HEALTHCARE WORKFORCE TASK FORCE

Report and Recommendations of the Mayor's Healthcare Workforce Task Force

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

Healthcare Workforce Task Force

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The Honorable Muriel Bowser, Mayor
District of Columbia

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EXECUTIVE SUMMARY

Mayor Bowser and DC Health launched the Mayor's Healthcare Task Force (Task Force) in May of 2022 to rebuild, strengthen, and expand the District's healthcare workforce. The Task Force was made up of leaders across the District in education, employment services, healthcare, and government and co-chaired by Dr. Wayne Frederick, President of Howard University, and Ms. Anita Jenkins, the Chief Executive Officer of Howard University Hospital.

The Task Force divided itself into six subcommittees that examined the barriers that negatively impacted the District's healthcare workforce. Each subcommittee then summarized the barriers and challenges and created short-term, mid-term, and long-term recommendations to expand the District's healthcare workforce.

> "Our health care workers have been incredible throughout the pandemic. At every single stage of the pandemic, they've demonstrated the utmost professionalism and compassion. But they've been through a lot, and this task force is going to put forth fresh ideas for how to best support current and aspiring health care workers. We have an opportunity, right now, to bring more residents into a high-demand field and, in doing so, to provide relief and support to our amazing frontline health care workers."
>
> - Mayor Muriel Bowser

The Subcommittee on Strengthening Recruitment and Retention of Existing Qualified Healthcare Workers made recommendations on improving District government processes to expedite licensure, increasing pay for healthcare workers in training, improving worksite wellness and reducing burnout, and reestablishing trust in public health.

The Subcommittee on Increasing District Resident Employment in Healthcare Occupations made recommendations on expanding trainings, lowering barriers to workforce entry, and improving recruitment and retention of the workforce.

The Subcommittee on Improving Opportunities for Advancement in Health Careers within the District made recommendations on building interagency partnerships, preparing the workforce for the future, removing barriers to training and advancement, encouraging apprenticeships and internships, and creating pathways to advancing careers.

The Subcommittee on Enhancing Access to High-Quality Allied Health Training Programs made recommendations on increasing Home Healthcare Aides (HHAs) and Certified Nurse Aides (CNAs), streamlining approval processes, and increasing scholarships and tuition support programs.

The Subcommittee on Focused Retention of DC-based Health Professional Students Post-Graduation made recommendations on building partnerships with local universities, analyzing health care workers' salaries, addressing burnout, and incentivizing retention.

The Subcommittee on Development of a Health Careers Pipeline Strategy made recommendations on increasing partnerships with middle and high schools, increasing awareness of internship programs, and expanding programs available to high school graduates.

The result of this work is 26 recommendations grouped by the six subcommittees' respective focus. These recommendations, which have garnered support across the diverse healthcare stakeholders serving on the Task Force, are all aimed at creating equity and ensuring the long-term strength of the healthcare workforce.

INTRODUCTION

Task Force Background

Mayor Bowser's Healthcare Workforce Task Force (Task Force) aims to rebuild, strengthen, and expand the District's healthcare workforce. The Task Force is responsible for making recommendations to the Mayor on the strategies and investments necessary to address current supply and demand challenges in the healthcare workforce.[1] The report also includes recommendations that are out of the scope for District government but should be considered by the healthcare industry to improve the District's workforce.

The Task Force's work shall focus on developing recommendations that address the current stresses in the District's healthcare system, while specifically addressing the following:

1. **Healthcare employer access to potential employees**. The Task Force should examine and report on barriers and facilitators that contribute to the recruitment and retention of healthcare workers, clinical and non-clinical, and what policy changes are needed to improve the current state. The Task Force should provide a broad array of options, including enhancing or revising, existing programs and initiatives.
2. **District resident employment in healthcare occupations**. The Task Force recommendations should consider how the District's dual goals of decreasing unemployment among District residents and increasing the number employed in healthcare can be accomplished simultaneously. The Task Force should focus on ensuring that populations and communities experiencing the highest rates of unemployment and who are underrepresented in higher-wage healthcare occupations have a path to those roles.
3. **Opportunities for advancement in health careers within the District**. The Task Force should consider how the existing healthcare workforce can be leveraged to address mission critical and urgent vacancies by upskilling current employees in clinical and non-clinical roles. The Task Force should consider a broad range of recommendations, including those that support continuing education and completion of degree programs that may have been voluntarily suspended due to life's circumstances.
4. **Access to high-quality allied health training programs**. The Task Force should make recommendations to increase the number of institutions offering a broad range of diploma and certificate programs in entry-level healthcare careers.
5. **Retention of health professional students post matriculation**. The Task Force should examine and report on factors that determine the retention of health professional students (i.e., nursing, social work, psychology, medicine) as licensed healthcare workers in the District and make policy recommendations accordingly.

[1] https://dchealth.dc.gov/hwtf22

6. **A health careers pipeline strategy**. The Task Force should make recommendations to establish a health careers pipeline strategy designed to increase the number of District of Columbia middle and high school students who choose careers in health-related fields. The Task Force should examine existing initiatives and make recommendations for alignment, where feasible, as well as recommendations to fill any identified gaps in the pipeline.

The Task Force's aim is to identify strategies to rebuild, strengthen, and expand the District's healthcare workforce which has suffered greatly under the recent pandemic. The current healthcare workforce shortage long precedes the pandemic, however. The current shortage is due to an increase in demand for nurses and other healthcare professionals which has far outpaced the current supply. An aging population, an aging workforce, and the expanded scope of practice for many professions has led to unprecedented demand for healthcare practitioners.

However, the background of the current shortage must be understood within both contemporary as well as historical, local, and national contexts. This is critical to ensuring that the proposed recommendations are not limited to short term solutions that are narrowly defined in response to immediate needs but are strategic and sustainable solutions that specifically seek to address persistent inequities in population health outcomes.

The Health Equity Report for the District of Columbia 2018 provides a baseline assessment of health equity and opportunities for health in the District.[2] While focused primarily on the social (non-health) and structural drivers of health, this inaugural report described how up to 20% of what drives the health of a population is related to clinical care. DC Health's COVID-19 Health & Healthcare Pandemic Recovery Report similarly prescribed an equity informed post-pandemic framework for addressing health and healthcare needs, including the relevance of a structural determinants' lens.[3]

In addressing their charge to bolster the District's health care workforce, the Task Force examined the barriers and facilitators that contribute to recruitment and retention of healthcare workers, both clinical and non-clinical, and addressed how the District's dual goals of decreased unemployment and increasing the numbers employed in healthcare could be accomplished simultaneously.

A study by Brookings in May 2020 provides evidence of the prevalence of racial and economic inequities in the healthcare workforce that results in a predominant number of women and people of color in the lowest paid jobs.[4] The overwhelming majority are underpaid and, not surprisingly, feel undervalued even though they are deemed "essential." The following excerpt and Table 1

[2] https://dchealth.dc.gov/publication/health-equity-report-district-columbia-2018
[3] https://dchealth.dc.gov/page/covid-19-pandemic-health-and-heathcare-recovery-report
[4] https://www.brookings.edu/research/essential-but-undervalued-millions-of-health-care-workers-arent-getting-the-pay-or-respect-they-deserve-in-the-covid-19-pandemic/

from this report underscores the extent of structural and institutional inequity across the health care sector nationally:

> Over 80% of health care support service, and direct care workers are women. They are disproportionately people of color. Like other low-wage jobs where women and people of color are concentrated, many of these positions are plagued by underinvestment and lack of benefits.

Table 1. Demographic profile of workers in the health care and social assistance industry, 2019

Occupation	Number of workers	Median hourly wage	% Women	% African American	% Latino or Hispanic
All health care support, direct care, and service workers	6,964,410	$13.48	81%	25%	21%
Registered nurses	2,604,000	$35.17	89%	12%	7%
Physicians and surgeons	562,440	>$100	41%	8%	8%

The U.S. Centers for Disease Control and Prevention (CDC) defines racism as a system, that is both interpersonal and structural, "consisting of structures, policies, practices, and norms—that assigns value and determines opportunity based on the way people look or the color of their skin. This results in conditions that unfairly advantage some and disadvantage others throughout society."[5]

Twenty years ago, the Institute of Medicine documented the high prevalence of implicit bias by medical practitioners within the healthcare system and its role in negative health outcomes for people of color.[6] Other research showed that the proportions of minority medical students — including Black, Hispanic, and American Indian or Alaska Native — increased at a much slower rate compared with students of other races and ethnicities, including white students.[7] As a result, the physician workforce and other healthcare professions has continued its failure to reflect the U.S. population's demographics. Without deliberate and intentional actions to disrupt these trends, historic and contemporary racial underrepresentation in the upper echelons of the healthcare workforce in combination with overrepresentation at the bottom as shown in the Brookings table above will remain stubbornly on track for the foreseeable future.

Our experience prior to—as well as during and since—the COVID-19 pandemic has contributed to heightened awareness of the depths and persistence of structural racism in the healthcare

[5] https://www.cdc.gov/minorityhealth/racism-disparities/index.html
[6] https://pubmed.ncbi.nlm.nih.gov/25032386/
[7] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2749233

sector and across its workforce, including its detrimental impacts on population health and on the health of communities and people of color both national and in the District.[8,9]

Structural unemployment happens when the skills of unemployed workers don't match the skills needed by employers, occurring as a result of underlying structural barriers and/or shifts in the economy, making it difficult for some people to find jobs.[10] Typically, structural unemployment has a greater impact on middle-aged and older cohorts rather than their younger counterparts because of outdated skills coupled with reskilling challenges. Addressing structural unemployment is especially difficult, however, because while jobs can be added, typically, they are low-quality. Additionally, recessions not only make unemployment worse, but structural unemployment can also keep unemployment rates high long after a recession is over.

As with the Great Recession, the COVID-19 Pandemic has similarly impacted unemployment in the District, with data indicative of differential racial, ethnic, and structural challenges. While the District's metropolitan area unemployment rate of 2.7% in early 2023 was the tenth lowest in the nation overall (vs. US rate of 3.5%); the District also registered the highest Black-White unemployment ratio of 6.7-to-1 and the highest Hispanic-White unemployment ratio of 2.6-to-1.[11] We know, too, that these racial and ethnic disparities also have a geographic dimension in the city, undergirded by historic and contemporary segregated living arrangements, and the persistence of structural and institutional racism, underscored by concentrations of unemployment and other social determinants, both by Ward and more granularly by statistical neighborhood, per the Health Equity Report.

Local patterns of inequity in the District are consistent with the evidence base, which "shows that centuries of racism in this country has had a profound and negative impact on communities of color. The impact is pervasive and deeply embedded in our society—affecting where one lives, learns, works, worships, and plays and creating inequities in access to a range of social and economic benefits—such as housing, education, wealth, and employment. These conditions—often referred to as social determinants of health—are key drivers of health inequities within communities of color, placing those within these populations at greater risk for poor health outcomes."[13]

Ward	Unemployment Rate (2023)[12]
1	4.3%
2	4.2%
3	4.0%
4	4.9%
5	6.4%
6	4.7%
7	6.9%
8	8.2%

[8] https://www.stkate.edu/academics/healthcare-degrees/racism-in-healthcare; https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.01466

[9] https://www.urban.org/sites/default/files/publication/85341/2000986-the-color-of-wealth-in-the-nations-capital.pdf; https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.01805

[10] https://www.thebalancemoney.com/structural-unemployment-3306202

[11] https://www.epi.org/indicators/state-unemployment-race-ethnicity/

[12] https://does.dc.gov/page/unemployment-data-dc-wards

[13] https://www.cdc.gov/socialdeterminants/index.htm; https://www.cdc.gov/minorityhealth/racism-disparities/index.html

In light of historic and contemporary challenges at the intersection of the health care sector with structural unemployment in the District of Columbia as summarized above, each of the Task Force's six subcommittees were asked to be intentional in examining the equity implications of the recommendations they proposed.

Task Force Membership

Co-Chairs	
Dr. Wayne Frederick	President, Howard University
Ms. Anita Jenkins	Chief Executive Officer, Howard University Hospital
Education	
Dr. Barbara Bass	Vice President for Health Affairs & Dean, GW School of Medicine and Health Sciences, Chief Executive Officer, The GW Medical Faculty Associations
Dr. Nicole Betschman	Director of Public Health and Health Services Programs & Assistant Professor of Health Services, Trinity Washington University
Dr. Aaron Dominguez	Provost, The Catholic University of America
Ms. Patricia McGuire	President, Trinity Washington University
Dr. Ronald Mason	President, University of the District of Columbia
Employment Services	
Ms. Alexis Roberson	President & Chief Executive Officer, Opportunities Industrialization Center of DC (OIC/DC)
Mr. Ian M. Paregol	Executive Director, DC Coalition of Disability Services Providers
Ms. Ahnna Smith	Executive Director, Workforce Investment Council
Mr. Robert Jordan	President & Chief Executive Officer, Constituent Services Worldwide Public Benefit Corporation
Ms. Dyana Forester	President, Metro Washington Council, AFL-CIO
Government Agencies	
Dr. Barbara Bazron	Director, Department of Behavioral Health (DBH)
Mr. Andrew Reese	Director, Department of Disability Services (DDS)
Dr. Unique Morris-Hughes	Director, Department of Employment Services (DOES)
Ms. Melisa Byrd	Senior Deputy Director and Medicaid Director, Department of Health Care Finance (DHCF)
Mr. Paul Kihn	Deputy Mayor for Education
Mr. Wayne Turnage	Deputy Mayor for Health and Human Services (HHS)
Dr. Sharon Lewis	Interim Director, Department of Health (DC Health)
Dr. Christina Grant	State Superintendent of Education for the Office of the State Superintendent of Education (OSSE)
Dr. LaQuandra S. Nesbitt	*Former Director, Department of Health (DC Health)* *(*Departure date 07/29/2022)*
Healthcare	
Dr. Gregory J. Argyros	President, MedStar Washington Hospital Center
Ms. Veronica Damesyn-Sharpe	Executive Director, DC Health Care Association
Mr. Robert Hay	Executive Vice President, Medical Society of DC
Mr. Mark LeVota	Executive Director, DC Behavioral Health Association
Ms. Jacqueline Bowens	President & Chief Executive Officer, DC Hospital Association
Mr. Justin Palmer	Vice President, Public Policy & External Affairs
Ms. Tamara Smith	President & Chief Executive Officer, DC Primary Care Association
Ms. Ruth Brinkley	President, Kaiser Permanente

Acknowledgements

Department of Health

Office of the Director

Sharon Lewis, DHA, RN-BC, CPM, Interim Director

LaQuandra S. Nesbitt, MD, MPH, Former Director

Jacqueline A. Watson, DO, MBA, Chief of Staff

Carl Filler, MSW, Director of Government Relations

Amanda Attiya, Policy Analyst

Jacqueline McKie, Executive Assistant to the Director

Office of Health Equity

C. Anneta Arno, Ph.D., MPH, Director, Office of Health Equity

Subcommittee on Strengthening Recruitment and Retention of Existing Qualified Healthcare Workers

Committee Responsibility

The subcommittee shall examine and report on barriers and facilitators that contribute to the recruitment and retention of healthcare workers, clinical and non-clinical, and what policy changes are needed to improve the current state. The subcommittee shall provide a broad array of options, including enhancing or revising, existing programs and initiatives.

Subcommittee Co-Chairs & Members

Co-Chairs:
Ms. Ruth Brinkley (President, Kaiser Permanente)
Mr. Mark LeVota (Executive Director, DC Behavioral Health Association)

Committee Members:
Dr. Sharon Lewis (Interim Director, DC Health)
Mr. Ian Paregol (Executive Director, DC Coalition of Disability Services Providers)
Ms. Melisa Byrd (Senior Deputy Director and Medicaid Director, Department of Health Care Finance)
Mr. Robert Hay (Executive Vice President, Medical Society of DC)

Contributing Members:
Ms. Yvonne Mitchell (Executive Director of Talent Acquisitions, Johns Hopkins Medicine/Sibley)
Ms. Tina Sandri (Chief Executive Officer, Forest Hills DC & Forest Side Memory Care)
Ms. Marla Lahat (Executive Director, Home Care Partners)
Dr. Rosalind Wright (Executive Director of Clinical Operations & Support Services/Administrator, Stoddard Baptist/Marigold)
Ms. Karen Brown (Director of Human Resources, Bridgepoint Hospital National Harborside)
Mr. John Coombs (Deputy Chief of Staff, District of Columbia Fire and EMS)

Subcommittee on Increasing District Resident Employment in Healthcare Occupations

Committee Responsibility

The subcommittee recommendations shall consider how the District's dual goals of decreasing unemployment among District residents and increasing the number employed in healthcare can be accomplished simultaneously. The subcommittee shall focus on ensuring that populations and communities experiencing the highest rates of unemployment and who are underrepresented in higher-wage healthcare occupations have a path to those roles.

Subcommittee Co-Chairs & Members

Co-Chairs:
Ms. Tamara Smith (President & Chief Executive Officer, DC Primary Care Association)
Ms. Patricia McGuire (President, Trinity Washington University)

Committee Members:
Ms. Alexis Roberson (President & Chief Executive Officer, Opportunities Industrialization Center of DC)
Ms. Ahnna Smith (Executive Director, Workforce Investment Council)

Contributing Members:
Mr. Darryl Evans (Deputy Director of the Rehabilitation Services Administration, Department of Disability Services)
Ms. Lori Jackson (President and Chief Executive Officer, Jane Bancroft Robinson Foundation)

Ms. Yolette A. Gray (Senior Manager, Public Policy & Community Engagement, DC Hospital Association)
Ms. Sherri Newman (Market Director, Senior Healthcare Leader, The George Washington University Hospital)
Mr. John Donnelly (Fire and EMS Chief, District of Columbia Fire and EMS)

Subcommittee on Improving Opportunities for Advancement in Health Careers within the District

Committee Responsibility

The subcommittee shall consider how the existing healthcare workforce can be leveraged to address mission critical and urgent vacancies by upskilling current employees in clinical and non-clinical roles. The subcommittee shall consider a broad range of recommendations, including those that support continuing education and completion of degree programs that may have been voluntarily suspended due to life's circumstances.

Subcommittee Co-Chairs & Members

Co-Chairs:
Ms. Jacqueline Bowens (President & Chief Executive Officer, DC Hospital Association)
Dr. William Strudwick (Chief Medical Officer/Interim Chief Executive Officer, Not-for-Profit Hospital Corporations/United Medical Center)

Committee Members:
Mr. Andrew Reese (Director, Department of Disability Services)
Dr. Barbara Bass (Vice President for Health Affairs & Dean, GW School of Medicine and Health Sciences, Chief Executive Officer of The GW Medical Faculty Associates)

Contributing Members:
Ms. Gayle Olano Hurt (Assistant Vice President Patient Safety & Quality Operations, DC Hospital Association)
Ms. Caroline Shafa (Vice President of Operations, Johns Hopkins Medicine/Sibley)
Ms. Claudia Schlosberg (Chair of the Subcommittee on Workforce Development, DC Coalition on Long Term Care)
Ms. Valerie Pasnau Bridgepoint (Vice President of Clinical Operations, Bridgepoint Hospital National Harborside)
Mr. Paul Hagens (Vice President, Human Resources, MedStar Washington Hospital Center)
Ms. Anika Holmes (Associate Director, Workforce Investment Council)

Subcommittee on Enhancing Access to High-Quality Allied Health Training Programs

Committee Responsibility

The subcommittee shall make recommendations to increase the number of institutions offering a broad range of diploma and certificate programs in entry-level healthcare careers.

Subcommittee Co-Chairs & Members

Co-Chairs:
Dr. Aaron Dominguez (Provost, The Catholic University of America)
Dr. Gregory Argyros (President, MedStar Washington Hospital Center)

Committee Members:
Dr. Unique Morris-Hughes (Director, Department of Employment Services)
Mr. Wayne Turnage (Deputy Mayor, Health and Human Services)

Mr. Robert Jordan (President & Chief Executive Officer, Constituent Services Worldwide Public Benefit)
Ms. Veronica Damesyn-Sharpe (Executive Director, DC Health Care Association)
Contributing Members:
Ms. Lori Jackson (President and Chief Executive Officer, Jane Bancroft Robinson Foundation)
Ms. Mary Jo Schweickhardt (Vice President of Human Resources, MedStar Health)

Subcommittee on Focused Retention of DC-based Health Professional Students Post-Graduation

Committee Responsibility

The subcommittee shall examine and report on factors that determine the retention of health professional students (i.e., nursing, social work, psychology, medicine) as licensed healthcare workers in the District and make policy recommendations accordingly.

Subcommittee Co-Chairs & Members

Co-Chairs:
Dr. Ronald Mason (President, University of the District of Columbia)
Dr. Nicole Betschman (Director of Public Health and Health Services Programs & Assistant Professor of Health Services, Trinity Washington University)
Committee Members:
Dr. Barbara Bazron (Director, Department of Behavioral Health)
Mr. Paul Kihn (Deputy Mayor for Education)
Contributing Members:
Ms. Laura Hendricks-Jackson (Vice President, Johns Hopkins Medicine/Sibley)

Subcommittee on Development of a Health Careers Pipeline Strategy

Committee Responsibility

The subcommittee shall make recommendations to establish a health careers pipeline strategy designed to increase the number of District of Columbia middle and high school students who choose careers in health-related fields. The subcommittee shall examine existing initiatives and make recommendations for alignment, where feasible, as well as recommendations to fill any identified gaps in the pipeline.

Subcommittee Co-Chairs & Members

Co-Chairs:
Ms. Dyana Forester (President, Metro Washington Council, ALF-CIO)
Mr. Justin Palmer (Vice President of Public Policy & External Affairs, DC Hospital Association)
Committee Members:
Ms. Jacqueline Bowens (President & Chief Executive Officer, DC Hospital Association)
Mr. Andrew Reese (Director, Department of Disability Services)
Dr. Christina Grant (State Superintendent for Education, Office of the State Superintendent of Education)
Contributing Members:
Ms. Tikeya Milburn (Project Manager, Department of Disability Services
Ms. Wendell Felder (Senior Program Manager, John Hopkins University & Health System)
Ms. Samaria Washington (Regional Director, Bridgepoint Hospital National Harborside)
Ms. Stephanie Heldreth (Director of Nursing, Bridgepoint Hospital National Harborside)
Ms. Queen Anunay (Assistant Fire Chief, DC Fire and EMS)

TASK FORCE RECOMMENDATIONS

Pursuant to the Task Force's unanimously adopted schedule, each subcommittee submitted "Subcommittee Recommendations" to the Task Force on Thursday, September 8, 2022. These "Subcommittee Recommendations" were, in turn, assembled and evaluated by the Task Force Co-Chairs, and presented to the entire Task Force for consideration and approval on Wednesday, February 1, 2023.

Summary of Task Force Recommendations

The following Subcommittee Recommendations were adopted by the full Task Force:

Subcommittee on Strengthening Recruitment and Retention of Existing Qualified Healthcare Workers

1. Expand data infrastructure to improve health professional license processing, allow for interoperability with third-party data providers and other jurisdiction licensing agencies, and improve data collection to support healthcare workforce development planning.

2. Accelerate coordinated health professional licensure across the District, Maryland, and Virginia through compacts and policy coordination, technology interoperability, expanded use of temporary licensure, and adoption of endorsement pathways for all comparable licenses, registrations, or certifications.

3. Allow for certain non-District residents to be considered for health professional licensing board membership.

4. Set a payment floor for District healthcare workforce wages at 120% of the District's Living Wage or minimum wage, whichever is greater, to ensure competitive wages and access to apprenticeship training funding (contingent on available funding).

5. Enhance healthcare workforce worksite wellness and safety to support workers.

6. Adopt healthcare reimbursement policies that support workforce retention for experienced members of the healthcare workforce, including creating mechanisms that value and more highly compensate tenure and experience in given roles in addition to quality of care and health outcomes, and adjusting provider payment rates based on beneficiary social risk stratification.

7. Reduce systemic factors contributing to healthcare workforce burnout, by reducing documentation burden, insurance prior authorization requirements for routine care, and improving healthcare workforce quality of life.

8. Undertake a public education and media campaign to restore public confidence in healthcare and educate the public about healthcare career options, including recognizing the outstanding contributions made by the healthcare workforce to the District, sharing information on the range

of careers available across the healthcare industry, and addressing health misinformation and reduced public trust and confidence in the effectiveness of healthcare.

Subcommittee on Increasing District Resident Employment in Healthcare Occupations

1. Engage employers and educational and training providers to enhance and expand trainings that increases the number of students graduating and gaining employment.

2. Increase the ease of entrance into the healthcare field for returning citizens, and address age limitations and citizen status barriers that prohibit/restricts individuals' ability to gain employment in the health care sector.

3. Support health care employers in recruitment and retention of the workforce through comprehensive case management and supports for new hires.

Subcommittee on Improving Opportunities for Advancement in Health Careers within the District

1. Build cross-agency partnerships and clarify roles to ensure alignment of programs, strategies, policies, and funding allocations contribute to a strong and sustainable health care workforce in the District of Columbia.

2. Adopt policies and practices for licensure, registration, and certification to ensure that the District's health care workforce can be prepared for the healthcare delivery system of the future.

3. Remove barriers for current health care workers to health care training, creating well-defined career pathways, transforming workplace culture, and identifying resources for providers to support training and advancement.

4. Encourage health care employers to create or expand certified apprenticeship or internship programs.

5. Adopt Competency Based Training Certification as an essential pathway to advancing careers in health care.

Subcommittee on Enhancing Access to High-Quality Allied Health Training Programs

1. Create the State of the State for Home Healthcare Aides and Certified Nursing Assistants (CNAs) and develop a targeted plan to increase the number of providers and enrolled participants.

2. Streamline the approval process and eliminate unnecessary entry barriers for health care providers interested in being certified as a training program in order to increase the capacity of the health care workforce system.

3. Increase the number of scholarships and tuition support programs for associate and four-year health care degrees.

Subcommittee on Focused Retention of DC-based Health Professional Students Post-Graduation

1. Create Partnerships with local universities that enroll high numbers of DC-based students to provide training in career ladder jobs, i.e., entry level to licensed clinical level positions.

2. Conduct market analysis to drive adjustment of health care workers' salaries

3. Address employee burnout through mental health services.

4. Create retention incentives for current health care workers.

Subcommittee on Development of a Health Careers Pipeline Strategy

1. Increase school partnerships with health care partners throughout middle and high school to increase exposure and immersion experiences.

2. Increase awareness of and merge existing internship programs with the Marion S. Barry Summer Youth Employment Program to provide year-round opportunities for students.

3. Expand health professional programs and certifications available upon high school graduation.

Explanation of Task Force Recommendations

Mayor Bowser's Charter establishing the Task Force directed its members to examine and provide recommendations regarding six key areas of interest. In order to accomplish this goal, the Task Force divided itself into six subcommittees, aligning with each of the key areas of interest. The full Task Force considered the individual recommendations of the subcommittees and selected the following for inclusion in this report.

Subcommittee on Strengthening Recruitment and Retention of Existing Qualified Healthcare Workers

Recommendation #1
Expand data infrastructure to improve health professional license processing, allow for interoperability with third-party data providers and other jurisdiction licensing agencies, and improve data collection to support healthcare workforce development planning.

Length: Short Term – 6 months to two years

Background: A District healthcare trade association survey results that showed 20% vacancy rates across hospitals, primary care providers, behavioral health providers, developmental and intellectual disability service providers, skilled nursing and long-term care providers, and home health providers. Those findings were supplemented by data from the Medical Society of DC and DC Dental Society. The Task Force also heard reports from DC Health's Health Regulation and Licensing Administration (HRLA) and Office of Primary Care about health professional licensing and the Health Professional Loan Repayment Program (HPLRP) that showed significant time from initial license applications to final approvals and limitations on access to health professional loan repayment.

The Subcommittee heard further presentations addressing barriers to professional licensing and to uptake of the HPLRP. Key barriers included insufficient data infrastructure; fragmented policy coordination across the District, Maryland, and Virginia; and significant professional licensing board vacancies that forced canceled meetings and reduced availability of board responses needed to address license applicant needs and attend to other board business in a timely manner. These barriers contribute to healthcare workforce shortages and inhibit healthcare workforce development planning.

Expected Impact: Adoption of this recommendation will result in a better customer experience for health professionals seeking licensure in the District, enhance technological interface with third-party data providers and other jurisdiction licensing agencies, improve understanding of

current and future healthcare workforce status, and support healthcare workforce development planning.

The District has moved health professional licensing to an online portal, but critical data infrastructure advancements must continue in order to process licenses expeditiously and support further District healthcare workforce development. The District should develop data infrastructure to improve health professional license processing and facilitate healthcare workforce status evaluation and healthcare workforce development planning. The license application platform should provide transparent status of all license applications and each element needed in each stage of the application review process to all applicants. If possible, employers should be offered a separate portal to track the status of applicants who grant permission to those employers to be made aware of their license application status. The District should work toward progressive interoperability with third-party data providers and other jurisdiction licensing agencies. More specifically, the District should develop its technology services to use data tools to allow exchange of information with third-party data providers that collect and distribute necessary licensing information such as copies of transcripts, exam results, fingerprint scan and background check results, or other such routinely collected licensing information as well as exchange of information with other jurisdiction licensing agencies or boards to allow verification of license status in other jurisdictions including status of any allegations or investigations or findings that resulted in suspension or termination of a license, certification, or registration in another jurisdiction. The District should also develop its technology services and licensing processes to include collection of standardized responses across all license types to improve understanding of current and future healthcare workforce status and to support healthcare workforce development planning, including necessary data elements for the District to work with federal partners in designations of Health Professional Shortage Areas (HPSAs), Medically Underserved Areas, or in other determinations regarding District sites' eligibility for the HPLRP.

Stakeholders: DC Health would be responsible for implementation of this recommendation.

Budget Impact: Major costs associated with this recommendation come from needed technology infrastructure investments for DC Health. Additional staffing may also be required in HRLA, particularly to complete implementation of this recommendation within the six-month to two-year timeframe envisioned.

Equity Implications: Timely license processing will help to ensure equitable access to healthcare careers and remove barriers to participation in the healthcare workforce for people whose socioeconomic status, often a result of racial inequities and historic disinvestments, makes delays in access to employment particularly difficult to bear. Increased uptake of HPLRP will improve the ability of those who have greater student debt to participate in the healthcare workforce, and the need to take on debt is again disproportionately among people whose socioeconomic status is negatively impacted by racial inequities. Both timely license processing and increased uptake of HPLRP and also improved workforce development planning will help improve access to care for District residents, particularly those who live in HPSAs or medically underserved areas, where healthcare resources are inequitably missing or underdeveloped.

Legislative Action: No legislative action necessary.

Recommendation #2

Accelerate coordinated health professional licensure across the District, Maryland, and Virginia through compacts and policy coordination, technology interoperability, expanded use of temporary licensure, and adoption of endorsement pathways for all comparable licenses, registrations, or certifications.

Length: Short Term – 6 months to two years

Background: A District healthcare trade association survey results that showed 20% vacancy rates across hospitals, primary care providers, behavioral health providers, developmental and intellectual disability service providers, skilled nursing and long-term care providers, and home health providers. Those findings were supplemented by data from the Medical Society of DC and DC Dental Society. The Task Force also heard reports from DC Health's Health Regulation and Licensing Administration (HRLA) and Office of Primary Care about health professional licensing and the Health Professional Loan Repayment Program (HPLRP) that showed significant time from initial license applications to final approvals and limitations on access to health professional loan repayment.

The Subcommittee heard further presentations addressing barriers to professional licensing and to uptake of the HPLRP. Key barriers included insufficient data infrastructure; fragmented policy coordination across the District, Maryland, and Virginia; and significant professional licensing board vacancies that forced canceled meetings and reduced availability of board responses needed to address license applicant needs and attend to other board business in a timely manner. These barriers contribute to healthcare workforce shortages and inhibit healthcare workforce development planning.

Expected Impact: Adoption of this recommendation will attract more health professionals practicing across the region to seek a license in the District.

The District has initiated work to coordinate with Maryland and Virginia, along with other jurisdictions, to acknowledge regional healthcare workforce needs and to attract existing healthcare workers to the region, and these efforts should be accelerated. The District should work with Maryland and Virginia to accelerate licensing compacts and take other policy coordination steps to align workforce expectations while recognizing the importance of ensuring quality of care and safety. The District should immediately work to complete physician licensing coordination now underway with a parallel project to achieve nurse licensing coordination, and the District should act expeditiously to resolve discrepancies in DC Certified Nurse Aid (CNA) and Home Health Aide (HHA) pathways to remove intra-District obstacles to employment and improve coordination with Maryland and Virginia. As noted above, the District should continue to pursue technology interoperability, particularly with Maryland and Virginia licensing agencies and boards, through use of application programming interfaces (APIs) or other electronic data sharing

to expedite cross-jurisdiction license status reviews and endorsement processes. While the District pursues policy and operational coordination with Maryland and Virginia, the District should continue its expanded use of temporary licensure, extend allowance for those with out-of-state licensure to continue to practice in the District so long as they have applied for and are working to receive a District license, and adopt endorsement pathways for all comparable licenses, registrations, or certifications across the District, Maryland, and Virginia.

Stakeholders: DC Health would be responsible for implementation of this recommendation.

Budget Impact: Some costs associated with this recommendation could come from needed technology infrastructure investments for DC Health. Additional staffing may also be required in HRLA, particularly to complete implementation of this recommendation within the six-month to two-year timeframe envisioned.

Equity Implications: Timely license processing will help to ensure equitable access to healthcare careers and remove barriers to participation in the healthcare workforce for people whose socioeconomic status, often a result of racial inequities and historic disinvestments, makes delays in access to employment particularly difficult to bear. Ensuring that workforce capacity needs are better met will help improve access to care for District residents, particularly those who live in HPSAs or medically underserved areas, where healthcare resources are inequitably missing or underdeveloped.

Legislative Action: No legislative action necessary.

Recommendation #3
Allow for certain non-District residents to be considered for health professional licensing board membership.

Length: Short Term – 6 months to two years

Background: A District healthcare trade association survey results that showed 20% vacancy rates across hospitals, primary care providers, behavioral health providers, developmental and intellectual disability service providers, skilled nursing and long-term care providers, and home health providers. Those findings were supplemented by data from the Medical Society of DC and DC Dental Society. The Task Force also heard reports from DC Health's Health Regulation and Licensing Administration (HRLA) and Office of Primary Care about health professional licensing and the Health Professional Loan Repayment Program (HPLRP) that showed significant time from initial license applications to final approvals and limitations on access to health professional loan repayment.

The Subcommittee heard further presentations addressing barriers to professional licensing and to uptake of the HPLRP. Key barriers included insufficient data infrastructure; fragmented policy coordination across the District, Maryland, and Virginia; and significant professional licensing board vacancies that forced canceled meetings and reduced availability of board responses needed

to address license applicant needs and attend to other board business in a timely manner. These barriers contribute to healthcare workforce shortages and inhibit healthcare workforce development planning.

Expected Impact: Adoption of this recommendation will help reduce the frequency of critical vacancies on health professional licensing boards.

The District relies on a steady pipeline of candidates to ensure health professional licensing boards maintain full membership, and the District should increase that pipeline through changes to board member recruitment. The District should allow any individuals, including non-District residents, to be considered for health professional licensing board membership. For board seats that require licensure, registration, or certification, non-residents should hold current DC licensure, registration, or certification. Non-resident candidates should be able to demonstrate that they practice in the District. The Mayor's Office on Talent and Appointments (MOTA) should provide regular status updates to those who have submitted interest in joining each board.

Stakeholders: DC Health holds the largest role in implementation of this recommendation, with support needed from MOTA.

Budget Impact: Additional staffing may be required in HRLA or MOTA.

Equity Implications: Timely license processing will help to ensure equitable access to healthcare careers and remove barriers to participation in the healthcare workforce for people whose socioeconomic status, often a result of racial inequities and historic disinvestments, makes delays in access to employment particularly difficult to bear.

Legislative Action: No legislative action necessary.

Recommendation #4

Set a payment floor for District healthcare workforce wages at 120% of the District's Living Wage or minimum wage, whichever is greater, to ensure competitive wages and access to apprenticeship training funding (contingent on available funding).

Length: Short Term – 6 months to two years

Background: The Task Force has heard from its members that wages for front-line District employees, especially but not exclusively at entry-level or requiring little formal education or training, are inadequate to attract qualified individuals, whether into roles that require a formal license, registration, or certification or to unlicensed roles.

The Subcommittee reviewed a report on a June 2022 Home and Community-Based Service (HCBS) Provider Workforce Survey from the DC Coalition on Long-Term Care's Subcommittee on Workforce Development. From 29 organization responses, respondents reported paying bonuses, paying for training and education, offering gift cards, personalized notes and flowers,

offering staff promotions, and addressing workplace culture, among other strategies. These incentives are not working at 82% of responding organizations to increase recruitment or to reduce turnover. The DC Workforce Innovation and Opportunity Act (WIOA) Unified State Plan PY 2020 – 2023 reports that Certified Nursing Assistants (CNAs) and Home Health Aides (HHAs) will experience average annual openings of over 3,000 jobs every year for at least the next seven years.[14] Multiple members of the subcommittee, both representing HCBS providers, as well as representatives from other healthcare sectors, reported similar challenges with wage rates as a key barrier to recruitment and retention while facing substantial vacancies, turnover, and increasing demand for services.

Expected Impact: Adopting this recommendation will positively impact outcomes in the District by expanding the pool of talent seeking healthcare careers, particularly in positions with low barriers to entry. It will make the labor market more responsive to projected future staffing needs. It will result in greater retention as healthcare workers will have a better overall standard of living and be less likely to leave these positions solely based on compensation.

The District should adopt wage standards for the healthcare workforce that close the gap between projected need and current staffing levels and recruitment and retention trends. The District healthcare workforce must be treated as a critical public resource, and wages must be sufficiently higher than roles in healthcare in neighboring jurisdictions or outside healthcare that require similar (or less) education, training, or experience.

The District has several possible strategies to implement this recommendation:

1) The District should use its purchasing power with District publicly funded health programs, specifically Medicaid and the DC Healthcare Alliance, to adopt provider organization payment rates based on expected wages for all healthcare workers being paid not less than 120% of the District's Living Wage or minimum wage, whichever is greater.
2) The District should use its purchasing power in District grants, contracts, and Human Care Agreements to require that any proposed services delivered by members of the healthcare workforce must be compensated at not less than 120% of the District's Living Wage or minimum wage, whichever is greater.
3) The District should use its healthcare provider organization licensing and certification authorities to require that those organizations pay members of the healthcare workforce not less than 120% of the District's Living Wage or minimum wage, whichever is greater, as a condition of continuing licensing or certification.
4) The District should adopt a Healthcare Workforce Living Wage by statute that members of the healthcare workforce must be compensated at not less than 120% of the District's Living Wage or minimum wage, whichever is greater.

These approaches have progressively wider applicability, with progressively comprehensive—but not mutually exclusive—impact. Non-government subcommittee members expressed support that the District should undertake at least strategy 1, and the District should adopt multiple or all strategies to achieve greater impact to close the gap between projected workforce need and current

[14] https://dcworks.dc.gov/sites/default/files/dc/sites/dcworks/publication/attachments/District_of_Columbia_WIOA%20State%20Plan%20Final%202-28-2022.pdf

staffing levels and recruitment and retention trends. Adopting multiple strategies would increase the number of eligible placement sites for any such apprenticeship training programs.

Stakeholders: DCCF would need to make updates to provider organization payment rate methodologies to implement strategy. The Office of Contracting and Procurement (OCP), along with the funding agency, would need to develop corresponding strategies when awarding dollars to fund healthcare services. The applicable regulatory agency—whether DC Health, the Department of Behavioral Health (DBH), the Department on Disability Services (DDS), DHCF, or the Department of Human Services (DHS), among others—would need to implement aligning strategies, such as when awarding subgrants. The Department of Employment Services (DOES) would also play a critical role.

Budget Impact: Each strategy would have a financial impact. Strategies 1 and 2 would require increases to District healthcare spending and procurement. Strategy 3 would have limited direct financial impact to the District but could, over time, increase the District's share of employer premiums for District government employee health insurance coverage. Strategy 4 would indirectly lead to similar cost impacts as adoption of strategies 1, 2, and 3, but over a different time horizon, delaying some budget impacts to later years, but possibly also requiring transitional subsidy payments to assist healthcare provider organizations with implementing the change.

Equity Implications: This recommendation would increase wages for members of the District's healthcare workforce who earn the least. This would help to ensure that members of the District's healthcare workforce are better able to afford to live and work in the District, which would include District residents from parts of the District that have experienced historical disinvestment, often due to racial inequities.

Strategies 1 and 2 above would help to ensure that District residents who rely on government assistance to access healthcare services, often because of racial inequities and historic disinvestments, would have better access to care and would be more likely to receive care from people who look like them and who live in the District. Strategies 3 and 4 would also help to mitigate access to care barriers that disproportionately affect people due to racial and other inequities.

Legislative Action: Legislation will be required to create a Healthcare Workforce Living Wage.

Recommendation #5

Enhance healthcare workforce worksite wellness and safety to support workers.

Length: Short Term – 6 months to two years

Background: The Subcommittee reviewed recommendations from "Addressing Health Worker Burnout: The U.S. Surgeon General's Advisory on Building a Thriving Health Workforce" and heard a presentation from Daniel Marchilak, MD, Executive Director of the MedStar Center for Wellbeing on transforming the culture of healthcare through creation of work environments

conducive to people thriving at work. This information highlighted healthcare workforce burnout that existed pre-COVID-19 and has been accelerated by COVID-19 and the healthcare workforce's role in COVID-19 response and highlighted the need to refocus on healthcare culture of wellness. The Surgeon General's advisory provides citation to 304 articles, papers, and resources documenting the extent of healthcare workforce burnout and the effectiveness of a variety of possible solutions. Dr. Marchilak's presentation drew on experience supporting 33,000 employees in the MedStar Health system across the District and Maryland. Members of the Subcommittee reacted and shared their own experiences and perspectives. These presentations and Subcommittee reactions included implications for healthcare workforce wellness and safety.

Expected Impact: Adopting this recommendation will support a culture of wellness in healthcare workplaces and mitigate stigma attached to seeking help. It will provide healthcare professionals with services suffering from, among other harmful factors, pandemic stress. These supports will result in a healthier workforce overall, a benefit that will be passed on to the patients and families those workers serve.

The District should support expansion of mental health and substance use services for the healthcare workforce. Members of the healthcare workforce should have access to occupational behavioral health supports including universal emotional wellness, non-clinical support for individuals and groups experiencing or at high risk of emotional distress, and clinical support through Employee Assistance Programs and health insurance coverage for diagnostic mental illness or substance use disorders. The District should provide financial support—through subsidies and through public program rate setting—as well as technical assistance and third-party resources for healthcare provider organizations with more limited capacity or capability to address healthcare workforce behavioral health well-being. District licensing boards should also take steps to encourage behavioral health help-seeking behaviors by licensed, registered, and certified health professionals, including through limitation of 'fitness for duty' questions during application and renewal cycles only to apply to current impairment to practice safely and work with employers to ensure that healthcare professionals do not fear loss of their jobs as a result of seeking professional behavioral health services, including through enhanced healthcare employer training on use of reasonable accommodation processes to support seeking treatment in a non-punitive manner.

The District should work to ensure that all members of the District healthcare workforce understand how to de-escalate aggression and to prevent or reduce violence experienced on the job. Healthcare provider organizations should be expected to provide regular training to clinical and non-clinical staff on crisis and conflict prevention and intervention, including within employer-operated offices and facilities as well as in home or community-based settings where some healthcare services are delivered.

Organizations that offer services in offices or facilities should also invest in facility modifications that can help to mitigate violence or the risk of violence. Again, the District should provide financial support and technical assistance to help healthcare provider organizations carry out these actions.

The District has taken steps to inform individuals how to avoid COVID-19 and other airborne infections, and the District should take further steps to invest in measures that reduce those

infections through modifications to the built environment. Healthcare offices and facilities are an important starting point for adopting higher ventilation standards and upgrading environmental systems and air filtration to reduce transmission of COVID-19 and other airborne infections. While members of the healthcare workforce will continue to need to take different levels of precaution as community spread of COVID-19 and other airborne diseases change over time, making their work settings safer without relying entirely on their own personal precautions or on community cooperation will help keep the healthcare workforce both healthy enough to do their important work and confident that their wellness is a priority within their work settings.

Stakeholders: DC Health and the Department of Behavioral Health (DBH) will need to support increased healthcare workforce access to mental well-being supports. Other District agencies, including the Department of Employment Services (DOES), might have a role to play helping healthcare organizations understand how to use reasonable accommodations to offer non-punitive approaches to support members of the healthcare workforce seeking mental health or substance use treatment or services.

District healthcare regulatory agencies with responsibility for licensing or certification of District healthcare provider organizations will need to support de-escalation and violence reduction programs and training.

DC Health, other District healthcare regulatory agencies, and perhaps the new Department of Buildings (DOB) could all play a role in supporting improved building ventilation standards, environmental systems, and air filtration mechanisms.

Budget Impact: Financial support and technical assistance would have budget implications for this recommendation.

Equity Implications: Apart from the impact on the healthcare workforce itself, District residents who routinely receive their healthcare services from organizations with limited administrative capacity or capabilities would benefit the most from implementation of this recommendation. Administrative capacity and capabilities are frequently more limited in organizations that rely more extensively on public payors, including the District as well as Medicare, so the District could reasonably target financial support and technical assistance to healthcare provider organizations or healthcare sectors with a large public payor portion of their payor mix to enhance equitable impact of these recommendations.

Legislative Action: No legislative action necessary.

Recommendation #6

Adopt healthcare reimbursement policies that support workforce retention for experienced members of the healthcare workforce, including creating mechanisms that value and more highly compensate tenure and experience in given roles in addition to quality of care and health outcomes, and adjusting provider payment rates based on beneficiary social risk stratification.

Length: Medium Term – two to five years

Background: The Task Force heard concerns from members about high turnover, high use of overtime, and over-reliance on temporary workers and staffing agencies. DC Health reported that these concerns were correlated with deficiencies in delivery of quality care.

The Subcommittee heard from many of its members that retention of the healthcare workforce is made more challenging by limited opportunities to earn higher salaries within their own roles. Role switching exacerbates churn, reduces continuity of care, and requires healthcare employers to spend more time on recruitment and retraining, and less time on workforce enhancement and healthcare quality improvement. Value-based payment strategies that are not indexed for the social risk of beneficiaries place higher burdens on healthcare providers who choose to work with more vulnerable members of the community, contributing to inadequate compensation relative to the care delivered and accelerating risks of burnout.

Expected Impact: The District should adopt strategies to reward the tenure and experience of members of the healthcare workforce. The District has several possible strategies to implement this recommendation:

1) The District should use its purchasing power with District publicly funded health programs, specifically Medicaid and the DC Healthcare Alliance, to adopt provider organization payment rates that allow provider organizations to pay more for longer tenured and more experienced members of the healthcare workforce for work within the same license, registration, or certification or for longer tenure or more experience in unlicensed healthcare roles.
2) The District should use its purchasing power in District grants and contracts, to allow provider organizations to pay more for longer-tenured and more experienced members of the healthcare workforce for work within the same license, registration, or certification or for longer tenure or more experience in unlicensed healthcare roles, including adjusting scoring formulas for grants and contracts minimally to avoid penalty and possibly to provide reward of bonus points for use of longer-tenured or more experienced members of the healthcare workforce.
3) The District should map licensed and unlicensed healthcare occupations to the U.S Department of Labor Bureau of Labor Statistics Standard Occupational Classification (SOC) system and recognize members of the healthcare workforce at progressive levels of skill and experience within occupations, for example Home Health Aide (HHA) I, HHA II, and HHA III, to further differentiate increasingly experienced and skilled members of

the healthcare workforce. The District should make every effort to distinguish these within-occupation differences and to collect data about current workforce composition and future needs without creating new licenses, registrations, certifications, or requirements other than on-the-job training for progression within these within-occupation different levels of skill.

4) The District should routinely monitor and publish reports on workforce tenure and experience as part of its licensing and certification authority and recognize high levels of tenure and experience as signs of quality.

The District should also, through use of its purchasing power in publicly funded programs, grants, and contracts, adopt social risk stratification for any value-based purchasing activities. This will decrease the risk that healthcare providers who work with more vulnerable members of the community will be undercompensated or experience excessive burnout.

Stakeholders: The Department of Health Care Finance (DHCF), or any other healthcare funding agency, and the Office of Contracting and Procurement (OCP) have significant influence in strategies 1 and 2. DC Health, other healthcare regulatory agencies, and the Department of Employment Services (DOES) have significant influence over strategy 3. DC Health and other healthcare regulatory agencies, perhaps supported by the DOES, have significant influence over strategy 4. The Department of Insurance, Securities, and Banking (DISB) might also be able to play a supporting role in strategy 4.

DHCF, or any other healthcare funding agency, and OCP have significant influence over social risk stratification in publicly funded programs and grants, contracts, and Human Care Agreements.

Budget Impact: Each strategy would have a financial impact. Strategies 1 and 2 would require increases to District healthcare spending, including through public-sector procurements. Strategies 3 and 4 might require redirection of District government staff from other duties or adding personnel to take on additional tasks but would have limited further financial impact directly to the District, at least in the short- to medium-term. Use of social risk stratification would likely require increases to District healthcare spending and procurement.

Equity Implications: Strategies 1 and 2 would help to ensure that District residents who rely on government assistance to access healthcare services, often because of racial inequities and historic disinvestments, would have better access to care and continuity of care. Strategies 3 and 4 would also help to mitigate access to care and continuity of care challenges that disproportionately affect people due to racial and other inequities.

Use of social risk stratification for District public purchasing would also directly contribute to equity and would help to ensure that District residents who rely on government assistance to access healthcare services, often as a result of racial inequities and historic disinvestments, receive appropriate care from an experienced healthcare workforce.

Legislative Action: No legislative action necessary.

Recommendation #7

Reduce systemic factors contributing to healthcare workforce burnout, by reducing documentation burden, insurance prior authorization requirements for routine care, and improving healthcare workforce quality of life.

Length: Medium Term – two to five years

Background: The Subcommittee reviewed recommendations from "Addressing Health Worker Burnout: The U.S. Surgeon General's Advisory on Building a Thriving Health Workforce" and heard a presentation from Daniel Marchilak, MD, Executive Director of the MedStar Center for Wellbeing on transforming the culture of healthcare through creation of work environments conducive to people thriving at work. This information highlighted healthcare workforce burnout that existed pre-COVID-19 and has been accelerated by COVID-19 and the healthcare workforce's role in COVID-19 response and highlighted the need to refocus on healthcare culture of wellness. The Surgeon General's advisory provides citation to 304 articles, papers, and resources documenting the extent of healthcare workforce burnout and the effectiveness of a variety of possible solutions. Dr. Marchilak's presentation drew on experience supporting 33,000 employees in the MedStar Health system across the District and Maryland. Members of the Subcommittee reacted and shared their own experiences and perspectives.

Expected Impact: The District can be a national model for reducing documentation burden in healthcare. District regulatory agencies and healthcare payors can cooperate to support achievement of this goal. Over- reliance on documentation reduces time available to care providers for direct clinical contact with people seeking health services and diminishes the sense of self-efficacy and satisfaction for members of the healthcare workforce. Reducing documentation burden can restore that sense of self-efficacy and satisfaction and increase access to care through more availability of healthcare workforce time for direct care delivery.

Significantly reducing prior authorization requirements for routine care is a key mechanism to reduce administrative and documentation burden in the District. The Department of Health Care Finance (DHCF) can play an important role through review of its own prior authorization requirements and through review of prior authorization requirements under its contracted Managed Care Organizations and other special purpose coverage contracts. The Department of Insurance, Securities and Banking (DISB) should also undertake health insurance carrier health plan reviews of prior authorization requirements and, if needed, take its own action or request additional enforcement authorities.

The District should reduce administrative and documentation burden through further standardization, digitization, and automation of insurance credentialing and provider paneling. DHCF can play a significant role in streamlining credentialing for Medicaid and DC Healthcare Alliance providers, either through its own operational activities or through its contracted managed care and special purpose coverage contracts. Similarly, DISB should review health plan credentialing provisions and, if needed, take its own action, or request additional enforcement authorities.

The District should also take steps to reduce workforce burnout through support for rest and self-care for members of the healthcare workforce. The District should use its purchasing power in the District's publicly funded healthcare programs, including Medicaid and the DC Healthcare Alliance, as well as in grants and contracts to support redundancy in hiring, including through use of reduced productivity expectations in payment rate setting for activities billable on a fee-for-service basis and including performance metrics that incentivize minimized use of overtime and pay for shift differentials for evening and weekend hours. The District should consider legislative or regulatory actions that would mandate offering minimum amounts of paid leave for members of the healthcare workforce and should consider adopting maximum hours of work per day or in a 24-hour period, such that members of the healthcare workforce have adequate time for rest and self-care between on-duty shifts. The District should provide financial assistance to healthcare organizations in exchange for phasing in reduced productivity expectations, reduced overtime, better shift wage differentials, enhanced leave, and mandatory rest periods between on-duty shifts.

Stakeholders: District healthcare regulatory agencies might help to reduce administrative and paperwork burdens through streamlined or simplified individual and organizational licensing and credentialing requirements or processes.

DHCF and DISB are the agencies with the most significant roles to play in reducing prior authorization requirements and credentialing administrative burdens. Since commercial insurance carriers are influenced by purchasers, specifically employers, and since other employers self-insure, major District employers can also exert pressure, including the District government through its purchasing power as an employer.

District agencies that pay for healthcare and District agencies that regulate healthcare, along with the Office of Contracting and Procurement (OCP) and the Department of Employment Services (DOES), could all have roles to play in supporting time for rest and self-care for members of the healthcare workforce.

Budget Impact: There should not be significant budget implications to healthcare regulatory agency streamlining or simplification of individual or organizational licensing and credentialing requirements or processes, particularly if other investments are already underway to enhance data infrastructure for health professional licensing and healthcare workforce development planning.

Proper risk adjustment techniques can redistribute focus of prior authorization requirements to non- routine authorization requests without significantly increasing total cost of care, so budget impact from changes to prior authorization requirements could be budget neutral or close to budget neutral.

Other costs of streamlining or simplifying provider credentialing depend on what, if any, specific strategies require financial or technical assistance or procurement and deployment of any needed technology. Costs of financial support in exchange for healthcare provider adoption of additional time for healthcare workforce rest and self-care would include any direct payments to be made by District agencies that pay for District health services.

Equity Implications: Reduction of healthcare workforce burnout and increased sense of self-efficacy and job satisfaction will also benefit people seeking healthcare services. Given higher relative administrative burden in healthcare provider organizations that serve a greater portion of publicly funded healthcare recipients, improved access to care and possibly improved clinical alliance due to improved clinical attentiveness can be expected to be more significant for populations that have been historically divested, including due to racial inequity.

Legislative Action: DISB may require additional authority, and that authority might require legislative action—or appeals to federal authorities for local jurisdictional enforcement authorities. Mandatory paid leave or mandatory rest periods between shifts will require legislative action for application to the widest possible set of healthcare settings, but those actions could be undertaken under existing procurement or licensing and certification authorities if applied more narrowly, only in government-purchased healthcare or only care provided by government-licensed or government-certified healthcare provider organizations.

Recommendation #8

Undertake a public education and media campaign to restore public confidence in healthcare and educate the public about healthcare career options, including recognizing the outstanding contributions made by the healthcare workforce to the District, sharing information on the range of careers available across the healthcare industry, and addressing health misinformation and reduced public trust and confidence in the effectiveness of healthcare.

Length: Medium Term – two to five years

Background: The Task Force heard concerns about lack of interest in healthcare as an industry and negative public perceptions about healthcare.

The Subcommittee reviewed recommendations from "Addressing Health Worker Burnout: The U.S. Surgeon General's Advisory on Building a Thriving Health Workforce," which included concerns about burnout for healthcare workers due to widespread health misinformation and diminished public confidence in the effectiveness of healthcare.

Expected Impact: The District's healthcare workforce should be recognized as unsung heroes. Current members of the healthcare workforce would be buoyed to see their contributions acknowledged, and members of the public might develop more favorable impressions by becoming more familiar with the excellent care being delivered in the District. Highlighting exceptional care might be one element of a successful campaign, but everyday contributions of people in the healthcare industry should also be highlighted. A well-structured campaign could help remind people that they interact with a variety of healthcare workers, including direct care providers and care aides, and that they also benefit from the services provided by hardworking receptionists, food service and custodial staff, social workers in their neighborhoods, and IT professionals that make sure their pharmacies get the right prescriptions from their doctors.

Reminding people of the variety of ways that people in the healthcare workforce offer them help and support can also help people recognize the variety of career opportunities available to them in the healthcare industry. People would benefit from knowing about healthcare careers in medical billing, population health analytics, and human resources, as a prompt to recognize that they might already have applicable skills. Others considering a healthcare career could learn more about how studying accounting or information technology, for example, could prepare them or help them switch to an industry with lots of needs and years of increasing workforce demand ahead.

The District has spent considerable effort on delivering relevant, timely, and high-quality information to District residents about health challenges, but District should do more to address health misinformation and reduced public trust and confidence in the effectiveness of healthcare. Health misinformation and reduced public trust need to be combatted through public service announcements and campaigns and through credible community messengers. This must also include repositioning public views to recognize healthcare workers for their commitment to the public good and for their skillful practice of healthcare. Improved public trust would help to restore healthcare worker confidence in the value of their own work and reduce their exposure to threats, aggression, and violence.

Stakeholders: DC Health, and perhaps the Department of Employment Services (DOES), could have important roles in reducing health misinformation and improving public trust in the healthcare workforce.

Budget Impact: Any public education or media campaign is likely to require financial resources, either by hiring new staff or use of third-party contractors.

Equity Implications: Members of the Subcommittee recognized that public concerns about the healthcare industry, while exacerbated in recent years due to the prevalence of health misinformation, pre-date the pandemic and have roots in long-standing wariness of the healthcare industry, especially by people who are Black, indigenous, or people of color, largely due to well-documented problems of racist medical practice, both systematically and structurally as well as due to individual prejudice, both historically and in the present day. People who are fearful or resentful of the healthcare industry are likely to have little desire to work in the industry, but people in the District regularly report that they would have more trust and be more likely to seek care if members of the healthcare workforce look like them and live in their community.

The District would need to pair its public campaign and media effort with ongoing work and increased emphasis on overcoming inequities and racist practice that persist in the District's current healthcare industry.

Legislative Action: No legislative action necessary.

Subcommittee on Increasing District Resident Employment in Healthcare Occupations

Recommendation #1
Engage employers and educational and training providers to enhance and expand trainings that increases the number of students graduating and gaining employment.

Length: Short Term – 6 months to two years

Background: There is a need to inventory and assess healthcare training programs that focus on District-based residents. Based on those assessments, required enhancements may include: more programs offering remote or evening and weekend hours; new and expanded coaching and preparation courses for those seeking licensure; competency-based training certifications; and alignment of existing programs with industry needs.

Additionally, the subcommittee recommends expanding vocation programs for youth in middle and high school to introduce them to potential career opportunities in the health professions. For high school students, there should be expanded early college and apprenticeship programs and mentors to support students.

Expected Impact: This recommendation is expected to lead to better alignment of job training with job requirements. As a result, more District residents will not only be credentialed but also will be securing full-time employment in the healthcare field.

Stakeholders: Potential stakeholders include District residents with a focus on underserved populations, health profession employers including government agencies, District of Columbia Public Schools (DCPS), the Office of the State Superintendent of Education (OSSE), Trinity Washington University, University of the District of Columbia, Howard University, George Washington University, American University, and Georgetown University.

Budget Impact: This may require supplemental funding to support modification and delivery of enhanced educational and training programs as well as funding for "Earn and Learn" for the workforce and other innovative approaches to upskilling training participants.

Equity Implications: As most colleges and universities in the District enroll fewer than 2% of District residents, with the exception of the University of the District of Columbia, Trinity and Strayer, engaging residents in training programs outside of those existing educational institutions is necessary to extend opportunity to all. Ensuring that students in District schools and residents have access to these training opportunities will reduce the disparities in the workforce and may encourage residents to seek additional education, further diversifying the student body at the District's universities.

Legislative Action: No legislative action necessary.

Recommendation #2

Increase the ease of entrance into the healthcare field for returning citizens, and address age limitations and citizen status barriers that prohibit/restricts individuals' ability to gain employment in the health care sector.

Length: Short Term – 6 months to two years

Background: Currently, in the District, seven years must have lapsed since a conviction occurred before a returning citizen can work in a healthcare field. In neighboring jurisdictions such as Virginia and Maryland, only five years must have lapsed. Also, for several positions, such as Home Health Aides (HHAs), individuals must be 18 years old to enter the job force. Schools and organizations are training individuals as young as 16 and 17; however, due to restrictive statutes and agency regulation, 16- and 17-year-old individuals are unable to enter the workforce in these fields. Highly qualified non-citizens are also unable to enter the field due to barriers involving credential not recognized in the United States or immigration issues. The restrictions on these populations drastically reduce the number of individuals that can and would like to work in the health care field and will be reviewed to ensure all qualified individuals who can safely work in health care are able to do so.

Expected Impact: By lifting some of these restrictions, there will be a 10% increase in the total number of prospective workers. Roughly 17,000 individuals are between the age of 15-17 in 2020 and 2,200 to 2,500 formerly incarcerated individuals return to the District each year according to the Criminal Justice Coordinating Council.

Stakeholders: Potential stakeholders include employers, prospective workforce, and the individuals served by the health care sector.

Budget Impact: Funding is needed to conduct an analysis and inventory of the barriers to entry for returning citizens, non-citizens, and 16- and 17-year-olds. Funding will also be needed to conduct a policy scan of other states' laws and to draft a report making recommendations.

Equity Implications: Over 80% of returning citizens are Black, most immigrants are people of color, and the majority of students aged 16 and 17 in public schools are Black, breaking down legal barriers to entry will reduce employment disparities and improve the quality of care by building a more diverse workforce.

Legislative Action: Legislation will be required to:

- Reduce the period between exiting incarceration and eligibility to obtain healthcare licensure/credentials;
- Allow non-residents to obtain healthcare licensure/credentials;
- Allow eligible individuals under the age of 18 to obtain healthcare licensure/credentials; and,
- Address the need to share data across agencies, organizations, grant organizations, and other relevant organizations.

Recommendation #3
Support health care employers in recruitment and retention of the workforce through comprehensive case management and supports for new hires

Length: Long Term – five years and beyond

Background: The health care field is enriching and often well-paying profession but there are challenges in training, employing, and retaining newly hired individuals. These barriers include: a low retention rate of new employees (less than two years) due to the increasing number of patients and a decrease in overall health care workers due to burnout. Also, skill gaps continue to grow as fewer people gain the skills and continued training needed to assume the roles of individuals exiting the field. To address this, the subcommittee recommends providing DC residents going through health care career training programs—and the subsequent 12 months of initial employment—comprehensive case management and wrap around services to ensure their success.

Expected Impact: The program aims in the first year to have a 15% increase in the number of District residents completing healthcare credentialing programs, at least 80-90% securing full-time employment after completing their program, and at least 50% maintaining employment for a year in the health care field.

Stakeholders: Potential stakeholders include health care employers, the prospective workforce, training organizations, DC Health, the Department of Employment Services (DOES), the Office of the State Superintendent of Education (OSSE), the District's Workforce Investment Council, philanthropic organizations, and the patients and clients of the health care facilities/organizations.

Budget Impact: Additional financial resources will be required from either government sources or private grants to support individuals in the training programs and in their initial year of employment. Other fiscal needs include supporting a community of practice and an expanded and improved licensure process.

Equity Implications: The supports in this proposed program will increase the ability for those in underserved communities, who often have additional barriers due to lack of resources, to successfully enter and stay in health care careers. It will also increase the diversity—and cultural competence—of the health care workforce which will also benefit underserved communities and improve health outcomes.

Legislative Action: No legislative action necessary.

Subcommittee on Improving Opportunities for Advancement in Health Careers within the District

Recommendation #1
Build cross-agency partnerships and clarify roles to ensure alignment of programs, strategies, policies, and funding allocations contribute to a strong and sustainable health care workforce in the District of Columbia.

Length: Short Term – 6 months to two years

Background: Fundamental to improving opportunities for advancement in health careers within the District is the necessity of aligned programs, strategies, and funding. To do this, public agencies must build a strong and supportive cross-agency partnership with clarified roles to maximize public resources and unify programs that will support a comprehensive education and workforce system.

The District should fund an independent comprehensive assessment of the District's health care workforce training capacity and build a cross-agency partnership with clarified roles (that support all industries); and plan and implement the strategy with stakeholder agencies and sector partnerships. The District should also use the Workforce Innovation and Opportunity Act (WIOA)[15] State Plan or other unified resource as a tool for building, strengthening, and holding accountable cross-agency partnership with clarified roles that support sector partnerships leading industry career pathways programs and systems.

Expected Impact: The cross-agency partnerships will work to align systems and provide education and training options that focus on the 21st century public health industry-validated health care workforce skills and competencies needed in the District. As a national best practice, cross-agency partnerships model interagency collaboration, integrate sector strategy principles, develop, and implement common goals, optimize the value-add of each partner's legal authority and subject matter expertise, and create a shared vision of career pathways as a strategy of the workforce system.

The partnerships will align public agencies to facilitate career pathway development as a key strategic priority of healthcare sector partnerships. Further, align public agencies to collaborate with local elected officials to champion bold and innovative funding mechanisms that allow for improvement for a competent health care workforce.

Stakeholders: Potential stakeholders include all District agencies with direct, aligned, and supportive responsibilities and roles related to the workforce system. Elected officials could serve as a key partner.

[15] https://www.dol.gov/agencies/eta/wioa

Budget Impact: Small to nominal impact on budget although it may require reprogramming of funds to support better alignment and integration of interagency resources.

Equity Implications: Aligned programs, strategies and funding is a value proposition: better alignment, integrated services and resources, enhanced service utilization, and increased opportunity for coordinated service planning and delivery; reduced duplication of efforts and investments; and improved outcomes for diverse partners, including District residents, businesses, education and training institutions, community-based supportive services, and philanthropic organizations. Aligned programs also support the District's goal of strengthening pathways to prosperity for District residents who face the highest structural barriers as articulated in the DC Upward Mobility Action Plan.

Legislative Action: No legislative action necessary.

Recommendation #2

Adopt policies and practices for licensure, registration, and certification to ensure that the District's health care workforce can be prepared for the healthcare delivery system of the future.

Length: Short Term – 6 months to two years

Background: Some District employers and health care workers have expressed concerns regarding the health professional licensure, certification, and examination processes in the District. The concerns have included long processing times, lack of communication and poor customer service due to a lack of licensing and certification specialists to respond to questions, lack of testing dates and cancelled testing dates, particularly for high demand, high need positions such as Certified Nursing Assistants (CNAs). Moreover, the rules vary by board on the processes for licensure, recertification, renewal, reinstatement, and examinations. The post COVID-19 reality and practice changes have brought increased urgency to these issues because of the increased volume of temporary agency staff which burdens both licensing boards and employers as there are regular, large influxes of licensing applications every several months.

While DC Health has made efforts to improve systems, service and workflow, concerns remain regarding the timely processing of applications and other responsibilities of the licensing boards. Recently one of the biggest delays identified has been the IT systems design that allowed licensees to submit incomplete applications which delays licensure because there is no mechanism to trigger a health licensing specialist to check a record once the requested information is added. Another issue recently identified is that messages from DC Health's Salesforce software licensing platform can go directly to spam which may go unnoticed by licensees who then fail to provide the requested information. Additional challenges include the lack of accommodation for applicants who are Limited English Proficient (LEP) or lack computer skills.

To address these challenges, DC Health should reduce barriers and expand accommodations for applicants, increase its staffing for boards with large number of licensees, revamp its renewal process, and explore additional licensing compacts.

- Ensure Adequate Staffing
    - The District of Columbia must ensure that the Board of Nursing and other licensing Boards are fully staffed and supported with adequate technology and technology upgrades to support its workload.
- Accommodate the Needs of a Diverse Workforce
    - Oral Certification Exams: DC Health should also look to expand certification exam offerings orally and in multiple languages to accommodate the needs of candidates with LEP), and with disabilities.
    - Alternative Renewal Options: Offer alternative ways for allied health workers to renew their certification that do not solely rely on electronic submission.
- Removing Entry Point Barriers
    - The Boards should look at reducing the age at which a person can be certified or qualified to work as a direct care worker (i.e., Direct support professional (DSP), Home Health Aide (HHA), Personal Care Attendant (PCA), CNA, and trained medication aides (TME)) from 18 years of age to 17 years of age.
- Renewals and Certifications
    - Establishment of rules and processes that would enable out-of-state allied health workers to work in the District as HHAs, CNAs and TMEs
        - Require more frequent testing dates and hold the vendor accountable when dates are cancelled.
        - The District of Columbia should participate in the Compact to allow nurses from other Compact states to practice in the District of Columbia.
            - To facilitate the entry into the Compact, DC Council must provide full funding to the Board of Nursing to reduce its dependency on licensure fees.
            - Accelerate coordination of professional licensure across District, Maryland, and Virginia—regional compact.
        - In the short term, eliminate the bridge course for CNAs who want to work in home care and combine the course material into the CNA curriculum and exam so that CNAs can work in any environment upon certification.
        - Continue waivers that have allowed CNAs to work in home care environments and certified medication technicians (CMTs) to work as TMEs.

Expected Impact: This recommendation is intended to improve the speed and ease of licensure within the District which will better allow providers in the District to ensure access to care and make it easier for health professionals to practice in the District.

Stakeholders: Potential stakeholders include direct care workers, health facilities and health care providers, health care workers, DC Health licensing and information technology (IT) staff, and consumers.

Budget Impact: The budgetary impacts would potentially include moving Health Licensing Specialists from O-type funds to general funds to account for reduced revenue due to compact participation, particularly the Board of Nursing. This would allow for licensure and investigatory staff without a dependence on licensure fees. Additionally, IT investments may be needed to support upgrades to the system.

Equity Implications: The District's health care workforce is diverse. The direct care workforce includes a high percentage of immigrants whose primary language is not English, while many competent workers lack computer skills. The District needs to accommodate this diverse workforce by offering exams in alternative formats (i.e., oral) or in alternative languages so that individuals who are not native speakers or who have low computer proficiency have increased opportunity to attain certification.

The fully electronic system creates equity barriers, particularly for those who lack access to computers and the internet or have limited computer skills. Boards should provide support to health workers to navigate electronic submission of licensure applications and renewals.

Legislative Action: Legislation authorizing compacts or regional District, Maryland, and Virginia (DMV) agreements may be necessary as well as repeal or changes to licensure requirements for certain professions including allowing 17-year-olds to engage in healthcare work.

Recommendation #3

Remove barriers for current health care workers to health care training, creating well-defined career pathways, transforming workplace culture, and identifying resources for providers to support training and advancement.

Length: Medium Term – two to five years

Background: When thinking of career advancement and retention, wages are an essential component of the equation. There is no question that low and non-competitive wages in many of the health sectors' critical jobs, including those with the highest vacancy rates (e.g., Licensed Practical Nurses (LPNs), Home Health Aides (HHAs), Certified Nursing Assistants (CNAs)) have been a major challenge to retaining staff. Establishing pay equity in these roles is essential to creating career opportunities for nursing assistive personnel. Studies have found that while pay and position are important, employees' views on advancement are also closely related to job quality. Researchers have found that focusing on small, achievable "micro-advancements" can lead to fulfilling, stable and better job quality. These advancements can include opportunities for additional benefits, creative hours, flexible schedules, childcare benefits, and job training.

The District of Columbia Health Care Workforce Partnership commissioned a DC Health Care Career Mapping Study in March of 2022.[16] The report is an outcome of a strategic recommendation

[16] https://dcha.org/wp-content/uploads/2022/07/HC-Occupations-Report-Final-July-8-2022.pdf

to inform the Partnership's Shared Priorities: Health Care as a Career Destination, Education and Training, and Career Pathways System. The report reflects the voice of health care workers as consumers of the industry. Self-paced and live sessions were conducted with current and former workers in five prioritized occupations - Certified Medical Assistant (CMA), CNA, HHA, LPN, and Pharmacy Technician. From the lived experiences of current and former workers, four themes emerged: Transform Workplace Culture: Better Define and Communicate Pathways, Enhance and Fund Training Programs, and Increase Awareness of Job and Education Opportunities. The following reflects on those themes and provides additional narratives on key drivers to support the Committee's recommendation for improving opportunities for advancement and retaining the health care workforce.

1. Committing to Livable Wages
    a. Increase the wages of all healthcare workers, including direct support professionals (CNAs, HHAs, and direct support workers).
2. See, Subcommittee on Strengthening Recruitment and Retention of Existing Qualified Healthcare Workers' Recommendation #4. Transform Workplace Culture
    a. Deeper understanding of employees as people and closer attention to task delegation, especially for CNAs and CMAs, is essential for improving workplace culture and retention.
    b. Ongoing guidance and support are needed for employees to make the most of their training and education.
    c. Mentoring and Networking: When an employee has someone guiding and advocating for them, it often leads to a faster, more fulfilling career track. Personalized, one-on-one support is key to helping employees grow and stay committed to their health care career.
    d. Peer-to-peer support and mental health services are impactful ways to improve workplace culture.
3. Eliminate Barriers
    a. Exam requirements are overwhelming. Offering exams in alternative formats for applicants with Limited English Proficiency or low computer skills will help support our diverse workforce. Counselors and tutors also could help bridge the gap.
    b. In some instances, exams cost hundreds of dollars, it would be helpful to support candidates financially through their exam process including the cost of the exam if it is an obstacle. In many cases, the candidate cannot apply to a role until they have passed the exam, so the affordability issue is compounded.
    c. Exam dates for allied health positions such as CNA and HHA must be offered with greater frequency and certainty. There have been multiple last-minute cancellations of exam dates. In some cases, recent CNA graduates have had to wait months for an exam date, delaying their employment prospects and necessitating the need to take refresher classes. These delays discourage students and frustrate employers who are desperate to fill vacant positions.
    d. Affordability: The overall cost of living and affordability of living in the District creates a major barrier to pursue a health care career, particularly for non-degree allied health professionals. This is further exacerbated by the impact of other socio-economic factors. Policy makers should consider *additional* financial incentives for

District residents to pursue the wider array of careers in health care, including non-degree positions.

4. Better Define and Communicate Pathways (current and new care models): Develop well-defined career pathways for employees that provide opportunities to move between, within and beyond their current roles, though on the job training.
    a. Maximize the use of technology to extend care teams. As care models change and shift to adapt to modern technology and patient demand, there is an opportunity to create and expand new care team roles/pathways and reskill a "new workforce" to support care model redesign.
    b. Explore creative staffing opportunities (maximizing use of care assistants, clinical learners).
    c. Propose scope of practice changes to ensure alignment with positions that are an outgrowth of care model redesign.
    d. Expand Acute Care LPN Pathway: Limited LPN positions close an important pathway for DC Residents: LPN positions have been extremely challenging to fill in both the acute and post-acute environment. As new care models evolve, there is the potential for an even greater demand for non-degree clinical staff including LPNs.
    e. Advocate for processes that better aligns skills and opportunities to ensure optimal utilization for CNA and CMA to maximize resources.
    f. Combine CNA and HHA training and offer one certification that allows the worker to work in either facility or home care environment.
5. Enhance and Fund Training Programs: Policy makers and employers should fund and deliver training programs that provide training opportunities for staff to advance beyond their current professional scope.
    a. Financial support through scholarships, stipends, employer sponsorship and other partnerships is vital to helping employees advance within or among pathways.
    b. Explore how stackable/transferable skills translate to certifications and advancement: Opportunity for employers to certify employees through on-the-job training.
    c. Provide funding to training programs so that they can hire experienced nurse educators.
6. Increase Awareness of Job and Education Opportunities.
    a. Limited awareness that potential jobs and pathways exists:
        i. Launch coordinated efforts to educate current body of health care workers and new entrants on the myriad opportunities for sustainable careers in health care that do not require college degrees.
        ii. Meeting people where they are and engaging those, they trust are impactful ways to reach people who want to start and advance in the health care field.
        iii. Creating opportunities for peer ambassadors to serve as brand ambassadors for allied health careers.
        iv. Cost and time required must be factored into the messaging. People also need to see themselves in the environment that fits them.
    b. Job opportunity and training program information needs to be more accessible. Employers are key partners who can offer paid leave and other professional development benefits.

Expected Impact: The intended impact of this recommendation is to increase and retain the health care workforce by establishing sound compensation policies and recognition of the myriad factors to "job satisfaction." In addition, these recommendations encourage the implementation of "upskilling" and apprenticeship opportunities to "earn while you learn" to provide advancement opportunities for new and existing care models and expanded scope of practice offerings.

Budget Impact: Financial support will be needed for training programs, scholarships, and employer assistance. Additionally, support will be needed for investments in subsidies for childcare, transportation, and housing to eliminate barriers and obstacles for participants.

Stakeholders: Potential stakeholders include health care employers and workers, training providers, DC Health, health insurers, and health care consumers.

Equity Implications: Achieving Livable Wages/Pay Equity: The District of Columbia Upward Mobility Action Plan documents that residents with lower incomes have not benefited as much from the District's economic growth as the residents with higher incomes and many workers with lower incomes have not experienced enough wage growth to keep up with rising costs of goods, services and, especially, housing. According to the Action Plan, these challenges tie directly to structural racism, which the District's Office of Racial Equity describes as a system of public policies, institutional practices and cultural representations and other norms that work to perpetuate racial group inequity. The report notes that employment discrimination prevented many people of color from holding jobs comparable to white people with the same education and training.

Nationally and locally, the healthcare direct care workforce primarily is composed of women of color and immigrants. Poor job quality, which is characterized by low wages, lack of benefits, poor training, few opportunities for professional advancement, and lack of respect all reflect and perpetuate structural racism that disadvantages communities of color and other marginalized populations. As early as 2008, the Institute of Medicine (now the National Academy of Medicine), found that low pay for direct care work contributes to turnover and chronically high staffing shortages. Studies also show that raising the pay of direct care workers to a locality-specific living wage, one that allows a full-time worker to pay for their family's basis needs such as housing, food, transportation, and health care, is an essential first step to remediating inequity. Higher wages will help alleviate the workforce shortage crisis and enhance workers financial well-being, reduce their reliance on public assistance, and enhance the prosperity of their families and their communities. Further, when coupled with other proposed strategies to support upskilling and access to additional education, these workers will be able to advance their careers and build wealth. In short, investing in this workforce aligns closely with the Mayor's Upward Mobility Action Plan to address structural racism and should be a priority.

Legislative Action: See, Subcommittee on Strengthening Recruitment and Retention of Existing Qualified Healthcare Workers' Recommendation #4 for legislative action on increasing the Living Wage.

Recommendation #4
Encourage health care employers to create or expand certified apprenticeship or internship programs.

Length: Short Term – 6 months to 2 years.

Background: Registered Apprenticeship has a proven track record of producing solid results for employers and workers. Apprenticeship programs offer access to hundreds of occupations in high-growth and emerging industries. Overall, the healthcare industry faces complex workforce challenges, including worker shortages and increasing service demand. Apprenticeship programs are a proven solution for recruiting, training, and retaining world-class healthcare talent and are a solution for training up and addressing the worker shortage.

In addition, experiential learning in a clinical environment with practicing clinical teachers/supervisors is fundamental to development of competent health care providers. While didactic education is essential, the value of immersive experience under supervision fuels development of observational skills, pattern recognition, communication, and technical skills. This irreplaceable learning environment applies to all levels of clinical care—from entry level positions to highly specialized physicians providing complex care.

Coupled to curricula with structured learning goals, the clinical environment provides the platform for acquisition and practice of didactic education. To optimize the educational experience of learners, a corps of clinical practitioners who have received training in how to optimize education and supervision of work-based trainees in the clinical environment is needed. This teacher/mentor skill is often a natural element in health care team members who are tasked daily with educating patients and families in a variety of care related skills and observations; many healthcare institutions have such a corps as exemplified in the nursing educator roles. Similar trainer/supervisor roles could be developed for healthcare team members for the full spectrum of health care needs in hospitals, clinics, long term care and other sites. There are numerous higher education institutions in the District that could develop clinical apprenticeship mentor/supervisor programs with streamlined training programs.

In house programs to support apprentice-based education would serve not only the purpose of introducing young talent to health care as a professional goal, but also serve the purpose of career development along the mentor/supervisor track for the professionals engaged in the teaching for each healthcare worker category.

In house programs would also benefit the host institution by drawing future employees into their programs, building relationships that may lead the trainee to seek employment at the same institution once their training is complete—a loyalty for education received.

To achieve these goals, the following concrete recommendations should be implemented:

- Assess and re-evaluate regulatory requirements that restrict entry-immediate occupations such as Certified Nursing Assistants (CNAs), Home Health Aides (HHAs), and Direct Service Professionals (DSPs) to people 18 and older. This age restriction limits opportunities for beginning internship or apprenticeship programs in high schools, as students who may wish to participate would not yet be 18; recommend consider reducing the age to 17, either for licensure or explicitly for training/apprenticeship program participants.
- Seek a commitment from major health care employers, across the continuum (primary care, acute care hospitals, post-acute and specialty care facilities) to establish training programs to provide opportunities for entry into health field for employees. The health care entity could either establish on its own or partner with a community organization for staff to receive the education needed to be prepared for work-based learning; and the person would move into a hospital-based (or other health care setting-based) paid apprenticeship, until the qualify for licensure or certification in the field. This could provide opportunities for existing hospital staff, who are not currently in clinical positions, to move into a clinical health care field.
- Enhance existing relationships with workforce intermediaries to establish apprenticeship programs This entity would then coordinate with various health care provider settings to create placements for apprenticeship placements, which could transition to entry level, full-time positions in a healthcare position.
- Work with schools to establish a pipeline for students who may be interested in entering a health care field following high school. This may require the change in regulation referred to above. Students would receive the classroom training at school and be placed in a health care setting for their clinical education. These students could exit high school with certification/licensure qualified to immediately enter the respective health field.

While this section has focused on clinical apprenticeship, health care employers should also consider launching apprenticeships in non-clinical roles such as environmental services, biomedical engineering, and health information services.

Expected Impact:

- With direct experience in the health care institution, greater numbers of young people may be drawn to health care careers.
- Experiential learning will deliver a more capable healthcare professional more rapidly.
- Institutions will create advancement pathways for trainers/educators who teach while practicing, aiding retention.
- Institutions will build connections with their trainee, fostering greater interest in continued employment after education is complete.
- Enables employers to increase the supply of skilled healthcare workers using a predictable model.
- Creates a pipeline to address workforce shortages and the growing demand that will come with emerging technologies and new care models.
- Opportunity to design new career pathways for workers who move into positions requiring advanced skills as they gain experience and knowledge.
- Provides opportunities to expand diversity and equity by improving leadership and supervisory skills in the healthcare workforce.

- Earn while you learn training system that allows employees to enter the workforce and earn a salary while gaining new skills or training.
- Reducing turnover and other related costs.
- Provides mentor/supervisor track opportunities for the professionals engaged in the teaching for each healthcare worker category.

Stakeholders: Potential stakeholders include the Department of Employment Services (DOES), the Workforce Investment Council (WIC), DC Health, public school systems, other related government agencies, learners in a range of healthcare roles, health care facilities, health care team members who seek career enrichment by developing mentor/supervisor roles, Training Programs, and higher ed institutions who offer training to teach on the job health care practitioners to be effective teachers in clinical environments.

Budget Impact: Public and private sector support for training, incentives, and other needed supports (e.g., childcare, transportation) are required. Additional funding for incentives for training institutions, new programs, and expanded program sites will also be needed.

Equity Implications: Early access to experiential training may facilitate outreach to young people in the District to enter healthcare related careers. Providing a ladder for advancement into higher level, better compensated positions while working will support individuals who cannot afford to leave the workforce for dedicated educational time.

Legislative Action: Legislation will be required to allow 17-year-olds to participate in training programs and work as CNAs and HHAs.

Recommendation #5

Adopt Competency Based Training Certification as an essential pathway to advancing careers in health care.

Background: Today, the health care industry is faced with myriad challenges to address workforce shortages and the growing demand of emerging technologies. In the aftermath of COVID-19, the health care workforce crisis has been exacerbated by an aging workforce, exodus of clinicians and other health care workers from the field, burnout, and other factors. There also are critical shortages of allied health and behavioral health professionals, especially in historically marginalized urban (and rural) communities. With growing pressures on educational and training programs, health care employers must re-imagine novel approaches to both sustaining and growing the workforce by helping their staff acquire new skills and competencies. Competency-based training models offer unique and individualized opportunities to receive educational/certified credits for experience and defined competencies and knowledge of a defined skill. Competency-based education also provides an opportunity for employers to expand the supply of on the job "trainers" and create a pipeline of new and expanded opportunities for workers to advance within, between and beyond their current roles and scope of practice.

Expected Impact: Competency models articulate the business and industry requirements that are essential components for the development of curriculum, skill assessment instruments, and certifications. Competency models, as the basic building block, also facilitate the development of the courses and the career pathways and career lattices that provide the framework for career advancement.

Stakeholders: Healthcare employers are crucial to develop competency modes for industry occupations within their local and regional industry sectors. Educators are key partners in reviewing existing competency models with employers. Employers and educators should engage subject matter experts (SMEs), that is, those who are currently performing the job tasks. Employers and educators validate competency models.

Budget Impact: No budgetary action necessary.

Equity Implications: Some residents may be barred from moving up the health careers ladder due to financial constraints. Postsecondary or industry-recognized or validated credentials are critical as a prerequisite to registration and licensure at the local and state level. Many entry-immediate healthcare occupations require a postsecondary credential from an accredited body. Competency - based training and certifications, much more feasible for individuals with less time and resources, will ensure that there are multiple entry and exit points aligned to skill level and personal situations.

Legislative Action: Review and revise registration and licensure polices, practices and processes that align with 21st century, market-validated workforce demands. For example, extend the externship sites for the Certified Nursing Assistant beyond skilled nursing facilities (SNF) as other healthcare sub-sectors, including acute care and ambulatory care, utilize the Certified Nursing Assistant (CNA) as part of the clinical teams.

Subcommittee on Enhancing Access to High-Quality Allied Health Training Programs

Recommendation #1
Create the State of the State for Home Healthcare Aides and CNAs and develop a targeted plan to increase the number of providers and enrolled participants.

Length: Short Term – 6 months to two years

Background: Home Health Aides (HHAs) and Certified Nursing Assistants (CNAs) are two of the positions in greatest demand in the District. Certification for both positions can be attained at low cost after only weeks of training rather than months or years. They also offer upward mobility to more advanced nursing licensure. However, the supply of qualified applicants has not kept pace with the number of open positions for HHAs and CNAs. Retaining these professionals over time also continues to be an issue. To address this, a "State of the State" report for HHAs and CNAs should be created to inform a targeted plan to increase both training providers and participants.

Expected Impact: A report and plan will be developed:

1. Publish a State of the State of HHA and CNA Training report that: (3 months)
    - Evaluates current programs' capacity to train new professionals
    - Identifies issues that District residents face
    - Contains a census on current training providers
    - Contains the number, location, and capacity of available trainings/classes
    - Covers participant barriers
    - Reviews current-state marketing of CNA and HHA programs to identify opportunities for improving recruitment
    - Documents any additional relevant information about the current status of CNA and Home Health Aide training
2. Identify solutions to increasing the number of practitioners and retention rates. and include in a targeted plan. (3 months)
3. Implement the plan with the target of doubling the number of HHAs and CNAs. (6 months)

Stakeholders: Potential stakeholders include training organizations, employers, the prospective workforce, and the patients and clients of health care facilities/organizations.

Budget Impact: For this recommendation, full-time employees (FTEs)—either existing government agency staff or an external consultant—will be required to conduct the initial data collection and analysis as well as prepare a comprehensive plan to address the issues found. A vendor or existing agency staff will also be required to aid those who have barriers which limit their ability to start or complete training.

Equity Implications: The plan will require employers to expand trainings to individuals by publicizing their offers and reducing or eliminating barriers that limit participants' ability to start or complete training. Difficulty accessing providers is common in lower economic areas such as Wards 7 and 8. Current marketing and recruitment strategies also need to be re-evaluated to ensure they are suitable, inclusive, and are presented through channels visible to the broadest range of District residents. Improving information distribution and the ease of access to training/certification programs will help individuals enter the workforce or get a career that offers higher wages. Employers must also improve their outreach and engagement in majority Black communities. Increasing availability and reducing barriers in these communities will increase the number of Black residents in health care careers.

Legislative Action: No legislative action necessary.

Recommendation #2

Streamline the approval process and eliminate unnecessary entry barriers for health care providers interested in being certified as a training program in order to increase the capacity of the health care workforce system.

Length: Short Term – 6 months to two years

Background: Based on labor market data from 2022, there are over 21,000 unemployed individuals in the District. This pool of potential health care workers faces many barriers including childcare needs, costs to training, transportation, and others. To grow the health care workforce, quality training programs are required. Training providers, however, also encounter obstacles in being approved as official District Providers and expanding to ensure they have the capacity and needed services to effectively serve their students.

Current procedures for becoming certified as a training program are cumbersome, inefficient, and spread out across multiple government agencies. Nurse training providers must go through at least the DC Board of Nursing, the DC Higher Education Licensure Commission (HELC), and a national accrediting agency such as the Commission on Collegiate Nursing Education to be approved as a training provider in the District. Allied health professionals such as Home Health Aides (HHAs) and Certified Nursing Assistants (CNAs) must go through the first two but there is no national accrediting agency for those professions which may hinder quality controls. This can hinder or delay providers from offering the needed services in a timely fashion. Additional qualified training providers with the infrastructure and range of services needed to train the workforce properly are needed. Resolving this issue will expedite greater overall supply of training programs and empower the market to be more responsive to the needs of prospective entry-level healthcare workers, or those seeking more advanced licensure. This includes the potential for opening training programs in areas of the District with untapped potential for recruiting a more diverse and inclusive healthcare workforce. It also improves responsiveness for those with practical barriers such as offering evening sessions and proximity to public transit.

Expected Impact: To address the delays in approving training process, the District will create a streamlined process under one regulatory authority to consolidate and shorten the approval process for providers. This process will lead to expansion of training options and will better serve prospective healthcare workers. The approval process will be led by the Department of Employment Services (DOES) and DC Health to review providers who meet the qualifications. District agencies will continue to have the authority to award or refuse approval of program services from prospective providers, but the revised process will take into considering that the vetting process often deters quality providers and training programs from applying. A streamlined process will create an environment where approved providers can focus on the quality of training by removing unnecessary administrative barriers and allow them to run successful training programs.

Stakeholders: Potential stakeholders include training organizations, DOES, DC Health, employers, the prospective workforce, and the patients and clients of health care facilities/organizations.

Budget Impact: Additional funding will be required to streamline the approval process, assist training providers in getting approved, and develop the proper infrastructure to provide quality training.

Equity Implications: Increasing the number of providers, improving access to providers, and creating new services offered by training providers will increase accessibility and reduce barriers that have stopped residents from underrepresented communities entering and completing these programs.

Legislative Action: Legislation will need to be changed to remove current administrative barriers that DOES and other organizations encounter when trying to onboard new training providers.

Recommendation #3

Increase the number of scholarships and tuition support programs for associate and four-year health care degrees.

Length: Short Term – 6 months to two years

Background: The high cost of health care career training and higher education burdens individuals looking to enter fields that can lead to rewarding careers, improved economic security and increased quality of life. This burden is insurmountable for many, causing potential future healthcare workers pursue another career instead that has less stringent degree requirements but provides significantly less pay. The health care field has many occupations requiring an associate's or four-year degree, and job openings continue to grow as a generation of professionals retire and the workforce struggles to recover from pandemic burnout. Additionally, some individuals with baccalaureate degrees in other fields would pursue a nursing degree as a Master's Entry pre-licensure program if provided with financial support to do so. Scholarships and tuition assistance

will give opportunities to individuals who would not otherwise be able to afford an associate's or four-year degree and those seeking to advance their career by entry into the nursing profession.

Expected Impact: Scholarships and tuition support will reduce financial barriers for District residents interested in enrolling in health care degree programs while also raising awareness of health care careers among those who may not have considered a future in the health care industry. These supports will also give a lifeline to students for whom cost may be a barrier to completing the program, offer greater stability to training program revenue by mitigating cost-based attrition, and create more lasting ties to District employers among those seeking long-term careers in the healthcare field as individuals who receive scholarships and tuition assistance will be required to work in the District for at least one year for each year of support they receive. The service requirements tied to receiving scholarships provide immediate short-term relief to understaffed District healthcare facilities and add value for the District residents served at those facilities.

Stakeholders: Potential stakeholders include existing public tuition support programs such as OSSE's District of Columbia Tuition Assistance Grant Program (DC TAG), the Department of Employment Services (DOES), training organizations, employers, and the prospective workforce.

Budget Impact: Supplemental funding will be needed for scholarships and tuition assistance programs.

Equity Implications: Higher education favors those of a higher economic status due to financial and other barriers to attendance. More advanced degrees facilitate access to higher paying careers. Reducing those barriers will increase economic diversity of health care professionals and in turn, raise their own incomes. By providing more scholarships and tuition assistance, individuals who in the past could not get associate degrees or four-year degrees in the healthcare field or a Master's Entry degree into the nursing profession will now have a increased opportunity to graduate with a springboard to a healthcare career with a living wage that serves District residents who need and deserve the best healthcare system available.

Legislative Action: Legislation will be needed to ensure that individuals who participate in scholarship and tuition assistance programs requiring years of service as repayment for assistance are legally binding and enforceable.

Subcommittee on Focused Retention of DC-based Health Professional Students Post-Graduation

Recommendation #1
Create partnerships with local universities that enroll high numbers of DC-based students to provide training in career ladder jobs, i.e., entry level to licensed clinical level positions.

Length: Short Term – 6 months to two years

Background: Students from the District are concentrated in specific universities and training programs. They offer a broad range of programs at all levels of the workforce. The entire pipeline should be charted and correlated with employment opportunities and salaries. The training and internship pipeline should be as seamless as possible, with multiple on and off ramps that lead to credentials at every level. Employers should support employees' journey as they progress through the pipeline. Specific activities should include:

- Creation of partnerships with local universities that enroll high numbers of District based students to provide training in career ladder jobs (i.e., entry level to licensed clinical level positions).
- Incentivize tuition support from public and private employers for employees to pursue a degree with the stipulation that every 6 college credits supported would require a post-reimbursement commitment to the organization. This may also include tax incentives to participating private employers who participate.

Expected Impact: This will result in an increased number of current District residents who gain new certifications or education who stay in the field but in a higher paid role. There will also be an increased number of District residents entering health care training and educational programs. Retention rates will also be increased through increased number of mentors and residents taking advantage of those mentors.

Stakeholders: Stakeholders include District universities, their healthcare profession partners, Saint Elizabeth's Hospital Training Program which includes the Psychiatric Residency and Fellowship training, clinical psychology, Advanced Dental Education and Residency Training, and the Clinical Pastoral Education Program.

Budget Impact: There may be a budget impact based on government funding for tuition and a negative impact on the District's finances through tax reductions by participating employers.

Equity Implications: As very few students at District universities are District residents, with seven out of 10 universities student bodies made up of fewer than 2% District residents, reducing barriers to increase District resident enrollment will reduce disparities in attendance and improve opportunities for residents who are more likely to be residents of color.

Legislative Action: Tax incentives to encourage employer tuition support might be considered.

Recommendation #2
Conduct market analysis to drive adjustment of health care workers' salaries

Length: Short Term – 6 months to two years

Background: Median wages in health care support, service, and direct care jobs were nationally just $13.48 an hour in 2019—well short of a living wage and far lower than the median pay of doctors (over $100 per hour) and nurses ($35.17 per hour). Home health and personal care workers earn even less, with a median hourly wage of only $11.57. The wages are so low that nearly 20% of care workers live in poverty and more than 40% rely on some form of public assistance. These fields are some of the fastest growing of all occupations, with more than a million new jobs projected nationally by 2028.[17]

Due to the low salaries in health care support, service, and direct care jobs, many workers are leaving the field entirely. This is particularly significant in smaller employers who already struggle to recruit or retain workers. By paying competitive salaries, health care employers are better able to attract and retain workers.[18] A District-wide pay study will help inform those salaries and make the District more competitive in the region and nationally. Both market analysis and pay study terms of reference should consider the impact of structural racism[19][20] in the health care industry in general, together with a racial equity impact assessment to inform their recommendations.

Conduct a market analysis of the healthcare workforce salaries in the District of Columbia and correlate with retention and adjust salaries consistent with the data. The market analysis should include both regional data (DMV) and national data and should include a human-centered design approach to center the lived experiences of healthcare workers. Use of a human-centered design approach to address serious healthcare workforce shortfalls could accelerate identification and adoption of such policies and strategies that are not typically the approach of healthcare government agency or private industry. See, also, Strengthening Recruitment and Retention of Existing Qualified Healthcare Workers Subcommittee's Recommendation #4 and Background and Equity Implications discussions.

Expected Impact: A pay study will allow employers to raise wages and improve recruitment and retention.

Stakeholders: Potential stakeholders include District residents, DC Health, District hospitals, and District long-term care (LTC) facilities, and the DC Chamber of Commerce.

Budget Impact: There is no budgetary impact.

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[17] https://www.brookings.edu/research/essential-but-undervalued-millions-of-health-care-workers-arent-getting-the-pay-or-respect-they-deserve-in-the-covid-19-pandemic/
[18] https://www.healthleadersmedia.com/finance/hospitals-face-pressure-pay-market-competitive-salaries
[19] https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2021.01466
[20] https://www.commonwealthfund.org/publications/2021/oct/confronting-racism-health-care

Equity Implications: The structure of the health care industry and its workforce across the US, as well as in the District, is such that jobs in health care support fields, such as home health service and direct care, have persistently been concentrated on the lower-to-lowest rounds in terms of both stature and compensation. As shown, employees in these roles typically earn low wages. They are also disproportionately people of color. By increasing their pay, communities of color will increase their net worth and help close the chasm in wealth and income between Black and white residents.

Legislative Action: The study will make legislative recommendations.

Recommendation #3

Address employee burnout through mental health services.

Length: Medium Term – two to five years

Background: Many healthcare workers both nationally and in the District, who were otherwise satisfied in their jobs, left their profession in the past three years due to the additional social and emotional impact brought by the COVID-19 pandemic.

The healthcare industry is an extremely rewarding one where employees improve peoples' lives and can see the tangible effect they have, which can be a motivating factor when work gets stressful. However, the healthcare field also has significant drawbacks that often centers on burnout.[21]

Managing acute and chronic disease, emergency, and specialized medicine during the COVID-19 pandemic had devastating effects on employee retention due to increasing burnout, an issue even before the pandemic. Rebuilding and maintaining a stable healthcare workforce in the District of Columbia will require innovative and resilient support systems for workers.

- Understand where the gaps in identifying burnout in the workplace are and close those gaps
- Provide onsite behavioral health counseling services
- Offer mental wellness days to staff who are experiencing burnout
- Encourage and provide space for wellness coping strategies (e.g., exercise and meditation)

Expected Impact: Addressing burnout will improve employee retention and ensure a more stable healthcare workforce by improving employee Satisfaction, productivity, and patient satisfaction.

Stakeholders: Potential stakeholders include District residents, DC Health, District hospitals, and District long-term care (LTC) facilities.

Budget Impact: No budgetary action necessary.

[21] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7604257/

Equity Implications: The issues of burnout, stress and trauma and acute in economically disadvantaged, black and brown communities. Many of the recommendations of this subcommittee recognize that fact and seek to increase diversity at all levels of the workforce despite the challenges presented by that system. Creating a stable healthcare workforce enables us to address health inequities to improve health outcomes.

Legislative Action: No legislative action necessary.

Recommendation #4
Create retention incentives for current health care workers

Length: Long Term – five years and beyond

Background: Recently, many healthcare workers have left their employers for other positions that include better benefit packages, flexible work schedules, retention and hiring incentives. Some evidence suggests that will keep their satisfaction level and productivity high which will improve retention rates.

The subcommittee suggests a report be conducted to recommend the expansion of loan repayment programs for non-clinical degrees, expanded recruitment and retention incentive packages, and other perks such as housing stipends, and free parking. Employers, both public and private, should explore expanded benefit packages to make the positions more appealing and reduce employee departures for more lucrative roles elsewhere. Finally, the District should expand its Health Professional Shortage Area Designation to make loan repayment available in behavioral health high need areas.

Expected Impact: Improved supports for existing health care providers will increase employee satisfaction, productivity, and retention.

Stakeholders: Potential stakeholders include District residents, DC Health, District hospitals, and District long-term care (LTC) facilities.

Budget Impact: Based on the above report, a budgetary impact may exist and will inform both the costs and how to pay for them.

Equity Implications: Many of the recommendations of this subcommittee recognize the fact that our educational systems have baked in systemic racism and seek to increase diversity at all levels of the workforce despite the challenges presented by that system. Creating a stable healthcare workforce enables us to address health inequities to improve health outcomes. Mayor Bowser has established an Office of Racial and Health Equity. Providers should be mindful of the guidance established by this office to address racial equity issues

Legislative Action: No legislative action necessary.

Subcommittee on Development of a Health Careers Pipeline Strategy

Recommendation #1
Increase school partnerships with health care partners throughout middle and high school to increase exposure and immersion experiences.

Length: Short Term – 6 months to two years

Background: One of the problems identified by the DC Health Care Workforce Partnership, an industry-driven, community-supported sector based-alliance, is secondary students' lack of exposure and knowledge of the various career opportunities in health care. Through recruitment and retention of heath care partners, District schools can increase classroom education and experiential learning opportunities. This includes incorporating health care employers into science, technology, engineering, and math (STEM) lesson plans and units and increasing their participation in the Office of the State Superintendent of Education's (OSSE) Industry Advisory Board for Health Sciences. The subcommittee includes post-secondary educational institutions and training providers in the definition of health care partners to create seamless pathways to careers through post-secondary education programs.

Expected Impact: Increasing opportunities to experience and understand various occupations available to students as they consider careers will increase the number of students pursuing certification or other post-secondary education. Additionally, it provides employers, organized labor, and training providers new connections with students.

Budget Impact: Potential costs of background checks for partners and transportation costs for immersion opportunities.

Stakeholders: Potential stakeholders include employers, labor unions, training providers, District of Columbia Public Schools (DCPS), District of Columbia Public Charter Schools (DCPCS), and OSSE.

Equity Implications: The District would need to ensure that these partnerships are accessible by all students and in schools across the District. As most students in both DCPS and DCPCS are students of color, this would expand and diversify the number of applicants to health care career programs.

Legislative Action: No legislative action necessary.

Recommendation #2

Increase awareness of and merge existing internship programs with the Marion S. Barry Summer Youth Employment Program to provide year-round opportunities for students.

Length: Short Term – 6 months to two years

Background: The District through the Department of Employment Services (DOES) and the Office of the State Superintendent for Education (OSSE) have expanded existing experiential learning and on the job experiences year-round. Rather than recruit separately, the District should consider automatically enrolling students in internship programs. This would streamline the process for OSSE, DOES, and health care employer partners. Additionally, the subcommittee recommends that these programs, particularly internship opportunities should be publicized to a greater degree and earlier so students can plan their course work and schedule to allow participation.

Expected Impact: This will increase the number of paid opportunities for students to receive on the job experience in health care and incorporate it into their education requirements. Additionally, it will create mentorship opportunities for students with professionals in health care to help guide them as they consider future careers.

Stakeholders: Potential stakeholders include District of Columbia Public Schools (DCPS), OSSE, DOES, health partners, and District of Columbia Public Charter Schools (DCPCS).

Budget Impact: No budgetary action necessary.

Equity Implications: These opportunities should be available to all students, including those with disabilities, and that barriers to their participation should be identified and removed.

Legislative Action: No legislative action necessary.

Recommendation #3

Expand health professional programs and certifications available upon high school graduation

Length: Medium Term – two to five years

Background: Subcommittee members identified the need to expand students' access to health careers and create opportunities to begin health care career training while still at secondary school. DC secondary schools already offer Certified Nursing Assistant (CNA), Home Health Aide (HHA), and Emergency Medical Technician (EMT) programs and these programs should be

expanded to additional schools and promoted more. There may be opportunities to add other training programs such as Pharmacy Tech programs and others. The DC Fire and Emergency Medical Services Department (FEMS) have an urgent need for EMTs and paramedics and believe these programs and increased exposure will improve recruitment and retention of District residents.

Expected Impact: Widening the career pipeline through programs that increase the number of high school students who graduate with certification will help address the significant need for health care workers. These students can then immediately start their careers fulltime or earn money while going to school for other health care careers.

Stakeholders: Potential stakeholders include District of Columbia Public Schools (DCPS), District of Columbia Public Charter Schools (DCPCS), health care employers, the Office of the State Superintendent of Education (OSSE), FEMS, and DC Health.

Budget Impact: Funding for faculty, equipment and supplies will need to be considered along with demand and capacity of programs.

Equity Implications: Increasing the programs at more schools in the District would allow for greater access to programs across the city. In 2021-2022 school year, 57% of DCPS students were Black or African American and 71% of DCPCS students were Black or African American. Ensuring greater access to healthcare career programs in public schools will give greater access to Black students to enter and diversify the healthcare workforce.

Legislative Action: No legislative action necessary.

CONCLUSION

The 26 recommendations contained in this report seek to create a more equitable, equipped, and supported healthcare workforce caring for residents across the District. While we recognize that while new challenges will arise, these recommendations will help address some of the most pressing healthcare workforce issues facing the District of Columbia at this time. Additional work from Task Force members may be warranted in the future and members have indicated their interest in continuing this work, as needed.

The Task Force hopes that these recommendations will guide the work of Executive agencies, the Council of the District of Columbia, and stakeholders throughout the health care system as they look for ways to ensure positive employment and health outcomes for District residents. Mayor Bowser should assign these recommendations to appropriate members of her administration for consideration and implementation. Key investments, policy changes, and the development of partnerships will be necessary for them to come to fruition, but the alignment achieved through the work of this Task Force provides an excellent starting place for this work.

APPENDIX A: TASK FORCE & SUBCOMMITTEE MEETINGS

Mayor's Healthcare Workforce Task Force *Meeting agendas and minutes for all full Task Force meetings are available here.*	• Thursday, May 26, 2022 • Thursday, June 16, 2022 • Thursday, July 14, 2022 • Thursday, August 11, 2022 • Thursday, September 8, 2022 • Wednesday, September 28, 2022 • Wednesday, February 1, 2023
Strengthening Recruitment and Retention of Existing Qualified Healthcare Workers	• Monday, July 11, 2022 • Monday, July 25, 2022 • Monday, August 15, 2022 • Monday, August 22, 2022 • Monday, September 19, 2022
Increasing District Resident Employment in Healthcare Occupations	• Monday, July 11, 2022 • Monday, August 1, 2022 • Monday, August 15, 2022 • Monday, August 29, 2022
Improving Opportunities for Advancement in Health Careers within the District	• Tuesday, July 5, 2022 • Wednesday, July 20, 2022 • Tuesday, August 2, 2022 • Wednesday, August 17, 2022
Enhancing Access to High-Quality Allied Health Training Programs	• Wednesday, July 20, 2022 • Wednesday, August 10, 2022 • Tuesday, August 23, 2022
Focused Retention of DC-based Health Professional Students Post-Graduation	• *Work conducted electronically, no formal meetings
Development of a Health Careers Pipeline Strategy	• Thursday, July 7, 2022 • Monday, August 22, 2022

GOVERNMENT OF THE
DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR