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March 20, 2023

Sen. Bernard Sanders
Chairman
Senate HELP Committee
United States Senate

Sen. Bill Cassidy, M.D.
Ranking Member
Senate HELP Committee
United States Senate

Dear Sens. Sanders and Cassidy,

On behalf of the nation's more than 200 children's hospitals and the children and families we serve, thank you for providing this opportunity to respond to your RFI on health care workforce challenges and solutions. We applaud your commitment to addressing the health care workforce challenges facing the nation and urge a focus on pediatrics, which is experiencing a unique workforce crisis.

Our ability to continue to meet children's health care needs, now and into the future, requires innovative approaches to recruit, retain and bolster our current pediatric workforce. A national investment in the health care workforce must include a focus ensuring that our health care system has full range of clinical and non-clinical pediatric providers needed to deliver optimal care to children.

It is imperative that meaningful policy solutions are advanced to strengthen the pediatric workforce pipeline and address recruitment and retention across the spectrum of both licensed and non-licensed pediatric providers and specialists. Solutions must include dedicated investments in the pediatric workforce that are not based on Medicare metrics as most of children's health care operates outside of the Medicare program. They must also support a diverse pediatric health and mental health workforce that is prepared to deliver culturally and developmentally appropriate care. Those solutions should include:

- Reauthorization of the Children's Hospitals Graduate Medical Education (CHGME) program this year. CHGME is the only national program focused on the training of pediatricians and pediatric subspecialists.

- Expanding existing – and developing new – Departments of Health and Human Services (HHS), Labor and Education programs to support the pediatric clinician and allied health pipeline, such as loan forgiveness, career academies, and other learning and outreach programs.

- Investing in the existing pediatric mental health workforce and its long-term expansion across disciplines to meet the ongoing and growing mental health needs of our children.

Pediatric Provider Shortages

The workforce shortages in pediatrics are different than those for adults, primarily affecting pediatric specialty providers, including pediatric physician subspecialists (e.g., pediatric pulmonologists) pediatric advanced practice providers, such as physician assistants and nurse practitioners and acute care nurses, and pediatric allied health and medical tech professionals (e.g., pediatric respiratory technicians and speech therapists, etc.). The recent surge in childhood respiratory illnesses, combined with the ongoing crisis in children's mental health, has placed an

extraordinary burden on our frontline providers, exacerbating persistent pediatric workforce shortages that have existed for years.

Staff retention is a critical issue for children's hospitals and being chronically understaffed poses major challenges to the care they can provide to their pediatric patients. It is particularly challenging to recruit and retain pediatric specialty providers because of the very nature of pediatric specialty care. The provision of pediatric specialty care requires time, monitoring, specialized medications and equipment, and specially trained health care providers to provide that care who are compassionate, understand kids of all ages and from all backgrounds and consideration of the whole family when caring for the child. These special skills require additional education and training time often leading to substantial debt on the part of the provider.

Shortages of pediatric subspecialists

Overall, we are seeing a decline in the number of medical students pursuing a career in pediatrics as compared to the number of students applying for adult residencies. In 2010, 9.7% of graduating medical students entered residency training in pediatrics, but with the graduating class of 2018, the percentage decreased to 8.2%. Over the same period, the number of medical school graduates who entered adult-focused residencies grew with a 19% increase in adult emergency medicine residents, a 10% increase in family medicine residents and a 47% increase in adult psychiatry residents.[1] That trend has continued in the last several years, with some pediatric specialty residencies having 20 to 40% fewer applicants. The residency choices of recent medical school graduates indicate a worsening shortage in pediatric specialty residents. In 2020, there was an overall residency match rate of 84%, but in pediatrics, subspecialists only filled about 70% of available positions in child abuse, developmental and behavioral pediatrics, endocrinology, infectious disease, nephrology, pulmonology, and rheumatology. [2]

The decline in medical students entering pediatric subspecialties impacts children's timely access to care. A sample of CHA member hospitals in 2017 reported that they frequently experienced vacancies of longer than 12 months for pediatric specialists in emergency medicine, physical medicine & rehabilitation, endocrinology, rheumatology, hospitalists, pain management/palliative care, and adolescent medicine. The children's hospitals reported long wait times for children to get appointments to see a pediatric specialist. For example, hospitals reported children waiting 21 weeks for a medical genetics appointment, 19 weeks for a developmental pediatric visit, 12 weeks for palliative care, 10 weeks for child and adolescent psychiatry, and eight weeks for dermatology and allergy appointments.

Pediatric nursing shortage

The shortages we are experiencing amongst pediatric subspecialists are exacerbated by a severe pediatric nursing shortage, particularly nurses with the needed specialized training to work in a children's hospital, which can include months of on-the-job training before a nurse can be bedside and taking care of pediatric patients. While nursing shortages occurred before the pandemic, they were made worse by the COVID-19 pandemic, the more recent pediatric respiratory illness surges, and the mental health crisis facing our children and youth. Children's hospitals reported an increase of more than 76% in the quarterly turnover rate among registered nurses from the first quarter of 2019 to the third quarter of 2021.[3]

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[1] IHS Markit Ltd. The Complexities of Physician Supply and Demand: Projections From 2019 to 2034. Washington, DC: AAMC; 2021.
[2] *Pediatrics* (2021) 147 (6): e2020013292. https://doi.org/10.1542/peds.2020-013292
[3] Source: PROSPECT, the Children's Hospital Association and the nation's only financial and operational comparative data set for pediatrics.

In particular, children's hospitals are seeing nurses and other bedside staff reducing their work hours, with many others leaving health care completely. Because pediatric acute and intensive care requires a higher level of training and expertise, the pool of nurses available to fill children's hospital staffing gaps is limited. Most children's hospitals have been forced to rely on temporary staffing agencies to fill their workforce gaps at considerably higher costs than pre-pandemic levels, further straining financial resources. At the same time, some children's hospitals have had to reduce their care capacity, with some forced to temporarily close entire pediatric intensive care units and other critical services.

We are also facing a severe shortage of pediatric home care nurses who have the very specialized skill set to care for children with medical complexity. Too often, children cannot be discharged home safely from the hospital because home care nursing support is not available, meaning they must remain in the hospital for weeks or even months until home support can be provided. Like the shortages affecting other types of pediatric nurses, these challenges are not new but have gotten worse in recent years.

Pediatric mental health provider shortages

Shortages of pediatric mental health providers are particularly troubling as our nation's children and youth continue to confront significant mental health challenges but are often unable to get the tailored care they need when they need it. There are too few pediatric mental health providers to ensure kids have access to the full continuum of care, from inpatient services to outpatient community-based services and supports. As a result, more and more children and families in crisis are suffering, waiting for beds in hospital emergency departments, while awaiting alternative placement options.

Pediatric mental health workforce shortages are persistent and projected to increase over time. Nationally, there are approximately 8,300 practicing child and adolescent psychiatrists and only 5.4 clinical child and adolescent psychologists per 100,000 children 18 years of age and younger, far fewer than needed to meet the existing and increasing demand. Shortages also exist for other vital pediatric mental health specialties critical to improving early identification and intervention for children with mental health needs. Additionally, there is a dire shortage of minority mental health providers, which represents an added burden on racial and ethnic minority communities who already face inequitable access to care.

Drivers of pediatric provider shortages

The pediatric subspecialty physician and nursing shortages are not a result of a decrease in positions or opportunities. They are the result of factors that are similar to those driving the overall health care workforce shortages as well as a number of factors that are unique to pediatrics. First, pediatric provider shortages – like the shortages affecting adult providers – stem from a variety of factors, including but not limited to an increase in retirements, overall burnout as a result of the additional workload and emotional stress tied to the COVID-19 pandemic, a rise in workplace violence, a shortage of nursing faculty to train the next generation of nurses, and the increase in travel nursing opportunities that is depleting hospital staff as nurses.

On top of those drivers are factors that particularly affect the pediatric specialty workforce, which requires a unique set of skills and expertise to treat children. Those factors include:

- **Pediatric subspecialty physicians and nurses require more training.** Pediatric subspecialists require more training than their adult counterparts and at least three more years of training than general pediatricians to develop the expertise needed to treat children with serious, complex or chronic

conditions. Similarly, the training requirements that are needed to practice as a pediatric specialty nurse must be met through additional time in nursing school and onsite clinical training at a children's hospitals.

Pediatric providers need training both in basic clinical care, i.e., the physiological aspects of care, and training in the developmental and psychological aspects of care. They need to learn how to use special-sized equipment, such as tiny tubing for preemies, child-appropriate medications and related dosing, for all stages of a child's development. They must also learn how to appropriately manage family members – parents, other caregivers and siblings – who may be under a great deal of stress.

- **There is limited financial support for pediatric specialty training**. Scholarship and loan forgiveness programs tend to be primary care- and adult-focused. The lack of targeted financial assistance programs not only limits the pediatric specialty provider pipeline but also leads to recruitment and retention challenges for children's hospitals.

- **Pediatric nurse orientation at a children's hospital is time- and cost-intensive.** The complex nature of pediatric nursing means that a significant amount of orientation – at a high financial cost for the institution – is needed to onboard nurses who are new to the field, as well as more experienced nurses who are entering pediatrics for the first time. The intensive clinical training required to onboard one pediatric nurse can cost tens of thousands of dollars, with costs of $45,000 and even higher. Those costs are borne by the hospital and are not reimbursed by third-party payers or covered by other federal programs.

  Orientation and training of a new pediatric acute care nurse can take up to three months and orientation and training for a neonatal intensive care nurse can take up to six months. That intensive level of training deters some from entering the pediatric nursing field, impacts the ability of the children's hospital to quickly fill existing vacancies with travel nurses or other nursing candidates, and has a financial impact on the hospital.

- **Reimbursement rates for pediatric providers are low.** Payments to pediatric subspecialists are lower than payments to their adult counterparts and to general pediatricians[4]. In large part, the lower compensation is linked to historically low Medicaid reimbursement rates. Medicaid is the single largest health insurer for children in the United States and more than half of all children are enrolled in Medicaid or the Children's Health Insurance Program. Children with medical complexity or specialized health care needs are more likely to receive care from pediatric specialists located in a children's hospital and to be enrolled in Medicaid. Those lower payment rates are a key factor in pediatric workforce shortages and related access challenges for children.

- **Pediatric specialty providers are more likely to experience burnout.** Pediatric specialty providers, particularly nurses, are at greater risk of burnout. In addition to burnout/exhaustion that affects more experience providers, newer pediatric specialty clinicians are susceptible to burnout as they are not always mentally and emotionally prepared for the unique challenges that come with working in a pediatric environment. Pediatric nursing is very labor-intensive and takes more time and emotional stamina as the nurse faces multiple demands caring for especially complex patients while trying to balance the needs of

[4] *Pediatrics* (2021) 148 (2): e2021051194. https://doi.org/10.1542/peds.2021-051194.

their child patients and family members.[5] Furthermore, we are not maximizing opportunities to build out the pipeline of non-licensed pediatric professionals, such as community health workers, who could perform some of the functions that licensed pediatric providers are currently doing.

Congressional Solutions

We urge the committee to give special consideration to ways to bolster the pediatric physical and mental health care workforce so children can get the care they need in a timely fashion. Several key opportunities for congressional action are highlighted below.

Reauthorize and boost funding for CHGME.
Congress must reauthorize CHGME, which will expire on September 30. This bipartisan program was established in 1999 because Congress recognized that a dedicated source of support for training in children's hospitals was necessary to strengthen the pediatric workforce. CHGME was created specifically to address the disparity between the funding that adult hospitals get through Medicare GME and the funding children's hospitals receive to train the pediatric physician workforce. Because children's hospitals care for extremely few children covered by Medicare, they receive very little Medicare GME.

Since its inception, CHGME has enabled children's hospitals to dramatically increase pediatric training overall, and in particular, grow the supply of pediatric specialists. The 59 independent children's teaching hospitals that now receive CHGME support train more than 60% of all pediatric specialists – including 65% of all pediatric surgeons and most physicians in fields like pediatric rehabilitation – and 50% of all pediatricians. In 2021, CHGME hospitals trained about 14,000 pediatric residents and fellows.

Beyond sustaining a critical supply of pediatricians, CHGME has enabled children's hospitals and their residents to provide significant value to the patients and communities they serve by advancing the quality of pediatric medical education, providing care for vulnerable and underserved children, and pioneering community-based pediatric training. The residents and fellows whose training is supported by CHGME learn from experienced practitioners. They provide critical access to care for children in rural and urban underserved communities, provide medical homes, and address heath care disparities. Close to two-thirds of CHGME-funded physicians who completed their training programs choose to remain and practice in the state where they completed their residency. CHGME is critical to the national goal of ensuring comprehensive and timely access to care for America's children, including children in military families and those in underserved rural and urban communities.

We also urge Congress to support robust funding for CHGME in the FY 2024 appropriations bill. An appropriation of $738 million for FY 2024 is the critical step needed to help children's hospitals sustain their teaching missions and create a strong pediatric workforce pipeline for our children. CHGME funding support represents about one-half of the support provided to adult hospitals through adult-focused training programs. Congressional investment to address that disparity will help sustain and grow pediatric training programs, strengthen the pediatric workforce and expand timely access to care for children.

[5] *Journal of Nursing Administration* (December 2022) Vol. 52, No. 12.

Expand existing and develop new programs to target pediatric clinicians.
We encourage the committee to consider targeted initiatives that strengthen the pediatric health care workforce early career pipeline and clinical training opportunities, and support children's hospitals' recruitment and retention efforts. The committee should identify opportunities under the jurisdiction of the Health Resources Services Administration and the Substance Abuse and Mental Health Services Administration, as well as in the Departments of Labor and Education. Pediatric-focused opportunities include:

- **Strengthening the Pediatric Subspecialty Loan Repayment program**, which provides loan forgiveness for pediatric subspecialists, including mental health providers, practicing in underserved areas.

- **Modifying the National Health Service Corps (NHSC) and the Health Professions Shortage Area (HPSA) requirements to expand their pediatric workforce footprint** in underserved rural and urban settings. For example, Congress could consider ways to add children's hospitals to the list of entities eligible to participate in the NHSC and specify that pediatric specialty nurses practicing in a tertiary setting are eligible.

  We also encourage the committee to examine the limitations of the current HPSA designation for eligible entities, which does not reflect an entity's service/catchment area. On average, more than one-half of the children cared for at a children's hospital is covered by Medicaid and most of those children travel to the hospital from a low-income community. The current HPSA designation does not adequately reflect the reach of children's hospitals and their staff into these underserved neighborhoods, limiting their eligibility for certain workforce program. We urge the committee to explore how to expand HPSA designation to specifically include pediatric tertiary hospitals in both rural and urban settings.

- **Developing targeted pediatric nursing and allied scholarship and loan forgiveness programs**. Existing scholarship and loan forgiveness programs can sometimes be difficult for pediatric providers to access because they are primary care or adult-focused. In addition to providing financial assistance to help cover education costs, financial assistance should be made available to cover the costs of pediatric nursing certification, such as the Certified Pediatric Nurse and the Certified Pediatric Emergency Nurse certifications. Pediatric nursing specialty certification programs are professionally recognized programs that offer additional training and continuing education to equip pediatric nurses to work in demanding settings like children's hospitals. However, the high costs of the training and examinations can act as a deterrent to program participation. While some children's hospitals try to cover the costs of these programs, federal grant support would help ensure more widespread access.

- **Directing support to children's hospitals that engage in community partnerships with K-12 schools and local colleges to promote pediatric health care careers**. These include classroom outreach experiences to strengthen the pediatric workforce pipeline and career academies that provide experiential learning to high schoolers and college students.

- **Providing targeted support to children's hospitals that offer hands-on clinical nurse and allied health/medical technician professional training** to expedite the move of pediatric clinicians from the classroom to the bedside. Some children's hospitals currently invest their own resources into home-grown recruitment programs to address nursing and allied health workforce shortages. Often these programs recruit, train and onboard individuals from diverse and underserved backgrounds, connecting to mentors and academic support. Some hospitals also devote staff and financial resources to partner with technical

community colleges and vocational schools to provide pediatric clinical training for nursing assistant and medical assistant students. Federal support for these types of initiatives would enable their widespread adoption and long-term sustainability.

- **Expanding existing or creating new pediatric nurse educator programs** to include a focus on recruiting and retaining faculty. Targeted programs can help ensure there are faculty with the expertise needed to train the future pediatric nurse workforce.

Address the pediatric mental health workforce shortages.
We appreciate the initial steps Congress took last year to increase support for addressing the mental health crisis. However, we need Congress to take additional steps to address the urgent need to relieve pressure on the existing pediatric mental health workforce, as well as invest in its long-term expansion across disciplines to meet the ongoing and growing mental health needs of our children. More dedicated support for a larger and more diverse pediatric workforce is critical to addressing children's mental health needs now and into the future. We urge Congress to:

- **Establish a HRSA workforce grant program focused specifically on bolstering the pediatric mental and behavioral health workforce.** Last Congress, a few bipartisan bills (Helping Kids Cope Act, Strengthen Kids Mental Health Now Act and Health Care Capacity for Pediatric Mental Health Act) included additional support through HRSA to boost the pediatric behavioral health workforce. Similar to the policy in these bills, we would like to see a grant program that would provide expanded training for the current pediatric mental health workforce and also invest in the recruitment, retention and diversity of the next generation of pediatric mental health professionals.

- **Provide additional targeted funding to support pediatric mental health training and development to meet licensure requirements.** For example, in some states, masters'-prepared therapists (e.g., licensed social workers and professional counselors) who have completed their educational requirements require supervised training hours to meet licensure requirements. There is no federal funding support to pay these trainees during this time or to financially support the children's hospital's supervision of the trainee for those hours, which can be as many as 3200.

  Targeted training and development programs including, but not limited to, scholarships to cover the cost of supervised hours can help mitigate the need for those interested in pursuing a career in the mental health field to take on a substantial amount of debt or front the cost of their education and training. It can also help avoid circumstances in which individuals refrain from completing their licensure requirements altogether because they cannot afford to engage in the unpaid supervised hours.

- **Explore how to sustainably expand the reach of programs, such as the Minority Fellowship Program and similar efforts, to enhance support for the participation of fellows from diverse backgrounds who plan to serve pediatric populations.** The value of a diverse pediatric health and mental health workforce prepared to deliver culturally and developmentally appropriate care cannot be overstated. While all mental health professionals receive training that prepares them to provide care with cultural sensitivity and awareness, the ability of a child, adolescent and their family to connect and identify with a mental health professional can be critical. Shared cultural beliefs and experiences can further strengthen therapeutic relationships and lead to better outcomes for kids and families.

Support provider well-being/address burnout.
Congress took an important step last Congress to protect the well-being of health care workers by passing the Dr. Lorna Breen Health Care Provider Protection Act. We encourage the committee to strengthen current federal efforts to support pediatric health care provider well-being and resilience and consider additional innovative approaches to help prevent burnout and turnover. Examples include:

- **Expand training, recruitment and pipeline programs for non-licensed providers so trained clinicians can operate at the top of their license**. For example, pipeline programs in high schools, and partnerships with community colleges, can be developed or expanded to train community health workers to take on non-clinical functions that nurses and social workers are increasingly doing. The availability of trained community health workers to assist children and families with navigation of non-medical resources to address their needs can reduce licensed providers' workload and enable them to perform at the top of their license, helping prevent clinical staff burnout and improving retention.

- **Ensure that grants provided through the Dr. Lorna Breen Health Care Provider Protection Act (P.L. 117-105) are reaching pediatric providers.** In addition, the law's required studies by HHS and the Government Accountability Office should include a breakdown of specific challenges facing pediatric physical and mental health providers.

- **Provide protections to pediatric health care workers against violence in the health care setting**. The incidence of workplace violence continues to grow throughout the health care sector, including in children's hospitals. Last Congress, CHA along with a number of other groups, supported the Safety from Violence for Healthcare Employees (SAVE) Act, which would provide federal protections for health care workers who experience violence and intimidation in their workplace. We encourage Congress to enact legislation, like the SAVE Act, to ensure health care workers feel safe at work and are able to take care of patients.

Strengthen the pediatric research workforce.
We encourage the committee to address the medical research workforce as part of its focus on solutions to the health care workforce shortage. In particular, investments should be made in early-stage researchers focusing in pediatrics, including those from under-represented populations. A robust pediatric physician research workforce—including physician-scientists—is essential to treating and finding cures for the millions of children nationwide who are fighting a disease.

Attracting and retaining qualified individuals – including those from diverse backgrounds that have traditionally been under-represented – to careers in pediatric medical research is increasingly challenging. According to the Physician Scientist Support Foundation, only about 1.5 percent of physicians are engaged in medical research[6] overall, and the number of slots available through NIH pediatrician-focused research training programs has declined in recent years. Furthermore, the COVID-19 pandemic had a significant negative impact on medical researchers due to closures of laboratory facilities. These closures affected researchers of all ages and statures but were particularly acute for early-career researchers with limited funding and in need of completing projects and publishing results to advance in their careers.[7] Without an adequate focus on this segment of the workforce, and particularly pediatric

[6] See https://www.nytimes.com/2019/09/23/opinion/doctor-scientist-medical-research.html?action=click&module=Well&pgtype=Homepage&section=Contributors.
[7] See https://www.statnews.com/2020/05/04/coronavirus-lab-shutdowns-impact-on-scientists-research-delays/.

professionals, our ability to achieve future research breakthroughs and to develop care innovations will be severely limited.

Oversight of workforce programs.
We urge Congress to exercise its oversight responsibilities to monitor and assess workforce funding and initiatives for their impact on pediatrics and to investigate private sector actions that are impacting children's hospitals' nurse retention and recruitment, such as those of nurse staffing agencies. While travel nurses can help fill workforce gaps temporarily, financial incentives agencies are offering nurses are depleting our trained institutional staff, exacerbating the nursing shortage and ultimately compromising quality of care.

Disseminate promising practices.
Congress should ensure that all federal agencies involved in health care workforce development are sharing emerging and promising practices, by the federal government, states, health care providers, etc., across the government. In addition, Congress should require agencies to collect and spread promising state-level initiatives that are focused on strengthening the pediatric workforce pipeline, recruitment and retention. The solutions to the pediatric workforce shortage require a multi-faceted approach based on a partnership between the federal government, states and the private sector. Congress can play a vital role in ensuring that the lessons learned across the federal government as well as in the states are shared and promoted.

Thank you again for your commitment to improving the current health care workforce shortage. Children's hospitals and their affiliated providers stand ready to partner with you to advance workforce policies that will make measurable improvements in the lives of our nation's children. If you have any questions or need more information, please contact Elizabeth Brown or Jan Kaplan.

Sincerely,

Leah Evangelista
Chief Public Affairs Officer
Children's Hospital Association