best combination of therapies for patients, but insurance reimbursement was abysmal, and a cash pay practice limited patient access. Psychiatrists might be able to build successful practices using that model in more affluent regions, but not in the rural farming community where my husband found work—and where my patients lived. I concluded that, tough and resourceful as I was in all other regards, somehow this doctoring thing just was not working out. It felt like the medicine I imagined I would practice when I went to medical school was no longer possible because the oath that had been a cornerstone of that work no longer meant what it once did.

+++

Each of these examples, different though they may appear, reflects the range of intensities, awareness, and duration of clinician distress. Countless earnest efforts to address clinician distress over more than three decades have fallen short. More than half of US clinicians reported feeling burned out in 2022.² Robust data tie clinician distress inversely to patient outcomes.³ Administrators and other healthcare leaders, too, are feeling more distressed.⁴ It is hard to know if healthcare is good for anyone today.

During my husband's illness, I was working for the US Army overseeing research progress at academic centers across the country that had received grants from the US Department of Defense. I regularly met and spoke with physicians at those institutions, and many of them seemed to find their clinical work ever more challenging. So I started asking them, informally, whether they felt shut down and unable to act, as my husband's physicians had seemed to be. Physicians, nurses, occupational and physical therapists, social workers, and, in confidential conversations, administrators all admitted they were struggling to do their jobs, constrained by healthcare's bureaucracy and unable to do what they knew was best for those they served. But the ubiquitous "burnout" label didn't quite fit. They knew, going into healthcare, that they were signing up for long hours and sometimes impossibly hard, tragic work. What they didn't know was that healthcare systems might work against them in accomplishing their mission of excellent care. None of us had language for that situation—so I started looking.

When I heard about moral injury and learned that drone pilots experienced the condition, even though they had never physically been in combat, I was sure the concept could expand to healthcare. Admittedly, there are some fundamental differences in the contexts of war and healthcare. Military moral injury usually arises from the misdirected deployment of specialized skills, like lethal force, a momentary overstep of the military's contract with society to provide protection. That situation is not a wholesale departure from the military's mission. Moral injury in healthcare, though, stems from a fundamental conflict between the profession's societal contract of healing and the pursuit of revenue-focused business values.⁵



Moral injury was first defined by a psychiatrist working with combat veterans from the Vietnam War. Originally conceived as “betrayal by a legitimate authority in a high-stakes situation,”⁶ it was later expanded to connote a transgression of deeply held moral beliefs⁷—for example, the oaths we take in healthcare to prioritize patient needs. These two elements are often viewed as the external and internal sources of moral injury, respectively, but it may be more helpful to view them as having a stimulus and response relationship: a betrayal, to which one acquiesces, resulting in transgression of moral beliefs. It is the relational rupture of betrayal, and the inescapable experience of transgression, that clinicians find unbearable.

What Distinguishes Moral Injury from Other Conditions?

Accurately applying a psychological construct in a new context requires strict adherence to how the experience is defined and methodical and constant parsing of the new condition from other conditions. This can be especially difficult with moral injury because several conditions share similar symptoms and may occur together. Moreover, at times the conditions influence each other—as when, for example, administrators repeatedly ignore nurses’ complaints about the burden of short staffing causing their burnout. Repeated often enough, the nurses no longer excuse this inaction as ignorance but see it as betrayal, heightening their risk of moral injury. Posttraumatic stress disorder, empathy-based stress conditions (compassion fatigue, secondary traumatic stress, and vicarious traumatization), and burnout are most easily confused with moral injury, and each warrants a brief discussion.

As with moral injury, the identification of posttraumatic stress disorder (PTSD) arose from work with military combat veterans. The current psychiatric *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) defines PTSD as a reactive condition arising after a real or perceived threat of death or serious injury.⁸ The basis of PTSD is a threat to one’s mortality, while moral injury stems from a threat to one’s moral foundations. Both conditions may arise from traumatic experiences, and responses may be similar, including shame, guilt, depressed mood, and mistrust. But studies are beginning to show that distinct brain regions process the experiences, suggesting different neurobiological processes.⁹

Empathy-based stress conditions such as compassion fatigue, secondary traumatic stress, and vicarious traumatization are also easily conflated with moral injury. Compassion fatigue is “a state of exhaustion and dysfunction biologically, psychologically, and socially as a result of prolonged exposure to compassion stress.”¹⁰ Someone experiencing compassion fatigue might once have been described

vernacularly as “crusty,” “hardened,” or “jaded.” My physician’s shrug about the consequences to me of a labyrinthine EMR might easily be construed as compassion fatigue, if he truly was unbothered by the constraints on his care. But while there are some health workers for whom this may be the case, most feel the obligation of their oath deeply. If the inaction of my husband’s physicians cloaked their anger and shame at not being able to deliver better care, then they were likely suffering moral injury as well as, or instead of, compassion fatigue.

Secondary traumatic stress represents the “natural, consequent behaviors and emotions resulting from *knowledge about* a traumatizing event experienced by a significant other [or client/patient]. It is the stress resulting from *helping or wanting to help* a traumatized or suffering person.”¹¹ Nurses working in the emergency room who exhibit the hypervigilance, flashbacks, rumination, and low mood associated with PTSD despite never having been exposed to life-threatening violence themselves may be suffering secondary traumatic stress. But, like PTSD, the condition is distinguished from moral injury because there is no sense of moral transgression.

Vicarious traumatization is a pervasive, longer-lasting shift in a caregiver’s inner experience that results from disrupted beliefs about the world after empathetically engaging with others’ traumatic experiences.¹² For example, emergency room staff may struggle to see the world as just or fundamentally good after caring for too many victims of gun violence or child abuse. Moral injury, on the other hand, leads those experiencing it to question not whether the world is still a good place but whether *they* are still good people. As Rita Gallardo said, if she had followed her employer’s directives and put profits ahead of patients’ best interests, she would not have been able to think of herself as the excellent physician she took an oath to be, which is the hallmark of moral injury. Questioning both one’s worldview and oneself would suggest co-occurrence of vicarious traumatization *and* moral injury.

Finally, burnout and moral injury are also discrete experiences and independent drivers of clinician distress. Like moral injury, burnout is not classified as a psychiatric disorder in the DSM-5. But in 2019, the World Health Organization included burnout in the 11th revision of its International Classification of Diseases as a “syndrome” that results from “chronic workplace stress that has not been successfully managed.”¹³ In other words, burnout corresponds to the demand-resource mismatches or operational challenges of mandatory overtime, overbooked clinics, and administrative burden. Moral injury may arise from these same situations when there is an added component of betrayal leading to relational ruptures such as broken trust, values conflicts, and unresolved miscommunications. Although they are independent

Calling this a mental health crisis pathologizes clinicians’ appropriate responses to a toxic situation.

experiences, early data¹⁴ suggest that burnout and moral injury occur concurrently¹⁵ often enough that when one is present, the other should be queried.

This is cause for concern because burnout is shockingly common. In a recent survey, two in three clinicians reported at least one symptom of burnout in 2021. Twenty-five percent of clinicians were considering switching careers; of those, fully 89 percent said burnout was the driving factor, followed by not having the resources they needed to operate at full potential and a lack of effective processes and workflows, supplies, and equipment. Moreover, 59 percent of clinicians considering leaving said their teams were not adequately staffed.¹⁶



A Longstanding Problem Made Worse by the Pandemic

Many who are not on the frontlines of healthcare might view the pandemic as having incited health worker distress. But on February 24, 2020, weeks before New York City shut down, I testified before the New York City Council's Health and Hospitals Committee about safety in the city's emergency rooms—which were (and remain) overcrowded, understaffed, and under-resourced—and the pressing need to address moral injury. Indeed, this issue existed well before COVID-19, but the pandemic brought the challenges into stark relief.

Health workers had long warned that staff, supplies, and space pared to the bone were potentially catastrophic in a crisis because there was no slack in the system to accommodate a massive surge. With COVID-19, what they had long feared came true. At the same time, many people in the United States take for granted that we can get healthcare whenever we need it, wherever we are, and that there are limitless resources available for our healing. That requires a constant supply of healthcare workers selfless enough to do exquisitely hard work driven by the personal satisfaction they derive. Administrators have depended on health workers' deep commitment to healing, too, relying on health workers' reluctance to walk away from their careers and abandon their patients to an unknown fate.¹⁸

But the healthcare workforce was changed by their experiences of working through the pandemic.¹⁹ One of the main options for mitigation—speaking up publicly or whistleblowing—was widely barred during the pandemic, ostensibly to allay patients' fears about hospitals being unsafe. Health workers were fired for speaking up,²⁰ and others who stayed silent for fear of retaliation faced an increased risk of moral injury. Many described to me an experience called *mortality salience*, or becoming aware of the inevitability of their own death, which led to a sudden reordering of their priorities.²¹ Clinicians experiencing mortality salience have reconsidered whether their obligation to their profession is imperative.

Now, administrators are left with the novel situation of a workforce they can no longer take for granted. In fact, after nearly one in three health workers left their jobs (voluntarily or not) during the first year of the pandemic,²² a recent survey forecasts a continuing exodus.²³ One nurse told a reporter:

In many hospitals, people felt like, you're throwing us to the wolves, and you're not helping us and providing us the necessary resources that we need—the personal protective equipment, that sort of stuff. And it still hasn't changed three years in. Our nursing turnover is huge. They're like, I don't want to do this anymore.... I'm leaving the

The healthcare workforce is speaking out and voting with its feet in a way it has never done.

Unfortunately, much of the rhetoric about distress in the last few years has encouraged managers to intensify mental health support for workers rather than addressing the systemic problems that the healthcare workers say are their big concerns. Pathologizing an appropriate response (e.g., frustration, anger, or withdrawal) to a toxic situation (betrayal) harms individuals and weakens systems. Fragilizing the healthcare workforce—although we know that physicians are more resilient than the average employed population¹⁷ and suspect other seasoned clinicians are as well—by calling their distress a mental health issue rather than a toxic work environment is yet more destructive. While mental health care and supportive well-being programs* should be viewed as baseline conditions for the difficult work of healthcare, the crisis of moral injury won't be solved in a therapist's office. It depends on reshaping healthcare systems and the environments they create—something no healthcare system has yet undertaken in earnest.

*Focusing on "reducing the stigma" of moral injury is also misplaced because it makes "stigma" a societal problem and effectively lets health systems off the hook for creating harmful conditions.

bedside, and going to work in an ambulatory clinic, or I'm going to completely leave nursing as a profession at all, because this is just not what it was like to be a nurse before.²⁴

A 2022 survey found that the top reasons nurses were leaving their jobs were hospital management and chronic understaffing; COVID-19 was a distant third.²⁵ Although workforce data in early May 2023 showed nurses returning to staff hospital positions from travel nursing jobs,²⁶ the trend bears watching. As the AFT's Healthcare Staffing Shortage Task Force report describes, there's no shortage of qualified individuals to do these jobs; there's a shortage of licensees willing to tolerate the conditions in healthcare workplaces.²⁷ If nurses find empty promises of workplace changes, they may turn on their heels and walk out again.

One in three nonclinical staff—including housekeeping, food service, administrative, and laboratory staff; receptionists; schedulers; lab or x-ray technicians; finance and information technology support personnel; and researchers without a clinical role—and one in five physicians also plan to leave in the next two years.²⁸ This exodus is the manifestation of the relational rupture of moral injury, the fundamental breach of the psychological contract between the healthcare industry and the workforce that serves patients. Moral people, especially idealistic young people, are enticed to join a moral profession and a moral organization to do moral good. They expect and trust that the organization is committed to what is best for patients and will be good to the workforce, honoring and aligning with their obligation to serve their patients. Breaking that implied psychological contract is costly:

As clinicians and their families do the reckoning of what's important in the wake of COVID-19, it is hard to imagine they will value employers who put the wellbeing of the organization ahead of the wellbeing of its workforce. It is unlikely that those who waded into the breach without sufficient protection, as their pay was cut, their protests gagged, their employment threatened, and their friends fell ill, will plan long, loyal careers with the organizations that treated them this way.²⁹

The healthcare workforce is speaking out and voting with its feet in a way it has never done.³⁰ Stemming that tide demands a change in organizational cultures to morally centered, just institutions.

Preventing Moral Injury

How does an institution become morally centered? Interventions to repair relationships with the healthcare workforce and reduce the risk of moral injury are a start. These interventions come from empowered clinicians, courageous leaders, and policy action.

For the individual who has experienced moral injury, addressing the “betrayal by a legitimate authority” puts them in the difficult position of having to call out the missteps of those in power. It takes rare courage to do that. For most, the stakes are too high, so they stay quiet. But clinicians can empower themselves by joining with their colleagues and speaking with a collective voice. Formalized bodies for speaking collectively include medical staff, professional societies, and unions, which typically have the strongest protections for worker voices and the most leverage at the workplace.[†]

Clinicians are essential for decision-making with clinical implications. Organizations that are serious about mitigating the risk of moral injury will formalize opportunities for clinicians to engage. For example, any organization can implement GROSS (Getting Rid of Stupid Stuff) initiatives, which ask clinicians to identify administrative tasks that add no value to patient care and should be eliminated. The idea started at Hawaii Pacific Health in 2017, when leaders asked clinicians to identify elements of the EMR that were “poorly designed, unnecessary, or just plain stupid.” They received nearly 200 nominations for items that included noting the condition of an umbilical cord in an adolescent; printing discharge papers and then scanning them back into the EMR to capture the patient's signature, which hospital lawyers deemed irrelevant; and alerts to document repeated head-to-toe nursing assessments during a single shift on some units.³¹ The Cleveland Clinic undertook a similar effort in 2018 and eliminated distracting alerts, unnecessary popups, and inaccurate trend reports.³² Other organizations have expanded the initiative to eliminate requirements based on overinterpretation or misinterpretation of regulations, like tuberculosis mask fitting and training requirements for outpatient physicians. One organization pushed back on state regulations requesting staff to repackage information already available through other reporting.³³ Yet another organization worked with the state to reduce an hourslong training for signatories of a single form down to just minutes.³⁴

While adjustments to existing platforms can make modest improvements to workflow or burden, real transformation would occur if health systems pressured vendors to develop truly intuitive user interfaces (think about the ease of operating an iPhone, for example), built with robust clinician input. An intuitive user interface could dramatically cut down on the outsized burden of documentation, improve communication between clinicians, and lead to better

Stemming that tide demands that organizations become morally centered, just institutions.

[†]Healthcare unions, including unions for advanced practitioners, are growing as clinicians seek to address the working conditions that lead to moral injury. Read one physician's story, “Do No Harm: Organizing as a Physician,” in the Spring 2023 issue of *AFT Health Care*: aft.org/hc/spring2023/garvin.



Organized workers can launch campaigns to cultivate community support.

care for patients from clinicians freed up to be more attentive and informed.

Ideally, those in positions of power (hospital CEOs, legislators, regulators, or insurers, most commonly) will accept responsibility and accountability for relational repair. They hold the most influence over the healthcare environment and therefore are most likely to betray the healthcare workforce, whether inadvertently by making underinformed operational decisions or intentionally by focusing on profits more than patients. They must commit to identifying and reducing those risks.

A few such leaders have been early adopters of a moral injury perspective, asking for guidance in caring for their workforces. One example is the late Dr. Leon Haley, who became the CEO of University of Florida Health Jacksonville in 2018—and with whom I collaborated briefly until his untimely death in 2021. Dr. Haley walked through the emergency department every day and spent time on inpatient floors weekly. He coaxed feedback from everyone from environmental services to department chairs, apologizing when he needed to and thanking them for their candor. Armed with that information, he secured millions of dollars from the city to upgrade his hospital’s physical condition. He approved a wellness office without hesitation, despite a significant cost. He was present, curious, concerned, and connected to his workforce while also communicating openly, especially during the most difficult stretches of the COVID-19 pandemic, about the challenges they faced. He moved effortlessly between those meaningful interactions with individuals to using what he learned from them to advocate for change.³⁵ Because of these connections, he knew his workforce was strained in the pandemic and the usual burnout mitigation strategies were not working. Always open to new approaches, Dr. Haley followed the suggestion of his wellness officer to consider reframing their burnout mitigation through a moral injury lens. Though our collaboration was cut short by Dr. Haley’s death, his leadership style was well matched

for this work, and most of the initiatives he started continue. Ed Tufaro, the interim CEO of a large physician-owned practice, described such leadership, including his own, succinctly: “If I do my job well, I’m taking care of the people who take care of the patients.”³⁶

Those in management roles between the frontline and the C-suite—the connectors—are ideally placed to facilitate the necessary and notoriously difficult free flow of bidirectional information. William Bird, the former senior vice president for Penn State Health Medical Group, established dyad partnerships—pairing each clinician leader with an administrative partner—to minimize clinician distractions from patient care. My husband’s radiology practice joined Penn State Health in 2019, so I have seen up close their system and its impact on his partners. When scheduling or prior authorization challenges arise at a radiology site, for example, the practice manager for outpatient imaging investigates the health system friction points and works with the necessary central offices to smooth them. The radiologists can continue their clinical care uninterrupted while patient issues are solved in the background. Four and a half years later, my husband and his partners still love their jobs. When they experience frustrating days, having a well-informed management partner working on their behalf so they can stay focused on their patients and their mission of excellent care goes a long way.

For organized workforces, labor-management partnerships (LMPs)* can be an effective way to raise worker concerns that fall outside the scope of typical collective bargaining.³⁷ LMPs can simultaneously improve working conditions and patient outcomes by creating an environment of mutual respect and problem-solving between management and front-line workers.

Organized workers can also launch campaigns to cultivate community support. After all, patients do not want profits to be valued more highly than patient care and workforce well-being. One example is in rural Willimantic, Connecticut, where Hartford HealthCare decided to end labor and delivery services at Windham Community Memorial Hospital in 2020, claiming declining births and retention issues. AFT Connecticut members from education and public employee locals joined nurses and health professionals in building a coalition of concerned community members and local organizations in the fight to resume these essential services. Together, they collected signatures, organized demonstrations, sponsored ad campaigns, and provided public testimony on how the closure harmed patients, workers, and the community. After a lengthy investigation,

*To learn about LMPs, see “Improving Working Conditions in Turbulent Times” in the Spring 2022 issue of *AFT Health Care*: aft.org/hc/spring2022/lazes_rudden.

the Connecticut Office of Health Strategy ordered Hartford HealthCare to reopen labor and delivery services and pay more than \$151,000 in fines. The health system appealed the decision.³⁸ According to AFT Connecticut Vice President John Brady, “Our members continue to organize with the coalition because we have an ethical responsibility, as a union of caregivers, educators, and public servants, and as members of our communities, to advocate for access to affordable, quality healthcare—not only in Windham, but across the state wherever such care is threatened. We do that through partnerships with various community coalitions and allies.”³⁹

While none (that I am aware of) have done so yet, organizations truly committed to building a just, courageous, and continuously improving workplace could initiate monthly administrative morbidity and mortality rounds. Attended by all levels of administration and clinicians, these meetings would parse the role of nonclinical decisions (including resource allocation and staffing) in suboptimal patient outcomes. The intention is not to lay blame but to improve *all* aspects of the system that impact patient experiences. Such action would restore a sense of shared values and responsibility between clinicians and administrators.

Finally, legislation at state or national levels is necessary. Through policy actions, legislators exert legitimate authority over clinicians. When they enact policies that protect clinicians, they mitigate the risk of moral injury (and of related distressing conditions discussed earlier). But only coalitions of healthcare workers from various sectors will move such policy actions forward.

Recently, unions and professional societies have called for worker protections against violence and in support of safe staffing ratios. “Our nurses and health industry workers care every day for the sick, the elderly and the mentally ill, yet they often feel unsafe or unprotected themselves from the assaults that occur in hospitals and other healthcare-related settings,” said AFT President Randi Weingarten in May 2022,⁴⁰ when the Workplace Violence Prevention for Health Care and Social Service Workers Act was reintroduced in the Senate.⁴¹ The legislation would require employers to implement prevention plans to protect healthcare and social service employees from incidents of workplace violence. The AFT also launched the nationwide Code Red campaign in February 2023 to address the healthcare staffing crisis; while the campaign is ongoing, at the time this article was finalized for publication in September 2023, affiliates in Connecticut, Oregon, and Washington had already secured additional staffing protections in state law, among other significant victories.†

Similarly supported by diverse health worker unions, Rep. Jan Schakowsky and Sen. Sherrod Brown reintroduced the Nurse Staffing Standards for Hospital Patient Safety and Quality Care Act⁴² on March 30, 2023. The bill would set minimum nurse-to-patient staffing requirements, study best practices for nurse staffing, and protect nurse whistleblowers speaking up for the safety of their patients.

In addition, dozens of federal agencies impose requirements on healthcare organizations. Harmonizing and consolidating those requirements began at the Centers for Medicare and Medicaid Services (CMS) in 2017, when Seema Verma was appointed director. By the time she left in 2021, the overall number of measures in the Medicare fee-for-service programs was reduced by 15 percent, from 534 to 460, saving an estimated 3.3 million hours of reporting effort, as well as \$128 million for the agency.⁴³ Chiquita Brooks-LaSure, the next CMS director, promised to continue the effort under the moniker Meaningful Measures 2.0.⁴⁴

Another positive step would be for healthcare organizations, including nonprofit organizations, to be included in the Federal Trade Commission’s proposed ban on noncompete clauses so that healthcare workers are free to leave unhealthy workplaces. And financially exploitative health system practices like failing to fully disclose the availability of charity programs to patients with financial need⁴⁵ and harming indebted patients by cutting off their care,⁴⁶ suing them,⁴⁷ or offering them credit cards from which hospitals benefit⁴⁸ must end. Likewise, we must ensure that the Consumer Financial Protection Bureau, the federal consumer watchdog, closely monitors how healthcare financial products and insurance are evolving. Simplifying benefits, patient financial liabilities, and negotiated rates would make it easier for clinicians to heal their patients without inadvertently inflicting financial wounds.

As we emerge from three years of the COVID-19 pandemic with scores of lessons learned (but relatively few acted on), it is time to reframe our understanding of workforce discontent. The transactional or operational challenges of burnout are still relevant, and the distress of PTSD and empathy-based stress must be alleviated, but expanding the framework to include the relational ruptures of moral injury clarifies the sources of harm to healthcare workers and better frames solutions. Frontline worker voices are crucial to reestablishing healthy healthcare workplaces through improving EMRs, addressing patient care safety and quality, standing up to violence, and insisting on transformative, compassionate leaders at the helm of courageous, continuously improving, and morally centered organizations. But it is risky for workers to speak up alone. So, what will we promise each other as we build solutions together? +

Frontline worker voices are crucial to reestablishing healthy healthcare workplaces.

†For more on Code Red victories, see the package of articles that begins on page 3.

For the endnotes, see aft.org/hc/fall2023/dean.

Caring for the Whole Person

A Model for Treating Mental Health and Substance Use



By **Rebecca Farley David** and **Connor McKay**

Rebecca Farley David, MPH, is a senior advisor on policy and special initiatives with the National Council for Mental Wellbeing, where she oversees the Certified Community Behavioral Health Clinic Success Center. Connor McKay is a director of communications and public relations for the National Council for Mental Wellbeing.

Michael,* a 43-year-old man living with schizoaffective disorder, was successfully managing his mental illness through regular outpatient treatment. But he hadn't told his mental health clinicians that he had heart disease—or that he did *not* have a primary care clinician. His care team did know that he lacked permanent housing and was moving in and out of different living situations in the Portland area, which could only make matters worse. Without access to regular physical healthcare, he soon began visiting the emergency department (ED) for each heart-related incident.

Each time he went to the ED, he left with a referral to a cardiologist. But—largely due to his housing situation and lack of primary care—he was never connected to the specialty services that could have changed the course of his disease. The situation kept worsening, until soon he was visiting the ED twice a month. Hospital workers gave him the best possible care while he was with them, only to see him readmitted again ... and again ... and again.

*The client's name, age, and mental health diagnosis have been changed to protect his privacy.

In a typical scenario, Michael might never have gotten access to the heart care he needed. All too often, patients like Michael fall through the cracks of our fragmented, overburdened healthcare system, continually utilizing EDs or hospitals for health crises that could be avoided with timely access to specialty outpatient services and chronic disease management. In the worst-case scenario, his untreated heart disease might have ultimately killed him; he would be one of millions of Americans living with serious mental illness whose lives are cut short due to untreated physical health conditions.

But Michael had the benefit of being a client at LifeWorks NW, a mental health clinic piloting a new model of care delivery under the Certified Community Behavioral Health Clinic (CCBHC) demonstration.[†] As a newly minted CCBHC—with enhanced funding designed to transform service delivery—LifeWorks NW had the strategies and know-how to help. The

[†]Demonstrations are projects conducted and sponsored by the Centers for Medicare and Medicaid Services (CMS) that test new ways to deliver and pay for healthcare; the CCBHC demonstration is overseen by the Substance Abuse and Mental Health Services Administration in partnership with CMS.

LifeWorks NW Rapid Response Team flagged Michael's frequent ED visits and stepped in to intervene.

LifeWorks NW's Rapid Response Team is just one of many innovations supported by the CCBHC model. It's a mobile team of three master's level clinicians whose sole purpose is to connect with clients who have been hospitalized or seen in the ED and keep them from being readmitted. With access to an electronic system that tracks hospital and ED usage in real time, the team can flag clients in need, coordinate with hospital staff, touch base directly with clients to help them navigate their time in the hospital or ED, and get them access to the right outpatient health services upon discharge—including community mental health services, primary care, and specialty services like cardiology. The team can also help clients address unmet social drivers of health, like lack of food or cold exposure, that all too often push them to EDs when there is nowhere else to go.

After the Rapid Response Team connected with Michael, they helped him set and attend his referral appointment with the cardiologist. With support from the Lifeworks NW care coordinators and outreach specialists, he was able to move into supported housing with primary care available onsite. Through LifeWorks NW's onsite pharmacy, Michael had convenient access to the medications he needed. His heart disease began to come under control. The result: Michael went from two ED visits per month to two total visits in the following six months—an 83 percent reduction. In all likelihood, the LifeWorks NW team had helped save Michael's life.

What Is a CCBHC?

CCBHCs are clinics that meet defined federal criteria for comprehensive, evidence-based mental health and substance use care that is coordinated and integrated with primary care, hospitals, and other partners. The CCBHC model recognizes that true well-being goes beyond addressing behavioral health or physical health needs to attend to the whole person. Using staff with appropriate training, CCBHCs must provide nine core services: crisis services; treatment planning; screening, assessment, diagnosis, and risk assessment; outpatient mental health and substance use services; targeted case management; outpatient primary care screening and monitoring; community-based mental health care for veterans; peer, family support, and counselor services; and psychiatric rehabilitation services. They must offer access to care at times and places convenient to those served, including by delivering services outside the four walls of the clinic, while still meeting standards for timely access to care. CCBHCs are also required to conduct client- and family-centered support activities—for example, the coordination of transportation and housing assistance that Michael received—that are not billable under typical payment systems but are critical to addressing each client's whole spectrum of needs. They must reach out into communities to engage

with vulnerable or high-risk individuals and bring them into care. Other criteria relate to organizational structure, including the requirements that members of the community served be part of the CCBHC's board, and specify the state and national quality reporting standards to which CCBHCs will be held accountable.¹ Importantly, given the high prevalence of co-occurring physical and mental health conditions, CCBHCs are expected to monitor clients' basic physical health indicators, screen them for any needs or barriers related to accessing primary care, and help connect them to physical health services as needed to address any acute or chronic conditions.

LifeWorks NW is one of 12 clinics in Oregon that went through a lengthy process to become CCBHC-certified when the model first launched in 2017 as a Medicaid pilot in eight states. LifeWorks NW provides quality, culturally responsive mental health and addiction services and integrated physical healthcare across the lifespan throughout Washington, Clackamas, and Multnomah counties. Its status as a CCBHC and the funding that comes with it have enabled it to greatly expand services like the Rapid Response Team that would not otherwise be reimbursable under standard payment models.

For clients like Michael, those services can make all the difference.

Today, LifeWorks NW is one of nearly 150 state-certified CCBHCs in 12 states. There are also more than 350 clinics in 37 states and territories that have received temporary, time-limited federal grants to initiate CCBHC activities. Interest in the model is growing, and the recent authorization of up to 10 new states in the demonstration every two years means CCBHCs could be nationwide within the next 10 years.²

Why the CCBHC Model?

To understand the CCBHC model's origin, it is helpful to take a short trip back in time. The nation's community mental health centers, or CMHCs, were established in 1963 under the last bill President John F. Kennedy signed into law. Envisioned as "a wholly new emphasis and approach to care for the mentally ill," these community-based providers were designed as an alternative to psychiatric hospitals that had become known for confining people with serious mental illness within "antiquated," "overcrowded" settings while providing suboptimal—and often actively harmful—treatment. In contrast, proponents reasoned, the newly created CMHCs would provide treatment and supportive services to individuals living within their own communities, with care based on the latest medical advances. Ultimately, this would enable the closure of costly, ineffective psychiatric hospitals and offer people living with mental illness the opportunity to thrive in their communities.³

Unfortunately, while the following decades brought a surge in psychiatric hospital closures, an accompanying surge in resources for community-based care



True well-being goes beyond addressing behavioral or physical health to attend to the whole person.

never materialized.⁴ Many people with the most severe conditions struggled to access care,⁵ while homelessness, unemployment, and poverty grew.⁶ Some former state hospital patients “began to cycle in and out of acute care settings or migrate to jails, prisons, homeless shelters, and similar settings, a trend that has come to be known as ‘trans-institutionalization.’”⁷

Congress’s 1980 passage of the Mental Health Systems Act attempted to “right the ship”⁸ with an infusion of funding for CMHCs, augmented with community support services. Yet, this landmark law was nearly entirely repealed by the subsequent Congress through the Omnibus Budget Reconciliation Act of 1981, signed into law by President Reagan. The following year, federal funds for CMHCs were shifted to a Mental Health Block Grant program, which was capped each year and routed through state mental health departments.⁹

Since that time, federal funding for the Mental Health Block Grant and its parallel program, the Substance Abuse Prevention and Treatment Block Grant, has not kept pace with the rising need for care.¹⁰ Though Medicaid has emerged as the single largest payer for mental health and substance use treatment,¹¹ Medicaid reimbursement for behavioral health services falls far short of payment for comparable medical/surgical services,¹² leaving community providers severely underfunded and frequently unable to meet the full need for care in their communities.

Inaccessibility and unaffordability of treatment are consistently cited among the top reasons that people do not receive care.¹³ The Substance Abuse and Mental Health Services Administration (SAMHSA) reports that only 47.2 percent of American adults with any mental illness received mental health treatment in 2021. Among adults with a serious mental illness, 65.4 percent received treatment—better, but still reflecting that more than 3 in 10 Americans who truly need care did not access it. The situation is even worse for those living with a substance use disorder: just 4.1 million of the 43.7 million Americans over 12 years old who needed substance use treatment received it in 2021.¹⁴

People whose mental health or substance use conditions go untreated all too often wind up in hospitals and EDs for conditions or complications that could have been more effectively addressed earlier in the course of illness. Lack of community-based care capacity has contributed to “boarding,” in which patients remain longer than medically required in a hospital or ED because there is no appropriate care setting to which they can be discharged. This limits bed availability for other individuals in need and places additional burden on hospital and ED clinicians and staff. According to the American College of Emergency Physicians, “the stresses created by psychiatric patient boarding can lead to longer-term problems for physicians, including increasing levels of frustration and burnout”¹⁵—but the problem isn’t

limited to physicians. Nurses and other hospital and ED staff experience comparable challenges and are just as likely to experience moral distress and moral injury under these conditions.¹⁶

Meanwhile, community-based providers struggle with a fractured financing system that fails to fully support and incentivize timely comprehensive services, care coordination, and population health management. Community-based mental health and substance use providers work tirelessly to cobble together funding from multiple private and public sources to deliver the latest evidence-based care. Yet, the scope and quality of services vary from community to community, creating inequities and leaving clients and health system partners unsure of what to expect from referral partners. Severe workforce shortages¹⁷ have contributed to long wait times for care, stretching to 48 days on average within community-based mental health centers.¹⁸ With Medicaid reimbursement rates too low to support competitive wages, clinics report losing staff to other employers that offer better pay, such as grocery stores, fast food restaurants, banks, and the hospitality industry.¹⁹ And without a defined status in federal law, initiatives to support the rest of the health-care system with technology adoption and other modernization efforts too often bypass behavioral health providers,²⁰ leaving them struggling to share electronic data and participate in value-based payment systems.²¹

Amid these problems, the CCBHC model emerged in 2014. The Protecting Access to Medicare Act²² established a new Medicaid demonstration program that articulated, for the first time since 1963, a federal definition for community-based mental health and substance use providers offering comprehensive outpatient care. This definition, which was further detailed in guidance from SAMHSA (updated in 2023),²³ established substantial new requirements for clinics in order to

- expand the scope of services they offer;
- engage proactively with unserved and underserved populations to reduce unmet need for care;
- ensure individuals receive high-quality, evidence-based services; and
- improve coordination and connectivity across health sectors.

CCBHCs must serve anyone in need of care, regardless of their diagnosis, ability to pay, or place of residence. They must meet standards related to timeliness of access, including 24/7 access to crisis services delivered by mobile teams. They are subject to quality reporting requirements aimed at ensuring accountability for services and outcomes.

In return, qualifying clinics receive a bundled daily or monthly Medicaid payment rate calculated to support their costs of expanding services and reaching new populations. This payment rate, known as the Medicaid prospective payment system or PPS, gives



The CCBHC model engages clients in early, community-based treatment that reduces their need for inpatient and emergency care.

CCBHCs flexibility to devote resources to a wide variety of activities not traditionally billable under the medical model of insurance, but which are known to improve clients' engagement in care and their health outcomes. For the first time, participating clinics have an ongoing, sustainable source of federal funding for supporting clients through care transitions, identifying and reaching out to individuals at risk in their communities, leveraging technology to expand their reach, and engaging in active collaboration with health sector partners.

The original eight-state demonstration program was expanded to two additional states in 2020 via the CARES Act.²⁴ Two additional states have implemented the model independently in Medicaid outside of the demonstration, and 15 states are currently going through a yearlong process to plan their CCBHC programs and apply for the demonstration. Meanwhile, a SAMHSA-run grant program offers temporary funding supporting hundreds of individual clinics around the nation in building out CCBHC services and activities. Most recently, Congress opened participation in the demonstration to all states over the coming years.²⁵ Today, there are nearly 150 certified CCBHCs, along with more than 350 CCBHC-like grantees. Together, they operate in 49 states and territories, serving an estimated 2.1 million individuals.²⁶

The results have been transformative, with clinics expanding staffing, increasing the types of services they offer, shifting expanding care delivery in communities outside the walls of brick-and-mortar clinics, and engaging with partners in innovative ways—ultimately, contributing to vastly improved care on behalf of the clients they serve.²⁷ The effects extend beyond mental well-being, with CCBHCs better positioned to help clients address their full spectrum of health needs. As our team regularly hears from clinic staff participating in the model, its financial flexibility gives them the ability to support clients in ways that were previously impossible. Put another way, as the *New York Times* noted in a recent editorial on the development of CCBHCs, “The solution to America’s mental health crisis already exists.”²⁸

CCBHCs Serve Patients and Communities

The CCBHC model has allowed demonstration participants to transform the ways they deliver care, improving patient health and well-being, but that isn't the only area where its results are measurable. CCBHCs also return significant benefits to the communities they serve, especially by helping to reduce strain on overwhelmed healthcare systems and health professionals—and they work because they allow each clinic to devote resources to the needs of their specific communities.

CCBHCs Help Alleviate Burdens on Hospitals and Emergency Departments

Utilization of inpatient and ED services frequently occurs when individuals experience a mental health or substance use crisis—yet research indicates that the

vast majority of these individuals do not require inpatient treatment and could be effectively helped at lower levels of care. For example, a decade of data from Georgia found that just 14 percent of individuals who were cared for by a mobile crisis team, ED, or crisis facility had clinical needs that aligned with inpatient treatment.²⁹

The CCBHC model offers improved opportunities to engage clients in early, effective, community-based treatment that reduces their need for inpatient and emergency care. It expands the continuum of crisis response by requiring CCBHCs to ensure all community members have access to 24/7/365 crisis care, including mobile crisis response, crisis stabilization, and other types of emergency intervention. In addition, all CCBHCs are required to establish care coordination partnerships with local hospitals and emergency departments. These partnerships are designed to reduce psychiatric boarding in emergency and inpatient units, improve care transitions, and reduce hospital readmissions by ensuring individuals don't fall through the cracks upon discharge, whether they were admitted for mental health or substance use issues or for physical health issues, as Michael was. With their hospital partners, CCBHCs have taken a variety of approaches. Among them: 50 percent report they have implemented a notification system in which CCBHCs are informed when a client is admitted for any reason or discharged and can follow up accordingly; 42 percent have established telehealth models in which CCBHC staff provide consultations, assessments, or other support to hospital and ED patients; and 20 percent report they have co-located CCBHC staff in an emergency department to conduct risk assessments, provide referrals and/or linkages to care, or offer peer support to assist patients with navigating the hospital/ED experience and discharge process.³⁰ Taken together, these interventions not only improve patients' access to treatment but also alleviate the burden on overworked hospital staff.

The model positions client needs—rather than financial constraints—as the driver of clinical care.

Data Spotlight Oklahoma and New York

Oklahoma reported notable decreases in the percentage of individuals admitted to inpatient care and treated in an ED among clients at the state's three CCBHCs. The CCBHCs generally showed a decline in the percentage of clients treated at the ED (an 18 to 47 percent reduction across the three clinics) and admitted to the hospital (a 20 to 69 percent reduction) from the period prior to CCBHC implementation to the fourth year of the program.¹

Over the first year of CCBHC operations in New York, individuals receiving CCBHC services utilized fewer of the more costly inpatient and emergency services. This included a 54 percent decrease in the number of CCBHC clients using behavioral health inpatient care, a 61 percent decrease in the number of clients using general hospital inpatient services, and a 46 percent decrease in the number of clients using the ED.²

—R. F. D. and C. M.

For the endnotes, see aft.org/hc/fall2023/farleydavid_mckay.



**One CCBHC
reduced
psychiatric
hospitalizations
by 93.1 percent.**

To measure and ensure the efficacy of their collaborations, clinics and states in the federal CCBHC demonstration must report on timeliness of post-hospital/ED follow-up for psych-related visits, and clinics in the CCBHC grant program must track changes in clients' utilization of hospital and ED services.³¹ SAMHSA reports that among CCBHC grantees, as of July 2022, clients had experienced a 72 percent reduction in hospitalization and a 69 percent reduction in ED visits over the period from individual intake to most recent reassessment (at least six months).³² Similarly, in a 2021 research effort, four CCBHC demonstration states provided data showing a reduction in utilization of higher levels of care, including ED visits and hospital inpatient admissions, through the CCBHC program. Remarkably, states reported the reductions even as they substantially increased the number of people served, many of whom had prior unmet needs and often had more complex mental health, substance use, and/or physical health needs.³³

The results have been even more impressive at some CCBHCs. As part of its CCBHC implementation in 2015–2017, GRAND Mental Health in Oklahoma put in place a new crisis response model designed to divert individuals in crisis from law enforcement involvement and psychiatric hospitalization. GRAND Mental Health opened several new crisis stabilization units across its 12-county service area in rural northeastern Oklahoma. Every individual who left the crisis stabilization unit went home with a tablet exclusively equipped to offer free access to behavioral health support at all hours of the day or night. Tablets were also provided to law enforcement officers so they could connect with mental health professionals as needed during calls. By connecting individuals in crisis to immediate behavioral health telehealth support, offering them a 24/7 facility for in-person observation and care, and delivering clinical support to individuals during encounters with law enforcement, GRAND was able to reduce psychiatric hospitalizations by 93.1 percent and eliminate inpatient hospital utilization in 2021.³⁴

Expanding access to care has proven particularly important in rural communities, which frequently lack a comprehensive continuum of care. A recent study of Oregon's CCBHC program found that access to community-based services increased 30.6 percent at rural and remote CCBHCs during the study period, in contrast to a 4.2 percent decrease in access among a comparison group of clinics that were not certified as CCBHCs.³⁵ These access expansions are coming at the same time rural hospitals are under increasing strain.³⁶ By reducing psychiatric patients' avoidable hospital use, the CCBHC model has the potential to remove a source of stress on our nation's hardest-hit hospitals.

CCBHCs Help Alleviate the Workforce Shortage

Expanded access and reduced hospitalization have been driven in no small part by CCBHCs' ability to improve staff recruitment and retention after implementation. The

National Council for Mental Wellbeing found in a recent survey that CCBHCs hired an average of 27 new staff per clinic—a 13 percent expansion over prior staffing levels.³⁷

Peer support specialists—people with lived experience who are trained to provide nonclinical support services—are CCBHCs' most common type of newly hired staff. They are essential to the model because they provide critical outreach and support to help keep clients engaged in care and in control of their health. Peer support specialists contribute to transforming the practice culture at CCBHCs with their focus on reaching clients by connecting through lived experience, often with individuals who otherwise might not have sought care. One clinic administrator in Oregon called this a “transformative” development in behavioral health because it enabled a culture shift: instead of focusing on treating “compliant” clients who show up at the clinic, peer support specialists are able to focus on reaching the clients who don't show up but who may be the most in need of assistance.³⁸

CCBHCs have also sharply increased their hiring of primary care providers, with 68 percent of CCBHCs reporting they have hired nurses, medical assistants, and in some cases primary care physicians.³⁹ These staff are responsible for screening and monitoring clients' physical health needs to ensure they receive care for chronic physical health conditions that all too often go untreated when care is not integrated.

The driver of this hiring is CCBHCs' financing model. Both grant-funded and Medicaid-funded CCBHCs have reported using their increased financial resources to support workforce expansion, but the results have been most significant among those that receive funds through the Medicaid prospective payment system.⁴⁰ Clinics have used their daily or monthly bundled PPS rates to introduce competitive pay, higher staffing levels with lower caseloads, revised job roles that allow clinicians to practice at the top of their licenses, and other workforce benefits into their practice model. The costs associated with these changes are included in the formula states use to calculate each clinic's PPS rate. That formula incorporates both the total cost of delivering care aligned with the CCBHC model and the number of daily or monthly encounters to arrive at an average per-encounter rate designed to support CCBHCs' true costs of serving their population. This means that for the first time, CCBHCs' payment is set at a level that allows them to better recruit, support, and retain their workforce. As an administrator at the Central Kansas Mental Health Center reported,

We have several positions to fill, but once filled, we are retaining employees for longer periods of time. We are finally more competitive with other area behavioral health agencies/positions/schools. We've had an increased interest in practicums, so much so that we don't have room for all of the interested students!⁴¹

Many CCBHCs report that these changes have had a profound effect on their workforce. At the National Council, our team hears regularly from CCBHC staff who report enjoying the practice climate of the CCBHC more than other community-based behavioral health settings, leading to improved retention. Without the time constraints and financial pressures of billing for units of service, they are freed up to practice in new ways and have increased flexibility to meet clients' needs.

This flexible practice environment also allows CCBHCs to be a better resource to health colleagues in their service area. With reduced wait times, referrals can get in the door more quickly. Because they have staff devoted to community partnerships and care coordination—along with financing for technology that supports electronic health information exchange—CCBHCs are better positioned to collaborate with their primary care and hospital partners on shared clients.⁴²

CCBHCs Tailor Care to Each Community

Part of what helps CCBHCs be effective is the way the model positions client needs—rather than financial imperatives or constraints—as the driver of clinical care. At the beginning of their implementation effort, states participating in the demonstration and clinics participating in the grant program must complete a community needs assessment to understand local demographics, service needs, co-occurring conditions, social determinants of health, and more.⁴³ Many of states' and CCBHC grantees' implementation decisions are driven by the results of this needs assessment—from the types of language translation services CCBHCs must make available to the types of partnerships CCBHCs must form with other local social service providers (such as homeless shelters or food banks), and more.

Critically, the community needs assessment must address the needs of not only individuals who are already in treatment but also community members who are unserved or underserved, with an emphasis on reaching populations who have historically experienced health disparities. These findings help clinics planning to become CCBHCs determine the appropriate levels and types of staffing for their client population, along with cultural or population-specific competencies staff must have. The costs associated with hiring and training these staff are then built into clinics' payment rates. Thus, reimbursement is set at a level specifically designed to secure the right number and type of staff to meet community needs.

This differs dramatically from a traditional fee-for-service system, where the availability of services and staff is driven by financial incentives and constraints within the Medicaid fee schedule rather than client needs. Under that traditional system, there is typically limited to no financial support for nonbillable

activities that are critical to achieving client health outcomes, such as outreach, engagement, and efforts to leverage data to identify high-risk clients and manage health across subpopulations.

This client-centered staffing model—along with the flexibility afforded by a bundled payment model—allows CCBHC clinicians and staff to prioritize client needs even when services or activities fall outside what behavioral health clinics are typically able to provide. At the same time, the CCBHC model supports and emphasizes the delivery of services outside the clinic, at times and places convenient to those served. Together, these changes have upended traditional service delivery by putting clients' needs at the forefront.

What's Next for CCBHCs?

Through the Bipartisan Safer Communities Act signed into law by President Biden in June 2022, every state will have the opportunity to apply to join the CCBHC demonstration by 2030. While that is a historic success and expansion of the program, without establishing a definition for CCBHCs in federal law, it could remain just that—a demonstration program with an end date. Securing a definition for CCBHCs in Medicaid and Medicare—much as hospitals and other healthcare facilities currently have—will also help ensure consistency and longer-term sustainability for CCBHCs across states. Right now, there's an opportunity to urge our elected officials to cement CCBHCs' status across the nation. Learn more and register to join our day of CCBHC advocacy on October 18 by going to our advocacy center (go.aft.org/9ut). Together, we can call on lawmakers to ensure there are more CCBHCs in every community nationwide.

The results are clear: CCBHCs are a game changer for improving access to mental health and substance use services coordinated and integrated with physical health and social services, helping reduce the burden on hospitals to provide care to people struggling with a mental health or substance use challenge. They expand access to comprehensive services and provide the person-centric care approach needed to make mental well-being, including recovery from substance use challenges, a reality for everyone. +

For the endnotes, see aft.org/hc/fall2023/farleydavid_mckay.

The CCBHC model allows participants to transform the ways they deliver care, improving patient health and well-being.

Want to Learn More?

Visit SAMHSA's website on the CCBHC model (go.aft.org/ipd) for links to detailed program information. You can also access data, videos, an interactive map, and more resources from the National Council for Mental Wellbeing's CCBHC Success Center (go.aft.org/m21).



Achieving Health Equity

The Invaluable Role of Nurses

By **Janice Phillips**

Janice Phillips, PhD, RN, CENP, FAAN, is the assistant director of the Illinois Department of Public Health. She was previously the director of nursing research and health equity at Rush University Medical Center and an associate professor in the College of Nursing.

J was an African American child residing in an impoverished community on the South Side of Chicago. Her parents and her grandparents had less than a high school education. J's mother was unemployed and suffered from a mental illness, so she was sometimes institutionalized. J never really knew her father. She also never really knew that she was born into poverty, although she and her sibling lived in substandard housing with grandparents with limited education and income, struggling to survive. Families in the surrounding low-income neighborhoods were struggling as well.

J attended elementary school, but her world began to unravel when both of her grandparents died. The lack of support and resources to attend school led J to drop out during the seventh grade. She didn't have health insurance. The family had access to healthcare at the local county hospital, but J did not have a primary care provider or pediatrician to guide her healthcare during her developing years, so she didn't have access to ongoing wellness or health promotion education.

J lived in a neighborhood without access to affordable fruits and vegetables and experienced many years of eating unhealthy fast foods, which brought with them the increased risk of chronic illnesses such as diabetes, hypertension, obesity, and even cancer—all of which disproportionately affect African Americans. J also recalled a brief period of food insecurity. When her family fell on hard times, she even experienced a short

bout of homelessness. After her mother was deemed unfit for parenting and they were evicted from her family's apartment, J was placed into foster care at age 11.

+++

J's story is all too familiar for many families across our country today. I often tell it at the beginning of a presentation I give to nurses about the social determinants of health—the social and economic factors that are known to influence the health and longevity of individuals and communities at large. Born to poor parents, J was already at risk for a number of health disparities and inequities. Childhood poverty remains a significant predictor of future poverty status, and African American children are among those hardest hit. We know that poverty limits access to healthy foods and safe neighborhoods. We also know that in communities with unstable housing, low-income and unsafe neighborhoods, substandard education, low health literacy, and lack of access to healthcare, health outcomes are strikingly poor.¹

We all are impacted by the social determinants of health: those social, economic, and even political factors that influence our lives, our environments, our resources, where we live, where we work, and more. Those factors can impact the health and well-being of patients and communities in positive and negative ways. Before I continue with the story of J, I'd like to explore the relationship between determinants and health outcomes, describe some of the progress in addressing the adverse impacts of the social determi-

nants of health, and consider the implications for nursing practice, research, and education and advocacy.

Defining Our Terms

We can't talk about the determinants of health without talking about health equity and vice versa—but it's important to understand the difference between them. When we talk about *health equity*, we mean that everyone has a fair and just opportunity to be as healthy as possible, which requires that we remove the obstacles to those opportunities: poverty, discrimination, and their consequences; powerlessness; and lack of access to good jobs with fair pay, quality education, adequate housing, safe environments, and healthcare. Working for health equity includes a focus on those conditions that drive health inequities, particularly among our underserved, under-resourced, marginalized, and otherwise excluded populations.

The National Academy of Medicine (formerly the Institute of Medicine) defines *health disparities* as racial or ethnic differences in the quality of healthcare treatment that are not due to what we normally might expect: they're not caused by access factors, clinical needs, patient preferences, or even what we do as an intervention.² Health disparities are similar to health inequities in that both mean differences in the presence of disease, health outcomes, or access to healthcare between population groups. But *unavoidability* is central to the definition. Some people experience health disparities because of policies and practices they cannot avoid.

Health equity and health disparities are closely related. Health equity embodies the ethical and human rights principle. It's the value that motivates us to eliminate health disparities or to focus on key determinants of health like education, housing, and discrimination. Without addressing some of these variables that drive health disparities, we will never achieve health equity. Determining the presence of, absence of, or decrease in health disparities are some of the ways we can measure how much progress we're making toward achieving health equity.

It's also important to work from a shared understanding of the social determinants of health. One common framework from the World Health Organization describes the social determinants of health as "the conditions in which people are born, grow, work, live, and age."³ Those social, economic, and political factors that influence where we live and what we have access to are shaped by the distribution of money, power, and resources at local, state, and global levels. We see the truth of this every single day. Some communities have more resources than others, buoyed by economics, policies, systems, and environments. Certain communities are struggling with environmental toxins and pollutants,* while others have different

regulations and policies that drive their access to a safe and clean environment.

We're talking about the social determinants of health because we are finally recognizing that while excellent healthcare is very important, it's not enough. Even with the amount of money that we spend on healthcare in the United States, we are lagging behind in some key indicators.⁴ We're far behind some other countries in maternal health outcomes, even though we have experts and state-of-the-art technology and facilities.⁵ Our life expectancy is lower than comparable countries.⁶ Medical care is insufficient for ensuring better health.

Understanding Health Outcomes

The social determinants of health have a lot more to do with life expectancy and quality of life than we might expect. According to population health researchers at the University of Wisconsin, only 20 percent of individual health outcomes are related to clinical care, including access to care and quality of care.⁷ (See the graphic on page 32 for more details.) As providers of care, we are all striving to give our patients the best clinical care, which is very important—but perhaps it's time to ask what else we could do.

Individual health behaviors—such as diet and exercise, tobacco use, alcohol and drug use, and sexual activity—account for about 30 percent of a person's health outcomes. On the other hand, about 40 percent of a person's health outcomes are directly tied to social and economic factors, including education, employment, income, family and social support, and community safety. And, of course, these factors are interrelated. Individuals with a higher level of education are more likely to have jobs that pay a livable wage and therefore are more likely to have health insurance. Individuals with higher-paying jobs have more money to take care of basic needs like food and housing. Individuals with family and social support may be more likely to engage in health-promoting activities because they have the help they need to get to and from a doctor's appointment or someone in their lives who is nudging them to take better care of themselves. And individuals who live in environments where they can walk freely spend time outside, getting fresh air and exercise.

The physical environment also accounts for about 10 percent of an individual's health outcomes. Poor air quality and poor water quality are not just problems in developing countries; we have these issues in our own backyards. In certain areas of the West Side and the far South Side of Chicago, for example, there are higher rates of asthma⁸ among our children because those neighborhoods are surrounded by refineries and other sources of air pollution. The quality of available housing and transportation is also important. How can we expect anyone to thrive or to experience optimal health while living in rat-infested or lead-contaminated dwellings? And do we have access to the transportation we need to get to and from our appointments and our jobs, or to just go about our daily lives?

We are finally recognizing that while excellent healthcare is very important, it's not enough.



*For details on environmental toxins, and environmental racism, see "Healing a Poisoned World" in the Fall 2020 issue of *AFT Health Care*: aft.org/hc/fall2020/washington.

All of these factors influence health outcomes, and they're all connected, primarily centered in where a person lives. The neighborhood you live in determines

- how much money your community has to invest in schools, libraries, and other resources;
- how easily you can access primary care providers, healthy foods, safe and sanitary housing, and other necessities for health;
- the safety and walkability of your community;
- the availability of reliable, affordable public transportation;
- the degree of racial and ethnic segregation; and
- the quality of the air you breathe and the water you drink and use to shower, cook, wash your clothes, and brush your teeth.

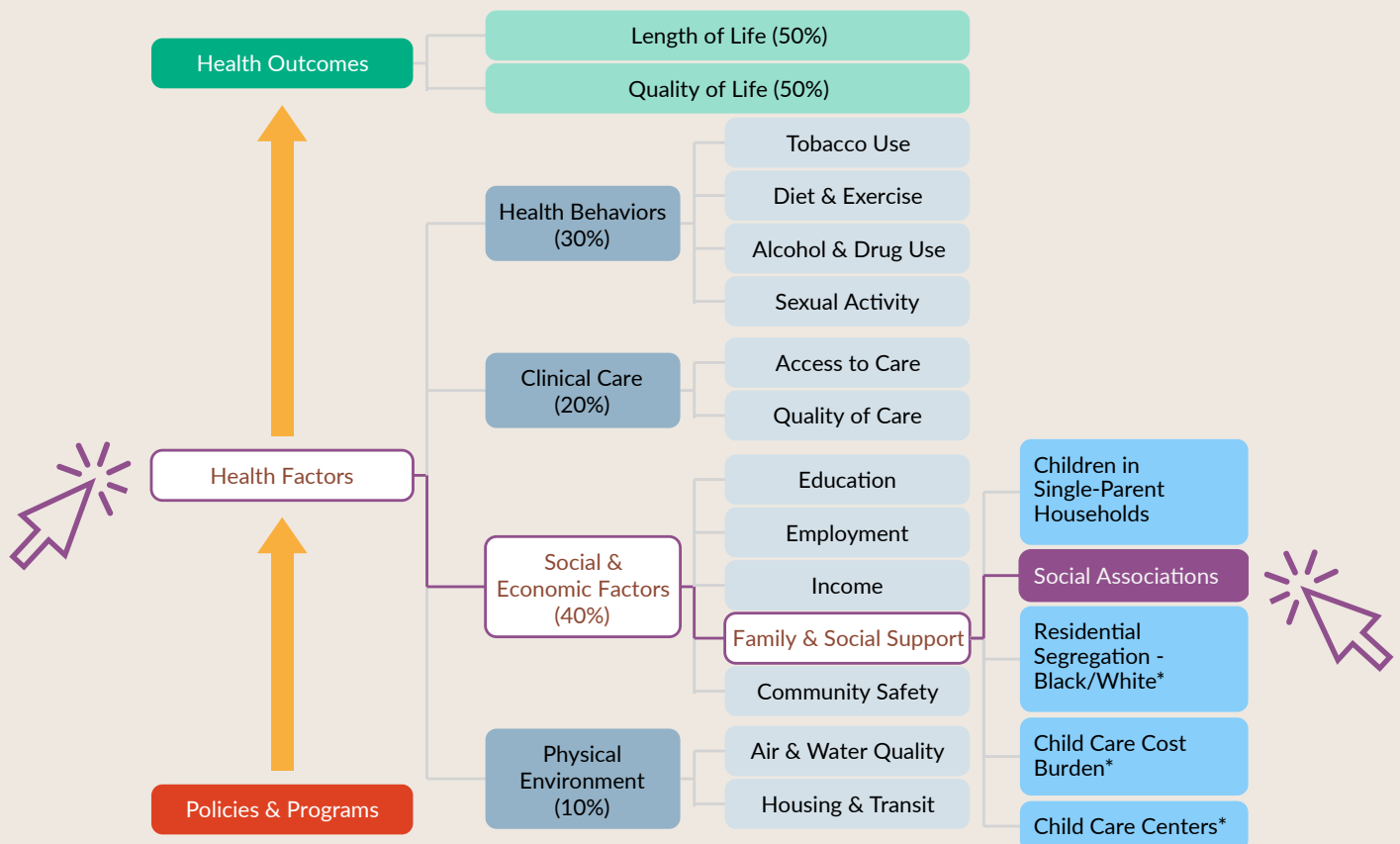
Here's one powerful example: individuals who live in the downtown Chicago area have a life expectancy of about 85 years.⁹ Compared with the rest of Chicago, they tend to have higher incomes, better jobs, higher levels of education, and better access to community resources and healthcare providers. They are mostly

white.¹⁰ But just a few stops away by public transit is a majority Black neighborhood called East Garfield Park, where the life expectancy decreases to about 66 years.¹¹ Those individuals have far fewer resources. Fewer residents have completed college, and they tend to have poor health literacy. Many live in substandard housing and don't make a livable wage.¹² It's no wonder that their life expectancy is not the same as those who reside in a much more affluent area of the city. (To learn more about East Garfield Park, see the excerpt of the 2022 community health needs assessment by Rush University Medical Center and Rush Oak Park Hospital on pages 34–35.)

When the COVID-19 pandemic was declared, everyone talked about its disproportionate impact on communities of color across our country; these communities suffered the greatest burden of disease and poor outcomes. Many individuals had public-facing jobs and didn't have the luxury of working remotely. Some were living in very crowded housing situations with increased exposure to and risk of contracting the virus. But as the example above shows, communities of color have long had adverse health outcomes and experienced these

Seeing Beyond Clinical Care

This model from the University of Wisconsin's Population Health Institute demonstrates some of the many factors beyond clinical care that influence health outcomes. Visit go.aft.org/8kg to explore this clickable model and learn more.



SOURCE: UNIVERSITY OF WISCONSIN POPULATION HEALTH INSTITUTE, COUNTY HEALTH RANKINGS & ROADMAPS, 2023, COUNTYHEALTHRANKINGS.ORG.

living conditions even before the pandemic. COVID-19 just unveiled these underlying inequities.¹³

Many healthcare institutions, insurers, and other stakeholders are now turning to these critical issues. The Centers for Medicare and Medicaid Services now requires hospitals to start screening some of their patients for the determinants of health, and community-based healthcare centers are following suit. They're asking questions like

- Do you currently have a place to live or stay? In the next two months, will you have a place to live or stay?
- Are you worried that your food will run out before you have money to buy more? In the last two months, have you run out of food that you bought and did not have money to get more?

There was a time when we didn't ask these types of assessment questions. But that's beginning to change as more people come to understand the importance of the social determinants of health. For example, while some health systems are working with local restaurants and convenience stores to make sure that residents have access to healthy food, others are developing safe and affordable housing. These institutions are taking on this work because they're starting to ask themselves, "What can we do to improve health outcomes and broaden our lens beyond clinical care to address unmet social needs?"

Moving Beyond the Essentials

Once we understand the roles these factors play, we have to start looking at the influence of policy. What are the political determinants that define whether we can achieve health equity? As clinicians, we can provide care at the point of illness, and we can offer interventions on an individual level when we screen patients and coordinate services with social workers and case managers. But the real impact comes when we address community needs and try to prevent harm from occurring by taking a critical look at the laws, policies, and regulations that can have such a dramatic impact on overall community conditions. With an equity lens, we can ask questions like: What do those laws, policies, and regulations say? Who benefits from them? Who might be adversely impacted by them? Who was at the table to help create them? That's where the rubber really meets the road.

Recognizing the Political Determinants of Health

If we are serious about eliminating health disparities, we have to get to the root of the problems that create them—what have been described as the political determinants of health.¹⁴ We can't talk about food security unless we talk about food deserts, areas with limited access to a variety of affordable healthy foods.¹⁵ We can't advance health equity if we overlook people who are unhoused or living in substandard housing or who don't have jobs that provide a living wage. Only by understanding these determinants, their origins, and their impact on equi-

table distribution of opportunities and resources will we be able to close the healthcare gap.

When we think about changing policies, most of us probably think about federal policy, but we don't all have to go to Capitol Hill to make a difference. What happens on the federal level does impact what happens at state and local levels, but we can use our health expertise much closer to home to advocate for policies that will improve health outcomes. In Illinois, for example, the Health Care and Human Services Reform Act, signed into law in 2021, focuses on improving health equity and the health and well-being of Illinois residents.¹⁶ There are many more opportunities at the state, city, and local levels, and all of us who work in healthcare can make valuable contributions by sharing our expertise.

Taking Action: What We Can Do

We have made some advances in the movement toward health equity. There is increased awareness about the determinants of health, more integration of this content into our nursing educational programs, and movement in healthcare institutions, the insurance industry, and the policy arena. But the determinants of health are just one steppingstone to achieving health equity, and we all have a part to play.

A 2021 report, *The Future of Nursing 2020–2030*,¹⁷ talks about the invaluable role of nurses and nursing in achieving health equity. It discusses what we as a profession need to do and what we can work on in our everyday practice as we strive to provide all our patients with affordable, equitable, and quality care. It's not just about access to care. We also have to make sure that our care is culturally relevant and addresses the individual needs of each patient. Once a patient overcomes the hurdle of accessing care, they may face additional struggles: Do they always understand what's going on with their care? Do they feel empowered and trust providers and others enough to ask the questions they need answered? Our patients face these struggles every day. And we as health professionals can unwittingly make these problems worse—or we can fight to make them better.

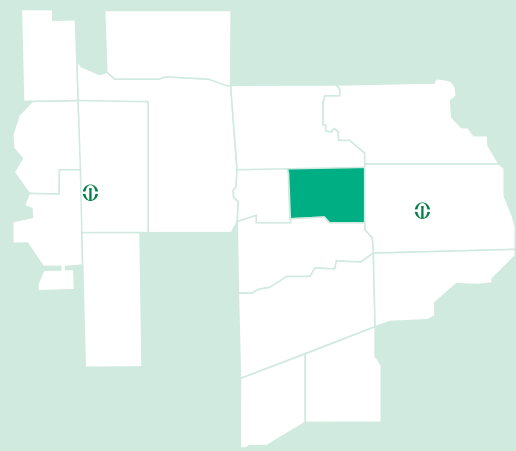
Making them better requires that we take a good hard look at ourselves. As you begin to consider what role you might play, pause for a few moments to think about these questions.

- To what extent do your employer, your local union, your state federation, and other specialty organizations you may be involved with address the determinants of health?
- Are you, as a health professional or a leader, able to take these variables into account in your daily nursing practice?
- What can your organization, your profession or specialty, or your voluntary organizations do in partnership with others to advance health equity?
- What other partners are needed to improve the health outcomes of those we serve?



About 40 percent of a person's health outcomes are directly tied to social and economic factors.

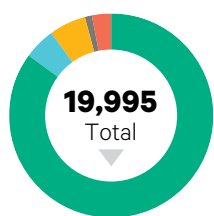
To view the full community needs assessment report, visit go.aft.org/y3l.



East Garfield Park

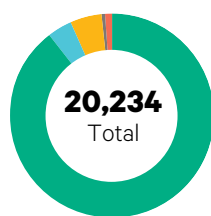
60624

Race/Ethnicity⁺



TODAY

19,995
Total

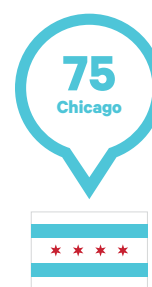


2019 CHNA

20,234
Total

⁺Percentages rounded. "Other" includes those who identify as other races, two or more races and/or American Indian/Alaska Native

Life expectancy



COVID-19



Positivity rate
7%



Mortality rate
.15%



Vaccination rate
58%



“We need quality grocery stores, fitness centers, job training, affordable housing, internet connectivity, safe day cares.”



26 grocery stores



4 childcare centers



4 health care and **7** mental health facilities



1 pharmacy



12 public parks



10 public and private schools

► **Unemployment**



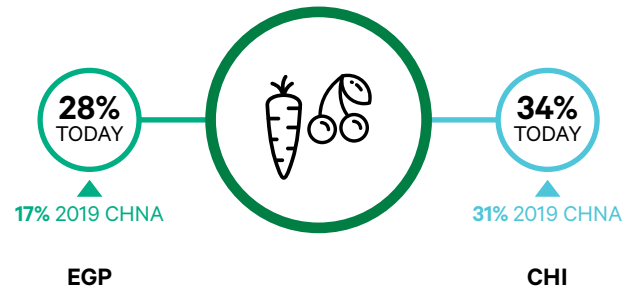
► **Moms getting good prenatal care**



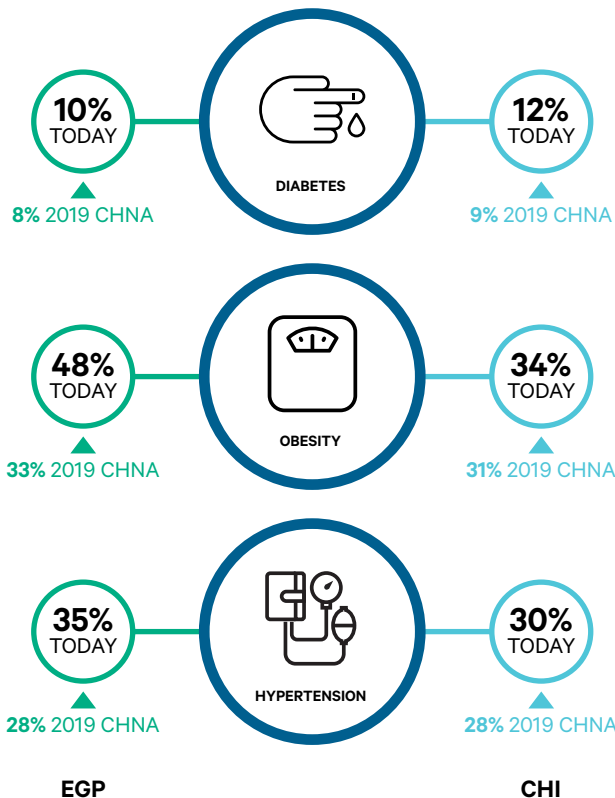
► **People who feel safe in their community**



► **Adults eating enough fruits & vegetables**

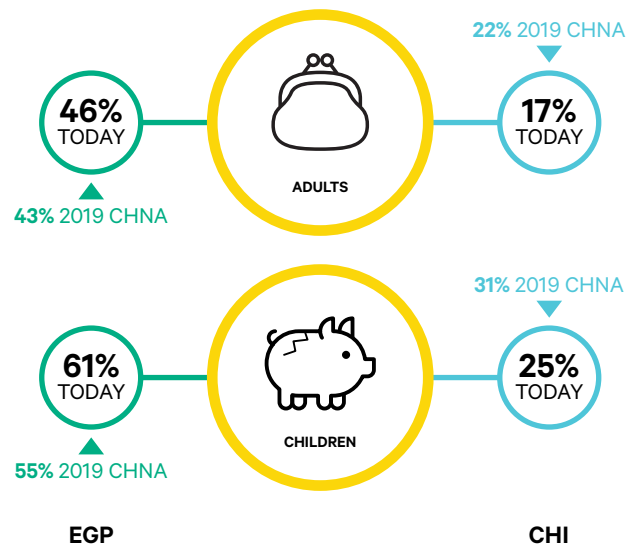


► **People with chronic conditions that contribute to the life expectancy gap**



“People stay in Garfield so long because they grew up here. It feels like home. And a lot of people want to leave the community better than they found it.”

► **People living in poverty**



Health professionals can't do this work alone. There is an African proverb that says, "When spiderwebs unite, they can tie up a lion." That just means this is an all-hands-on-deck effort. We will need to join with many other partners to advance health equity, including community-based organizations, faith communities, elected officials, and others also engaged in advancing health equity whom many of us may not have considered before.

Building Effective Partnerships

What can we do in our communities? No matter where we sit or work, we want to make sure that the decision-making body reflects the composition of the populations or constituents we serve. Partnerships are critical in this effort.

Establish a roundtable discussion. You might consider establishing regular discussions about equity issues to stimulate dialogue around what it means to have inequitable access or to experience inequities. Such a discussion could include not only clinicians from multiple disciplines and specialties but everyone who has a stake in the game—e.g., consumers, patients, and elected officials—to describe and discuss these issues and come up with solutions. In these conversations, community perspectives and input should be at the center. In community-based participatory research,* we are trying to engage communities in shaping a research agenda, and the same thing applies to advancing health equity. We need to bring our communities on board, not only to hear what some of the issues are but also to identify some of the solutions, which should be driven by community members' lived experiences and input.

Analyze policies using an equity lens. There are equity assessment tools emerging now that can help us consider who's benefiting from policies being proposed or enacted. What are the burdens of the policy? Is one policy going to be more burdensome or detrimental for any groups, particularly any underserved populations? These kinds of assessments look at both narratives and numbers. Paraphrasing Sir Austin Bradford Hill,¹⁸ a pioneer of epidemiology, African American cancer surgeon Dr. Harold Freeman once said, "Statistics are just the numbers with the tears washed away."[†] Statistics are essential, but so are the stories from people who are living every day with these poor environments, poor living conditions, and poor odds of good health.

Attend implicit bias and other anti-racist training. In the state of Illinois, we now have a law that all our

healthcare providers must have implicit bias training because we know that some of our patients and communities are still facing racism. They're not always welcomed when they come to our facilities. Healthcare providers aren't always sensitive to the conditions they live in or to that lived experience. A recent report from the National Commission to Address Racism in Nursing revealed that there's a lot of racism in the nursing profession that undermines the good work we're doing.¹⁹ We need to take a step back and assess how we might be further perpetuating these disparities.

Incorporate a community needs assessment into your nursing endeavors. Your employer or other organizations in your community may be required to conduct community health needs assessments. The Affordable Care Act requires that all healthcare organizations that claim tax-exempt status conduct and make public a community health needs assessment and implementation plan every three years. These assessments can provide key information to health professionals, as the example from the Rush University System for Health shows. If I were a nurse working in East Garfield Park, for instance, it would be important for me to know that there is a decreased life expectancy in this community. There are no high-quality, affordable grocery stores or food markets,²⁰ so if my patients are coming into the hospital malnourished or underfed, that could be due to the variety or affordability of the foods they have access to. I would also see that there are few community-based health centers or mental health centers. There are a lot of public and private schools in this community, but what is the quality of those schools? All of this is helpful information.

In my experience, community health needs assessments tend to be underutilized. They can inform us about where our patients are coming from and what they're living with day to day. They can also help us plan programming and outreach activities that we believe will meet our patients' needs. If your employer or local hospital doesn't produce needs assessments, you can also get helpful data from your city, county, or state health department or from the Centers for Disease Control and Prevention ([cdc.gov](https://www.cdc.gov)).

Imagining a Brighter Future

When I give this presentation to nurses, at this point I ask them to return to the story of J. I ask what they think might have happened to her, based on the information they have about the circumstances of her young life—and here I ask you to do the same. Spend a few moments pondering, and perhaps jot down a few notes in the margin about where you think J might have ended up.

Attendees often suggest that the cycle of poverty continued, that J became pregnant as a teenager and had several children, or that she began using drugs, experienced extended homelessness, or had her own



If we are serious about eliminating health disparities, we have to get to the root of the problems that create them.

*For examples of community-based participatory research, see "Brave Spaces" in the Fall 2021 issue of *AFT Health Care* at go.aft.org/g8h and "Environmental Justice" in the Spring 2022 issue at go.aft.org/xt6.

[†]Dr. Freeman said this during a talk on poverty and cancer many years ago, and I have carried it with me ever since.

mental health struggles. All of these guesses are reasonable based on what we know about people who have had similar experiences.

But I then ask them to imagine what could happen if we changed the script.

Imagine J born into poverty—but somewhere along her journey to adulthood, she received support to finish her education instead of dropping out in seventh grade. Imagine she received financial support to complete her college education, allowing her to secure meaningful employment with benefits and an hourly wage that started at double the minimum wage. She could now afford stable housing, and she had insurance because her employers provided healthcare coverage.

J's health literacy skills greatly improved because she was able to complete her high school education, which exposed her to more health-related resources and information. She also had a regular primary care clinician who provided lifesaving health information. Her nutritional status improved because once she knew better, she could do better, but also because she had the means to buy more nutritious foods instead of relying exclusively on fast food. Her chances of living a long and healthy life improved because her social and economic status improved.

Today, J attributes these changes to the strong social support she received, particularly from her social worker during her junior year in high school. She feels blessed to have beaten the odds and to have overcome the myriad issues that we know lead to disparities for many children born into poverty. Resiliency was an important factor in improving J's outcome, but it wasn't the only factor. She experienced a positive change in the social and economic factors that can adversely influence the health status and health outcomes of any child, any adult, and any community over time.

Education was probably the most powerful determinant of health for J. As discussed earlier, education can influence the opportunity to even get a job, let alone a good one with benefits and insurance. And the higher the level of education, the more likely we are to know more things, to have access to resources, to understand those resources, to navigate the system, and to have a higher degree of health literacy. Demonstrating the importance of political determinants of health, J was only able to get funding to go to college because of a state initiative that provided scholarships to children in foster care. Hers could have been a different narrative, but J met someone along her journey to adulthood who helped to shape and change that narrative and produce a more positive outcome.

Telling a New Story

What I don't usually tell attendees is that I know so much about J's story because J is me. We live in the

land of plenty, where each person is supposed to have the same opportunities to work hard and succeed, but for far too many children in the United States, that is a myth. Only an estimated 3 to 10 percent of foster youth even finish college, and the numbers for high school graduation also lag far behind other students.²¹ We hear that narrative pretty often—but we don't hear about those who do succeed against the odds. Their stories—our stories—have a lot to teach us, too.

It may not make sense to some people, but in some ways I'm grateful for my childhood experiences because I don't think I would have had access to a social worker who was committed to young people had I been in different circumstances. Without her, I probably would still have lived the typical narrative: dropped out of school, gotten evicted, perhaps even struggled with mental illness. From my perspective, that's a very dim outlook. But then, this social worker appeared in my life, picked me up, and said, "I think you've got some potential. Let me work with you."

Our world—and our patients—need more people like that social worker: someone who was passionate about their job and cared enough not only for me but for so many others to help make a difference in our lives.

I received state funding to go to college, and I also worked a few campus jobs to get some extra spending money. I entered the nursing program, which was very challenging. Even though I was a good student in high school, in college I was competing with kids from all over the globe who came from better schools, including private schools. It took me two solid years to get into the groove of being a college student. I had to learn how to study. I loved learning how the body worked, but I didn't like bacteriology or any of the more abstract prerequisite courses. But even though those first few years were hard, I was driven to complete the program because I knew I didn't have much of another option. I had to stay in school, try to get some support from college administrators (which I was blessed to receive), and get out and do something with myself. I knew that I couldn't go back to where I was. That was my driving force.

I finished college and went on to get a great job at the University of Chicago making \$5.65 an hour, which at that time was more than double the minimum wage. That was a lot of money for someone just out of college in the mid-1970s. It was enough to rent an affordable apartment in a safe neighborhood, buy nutritious foods, and take care of my other basic necessities.

I eventually decided to go back to school for a master's degree because my medical center offered 100 percent tuition reimbursement. It's hard to say no to that type of resource. When I graduated and started doing my community work, I fell in love with public health concepts and became fascinated with health disparities work. That's when I decided to go back to school for a PhD in nursing, and that research led me

We will need to join with many partners to advance health equity, including some we may not have considered before.

None of us knows the road another person has traveled—or what potential they hold.

to places I never imagined. I studied adherence to breast cancer screening guidelines among low- and middle-income Black women, and teachers were my sample of Black women with middle income. Because of that work I met Barbara Van Blake, the former director of the Human Rights and Community Relations Department at the AFT; working as a consultant for the AFT, I traveled the country with Barbara doing breast cancer education.

Since then, I've been blessed to travel the globe. I've been invited to present my work on disparities and other equity issues on every continent except Antarctica. (I don't know of any conferences there, but if I'm invited, I'll go.) And I find time to write books and articles because I feel that's what I should be doing as a woman with a PhD.

I'm passionate about equity issues, and I've met great people and worked with great colleagues and partners along the way to address these issues. In my new role as the assistant director of the Illinois Department of Public Health, I'm excited to address health equity across the state.

When I started this journey, I had no vision, no clue, no road map. But somehow, I found guides. We often talk about mentors, but there are also models. Not everybody can be a mentor, but there are a lot of people who modeled the behaviors that I wanted to emulate. I've learned a lot just from watching, reading about, and hearing from these people. They probably don't even know how they've impacted my trajectory, but I have them to thank.

Most nurses attending my presentation expect J's story to end in tragedy. Very few suggest positive outcomes. But I don't tell them that J is telling the story because I want them to understand that J could be anyone. I hope they'll think about J when they encounter patients and other people they don't know. I hope they'll consider J before having unkind thoughts or making stereotypical remarks about people. None of us knows the road another person has traveled—or what potential they hold.

Once, I was walking the University of Illinois campus and someone I didn't know came up to me and told me I was the reason they went back to school. I asked why, and they said, "I've always watched you, and you really have inspired me." We never know who's watching us. We never know how our words or actions or the way we treat people might inspire someone, give them the hope of doing something more.

Not everybody is going to go to college, but every job—no matter what it is—is important because it helps advance society or keep it running. We want everyone to at least have a decent life, no matter their chosen vocation. And we definitely want people to experience better health. Breaking down those barriers that we know prevent people from achieving better outcomes—that's part of our mission as health professionals. +

For the endnotes, see aft.org/hc/fall2023/phillips.

Surveying Nurses About the Social Determinants of Health

In 2020, my colleagues and I conducted a study with nurses at the three hospitals in the Rush University System for Health.¹ The study came about because we were preparing to ask nurses to start screening patients on the social determinants of health, and I realized that we first needed to survey our nurses to find out what they knew about the determinants and how they felt about screening patients.

We found that our nurses were not comfortable asking these types of questions. They wanted to help patients, but many feared that in asking screening questions, they would identify needs they didn't have the time or knowledge to address or would be interfering with the work of social workers and case managers. Ascertaining those issues helped us shape our education and training with the nurses.

Now, every nurse who comes to work at a Rush hospital receives that education in orientation, and some of our nurses and other team members are also screening patients for the determinants of health. Patient responses are entered into the electronic medical record, so if a clinician interacts with the patient and finds that they don't have food, a home, a primary care provider, or another necessity, they can work with a case manager and social worker to address these issues. No individual has to feel responsible for providing access to all the resources.

Ours was one of the first studies in the country to evaluate staff nurse perspectives around the determinants of health. Now, increasingly, people are asking to use our nurse survey because there isn't another like it—and there is growing

interest in clinicians' perspectives around the determinants of health. Now that the Centers for Medicare and Medicaid Services requires hospitals to screen some of their patients, it will become more important that clinicians are aware that they may be asked to do some of this screening or to collaborate or partner with those who are.

If you're looking to start a conversation in your workplace or in your local about how you can address the social determinants of health, this survey may be a good place to start. The entire survey is available for free at aft.org/hc/fall2023/phillips_survey.

—J. P.

For the endnote, see aft.org/hc/fall2023/phillips.

Tearing Down Invisible Walls

Ending Economic Housing Discrimination



Janet Williams, a Black single mother of two, works at a community health center and frequently faces a tough dilemma when her meager paycheck arrives. On several occasions, it's gotten "to the point," she says, "where I had to choose to pay for groceries, pay rent, pay gas and electric or ... pay childcare."¹ Sometimes her hand is forced. "I've had times where, if I didn't pay my rent, the next day I was going to have eviction filed." On those occasions, "the whole check goes to my rent," and while she waits for the next paycheck to arrive, she may have to tell her kids, we will "not have hot water and not have the electric working."²

With two kids and loans from college, Williams says her job as a community mental health worker and substance abuse case manager for a nonprofit doesn't provide enough. Williams did what society asked her to do by working hard and getting a college degree. But she took on \$70,000 of debt in the process. Her income is just above what would qualify for food stamps, she says, so "it's on me to put groceries in the house." She hates owing money, so when she gets a windfall, like a COVID-19 stimulus check, she uses it to pay down her credit card debt. But she's frustrated that high housing costs mean she is constrained to a neighborhood where her kids don't feel safe. "I can't tell you how many times we've seen

the police outside of our window," she says. To avoid dangers in the neighborhood, she says, "we pretty much keep to ourselves."³

Why Is Housing So Expensive?

The solution, when many people think about Williams's dilemma, involves finding ways to raise wages or increase government housing subsidies. Both approaches make good sense and are necessary.⁴ But equally, perhaps more, important is doing something about the "supply side" and addressing the question: What is driving housing prices so high? To what degree do hidden government policies, such as exclusionary zoning, help create the housing affordability crisis in the first place?

There is near-universal agreement among economists that since the 1970s, the rise of zoning laws that forbid the construction of multifamily housing has prevented housing supply from keeping up with demand. The 1970s were a turning point, in part because they were an era of growing inflation, and home equity became an increasing proportion of the financial portfolio of most families.⁵ As homeownership was transformed from a consumer commodity to an investment, homeowners became increasingly anxious about how new development might affect their property values—and demanded new zoning constraints.⁶

By **Richard D. Kahlenberg**

Richard D. Kahlenberg, JD, a researcher and writer on education and housing policy, is a senior fellow at the Progressive Policy Institute and a nonresident scholar at Georgetown University's McCourt School of Public Policy. Previously, he was a senior fellow at The Century Foundation. This article has been excerpted from *Excluded: How Snob Zoning, NIMBYism, and Class Bias Build the Walls We Don't See* by Richard D. Kahlenberg. Copyright © 2023. Available from PublicAffairs, an imprint of Perseus Books, LLC, a subsidiary of Hachette Book Group, Inc.

Families in poor neighborhoods are often cut off from healthcare.



Government policies that forbade multifamily housing generated and continue to perpetuate a housing shortage. If homeowners were allowed to subdivide their houses into duplexes or triplexes, or if more multifamily housing could be built near transit, for example, a community would be able to increase the supply of housing available. But single-family exclusive zoning prohibits that possibility.

When government zoning policies curtail housing supply in a metropolitan area and increase competition for housing, including in trailer parks, rents rise and millions of Americans suffer. Researchers found that, “Nearly 4 in 10 nonelderly adults reported that in 2018, their families had trouble paying or were unable to pay for housing, utilities, food, or medical care at some point during the year.”⁷ And a 2021 report, vividly titled *The Rent Eats First*, found that “nearly a quarter of renter households were spending more than half of their incomes on rent each month, leaving little income to cover other expenses.”⁸ Making housing more affordable, one author writes, “is literally a lifesaver. People who spend less on housing costs have more money to spend on food and medical care.”⁹

Does Your Neighborhood Really Matter?

Where you live in the United States matters greatly to your quality of life and the life chances of your children. It determines your odds of being safe, of getting a job, of accessing good healthcare, and of enrolling your children in strong public schools. Poor families who live (often because of government zoning) in low-opportunity neighborhoods with struggling schools and high crime rates face very different odds than poor families who live in higher-opportunity neighborhoods where schools are stronger and streets safer.¹⁰

Adults in high-poverty neighborhoods are often cut off from transportation and jobs, which can have a crushing effect on families. If a parent does not live in a neighborhood with good transportation options, commutes can become hours long. That can mean less time to help nurture a child when home after work.¹¹ Miss one bus exchange, and a worker can get fired for showing up late, with devastating effects on the whole family.

Families in poor neighborhoods are also often cut off from healthcare. To take one example, Bethesda, Maryland, an affluent suburb of Washington, DC, has one pediatrician for every 400 children, compared to poor and predominantly Black Southeast DC, where there is one pediatrician for every 3,700 children.¹² Poor neighborhoods are also more likely to have environmental hazards such as lead paint that can lead to lower IQ for children.¹³

Overall, the cumulative lifetime impact of neighborhood on opportunity can be enormous. A 2014 study estimated that “the lifetime household income would be \$910,000 greater if people born into the bottom quartile of the neighborhood income distribution had instead grown up in a top-quartile neighborhood.”¹⁴

An Economic Fair Housing Act

In August 2017, I proposed the idea of creating an Economic Fair Housing Act to make it illegal for government zoning to discriminate on the basis of income, just as the 1968 Fair Housing Act makes it illegal for parties to discriminate on the basis of race.¹⁵ It is time, a century after the Supreme Court struck down racial zoning, to outlaw unjustified economically discriminatory zoning.¹⁶ Although the private housing market would continue to function based on a consumer’s ability to pay, the idea behind an Economic Fair Housing Act is that local governments (and homeowners’ associations) should not themselves engage in economic discrimination by erecting artificial barriers to working-class people who wish to move with their families to higher-opportunity neighborhoods.¹⁷ When local governments adopt exclusionary zoning laws, which telegraph that less-advantaged families are unwelcome in a community, that government-sponsored income discrimination should be illegal.

Imagine how life would be different if we began to tear down the invisible walls that local governments erect to keep people apart. Imagine if the supply of housing weren’t artificially capped by zoning rules, and people like Janet Williams didn’t have to worry so much about whether to pay rent or buy groceries. If more affordable housing prices meant less homelessness. If people who wanted to move to coastal areas for a wage boost could do so because housing prices were not astronomical. If workers had less stress because they didn’t have to live on the outskirts of metropolitan areas and take two buses to work. If housing were built where people needed it so that auto emissions declined and we had fewer severe weather events.

Imagine if, because walls were coming down, metropolitan areas were less racially segregated and people met more neighbors who came from different racial and ethnic backgrounds—and as a result (according to 94 percent of studies) this interracial contact resulted in less racial prejudice.¹⁸ Imagine also what life would be like if more African Americans experienced the higher employment and higher wages that result from reduced segregation.

Imagine a United States in which low-wage workers of all races had the legal tools to fight government-sponsored economic discrimination in zoning; if people could fight back against humiliating policies that tell them they are unwanted in entire communities.

The government-sponsored walls that divide us do enormous harm—blunting opportunity, making housing unaffordable, damaging the environment, segregating us by race and class, and doing significant injury to our fragile democracy. It is time to recognize the walls that separate us, and then proceed to tear them down. +

For the endnotes, see aft.org/hc/fall2023/kahlenberg.



Free Trauma Counseling for Workplace Violence



A Union of Professionals

AFT+
Member Benefits

Workplace violence is any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior or bullying that occurs at the work site.

The AFT is committed to preventing workplace violence and to empowering the recovery of members who experience it. The AFT provides all active, working members with free trauma counseling if they experience or witness violence on the job. This invaluable benefit offers one-to-one counseling sessions with a therapist with a master's degree (or higher) who has advanced training in post-traumatic incident recovery.



If you're an AFT member and would like to learn more about this free benefit, call 202-393-8643 or log in to your member benefit portal by scanning the QR code or visiting aft.org/members-only.



TRAUMA COVERAGE
EMPOWERING RECOVERY™



LifeBrand® x



A Union of Professionals

AFT+
Member Benefits

A TOOL TO REVIEW *YOUR* Social Media

~~was \$59.97~~

now \$45.00

To claim your one-time social media wellness check!



~~was \$129.97~~

now \$96.50

To claim your one year of unlimited social media wellness checks!

25% OFF





Get involved!

The AFT has voted to endorse **Joe Biden** for president and **Kamala Harris** for vice president in the 2024 Democratic presidential primary. Following an extensive endorsement process, including member engagement, the AFT's executive council voted unanimously for a resolution to endorse Biden and Harris, in concert with the AFL-CIO, because of their record, their profound understanding of the issues facing working families and their impassioned commitment to using government to help make people's lives better.

This will be a vital election with so many key issues at stake—from book bans, to school funding, to safe staffing, to the very foundations of our democracy.



Stay involved! Visit [AFTvotes.org](https://www.aftvotes.org) to get the latest information on how you can share your voice to support this election.