NCIOM/IMPH Carolinas Pandemic Preparedness Task Force - North Carolina

Meeting 4 Summary

October 18, 2021

12:00 pm – 3:00 pm

Virtual Meeting

Meeting Attendees

Co-Chair: Machelle Baker Sanders

Steering Committee Members: Cardra Burns, Kelly Fuller, Tatyana Kelly, Emily Roach

Task Force Members/Interested Parties: Sam Cohen, Lenora Campbell, Jennifer Copeland, Laurel Edwards, Natalie English, Jill Forcina, Lynn Harvey, Kathryn Lanier, Robin Tutor Marcom, Norma Martí, Sel Mpang, Tracie Neilson, Shannon Pointer, Omari Richins, Tim Rosebrock, Valerie Stephens, Janice Somers, A. Vernon Stringer, Hugh Tilson, Louise Vincent, Amy Widderich, Ciara Zachary, Cornell Wright

NCIOM Staff: James Coleman, Kathy Colville, Brieanne Lyda-McDonald, Emily Hooks, Alison Miller, Michelle Pendergrass, Kaitlin Phillips, Michelle Ries

IMPH Staff: Brie Hunt, Brittney Sanderson

I. Fostering Connections: 12:00 – 12:10 PM

Alison Miller, MA, MPH
Project Director
North Carolina Institute of Medicine

Ms. Alison Miller started the meeting off by welcoming attendees. She then informed attendees that they would be put into small breakout rooms with 3 – 4 other task force members to provide an opportunity to meet and connect. Meeting attendees were then moved into breakout rooms to meet, connect, and respond to several discussion questions. In the breakout rooms, meeting attendees introduced themselves and discussed what resonated with them during the panel discussion on historically marginalized and vulnerable populations during the last meeting.

II. Welcome and Framing the Discussion: 12:10 PM – 12:30 PM

Kathy Colville, MSW, MSPH
President and CEO
North Carolina Institute of Medicine

Machelle Baker Sanders, MHA
Secretary
North Carolina Department of Commerce

Once attendees returned from their small groups, Ms. Kathy Colville framed the conversation for the day. She reminded the task force that the discussion would focus on the health care workforce and reiterated to the task force the vulnerabilities associated with vaccination status by emphasizing the impact of low vaccine uptake on older and historically marginalized populations, as well as those with chronic conditions. Ms. Colville also reviewed the goals and outcomes of the task force, ending with a discussion of how task force recommendations can be used to influence policy across the state.

Ms. Colville then offered Secretary Machelle Baker Sanders an opportunity to provide opening remarks. Secretary Sanders memorialized former U.S. Secretary of State Colin Powell, and connected his legacy to the importance of the task force's work and cross-state collaboration. She also expressed gratitude for the work of the task force members and the recent decline in cases related to the Delta variant. Secretary Sanders briefly reviewed the content and key takeaways from the September meeting, which focused on the impact of the pandemic on historically marginalized and vulnerable populations, and concluded by stating that we will look forward to reconvening with the South Carolina task force in November.

At the conclusion of her remarks, Ms. Alison Miller reviewed the agenda for the day and introduced the moderator and panelists for a discussion on the health care workforce in North Carolina.

III. <u>COVID-19 and the Health Care Workforce – Key Perspectives</u>: 12:30 – 1:15 PM

Discussion Moderator:

Tatyana Kelly
Vice President for Planning, Strategy, and Member Services
North Carolina Healthcare Association

Key Perspectives:

Tracie Neilson, RN
Critical Care Nurse
Cone Health

Janice Somers, RN, LNHA
Administrator
Westwood Hills Nursing and Rehabilitation

Valerie Stephens
Respiratory Therapist
CarolinaEast Health System

Discussion Questions:

1. When you reflect on the peak in COVID-19 cases in January/February 2021, what were some of the most difficult challenges for you and others in your professional role that were caused or exacerbated by the pandemic?

2. How have those challenges been addressed, and what were some of the outcomes associated with the changes that were implemented?

3. How have those lessons learned influenced or changed the response to the current surge in cases?

4. What are some ongoing challenges or barriers facing the health care workforce in North Carolina that still need to be addressed in anticipation of future surges?

Ms. Tatyana Kelly welcomed the panel, and thanked them for their time and sharing their experiences and perspectives today. She began the discussion by asking Ms. Tracie Neilson, a critical care nurse in Greensboro, North Carolina, to reflect on her experiences during the January/February 2021 peak in cases. Ms. Neilson shared that back then, a lot of challenges related to understaffing. She shared that they were fortunate to manage the caseload by having patients treated at a separate hospital facility, but they also worked to supply other hospitals with staff support at the same time. She recalled feeling hopeful that the vaccine would be widely distributed soon as cases peaked in the winter, but helpless at the same time as they tried approaches to navigate the surge that sometimes weren't effective. She shared that it felt like the health care workforce was in the midst of managing a mass casualty and mass disabling event.

Ms. Somers, an administrator at a long-term care facility in Wilkesboro, North Carolina, shared that by the time January 2021 arrived, they had already lived through the devastation of the July and August cases and 80% of their residents had been vaccinated, but only 20% of their staff had received the vaccine. As a result, staff were left feeling behind, and communications from the CDC, NCDHHS, etc. seemed to change every day so it was often challenging to keep up. She also shared that their home office was sending guidelines for them on a weekly basis, staff were feeling left out, and several employees resigned. She added by stating that staffing in health care is their top concern moving forward.

Ms. Stephens, a respiratory therapist in New Bern, North Carolina, shared that she was one of the first staff in her facility to receive the vaccine because she works at the bedside of COVID-19 patients. She shared that before the winter peak in cases, their staff had started to feel like the situation was the new normal and could be managed. She shared that supply shortages, reusing personal protective equipment, staff burnout, and mental exhaustion from losing so many patients were the key challenges at the time. By January 2021, the political landscape had changed to the point where health care workers were no longer heroes or trusted, so people didn't believe their message as the vaccine roll-out progressed. She expressed that it felt exhausting and disheartening trying to understand the dissolution of trust.

Ms. Kelly then asked Ms. Stephens to share how some of the challenges have since been addressed, what the outcomes have been, and whether there has been a notable shift in public trust since the January/February 2021 peak in cases.

Ms. Stephens shared that she hasn't seen a significant change in trust in recent months. She compared the COVID-19 pandemic to cancer and other chronic conditions by emphasizing that the disease doesn't discriminate by political affiliation, health status, race/ethnicity, and other factors, and that the disease is global. She shared that she lost her 35-year-old brother to COVID-19, and he left behind a widow and two children. She also expressed that she didn't view the vaccine as a cure, but it represents hope.

Ms. Somers shared that staffing is much worse now, with 75% of nursing facilities in the state relying on agency personnel while rates to pay for them are very high and funding for long-term care has not increased. She shared that they have given raises to people across departments and increased benefits to support retention of staff. For almost a year, people had to trust them to care for their loved ones as visitation was not allowed, but after that, people were more satisfied in knowing that they were able to take care of people. Ms. Somers also shared that a lot of people have left long-term care because of

COVID-19 fears, and a lot of people are leaving because of vaccine mandates. She stated that it would be a huge deal in her region of the state—Wilkes County is rural, 55% of her staff now have the vaccine and another 20% will probably get vaccinated. The remaining staff will likely leave unless weekly testing will suffice.

Ms. Neilson shared that staffing challenges from the winter peak in cases still continue. She expressed that loyalty to a company should be returned, and she is concerned that the health care workforce may never mentally recover. It will be quite some time before the toll is understood, and it has been disheartening to go from heroes to nearly zeroes. She shared that the industry is mostly women, particularly nurses and respiratory therapists, and eventually no one is going to have the stamina to continue after responding to the pandemic day in and day out for nearly two years. People are starting to prioritize their mental health and leaving the field as a result. Some have left because of vaccine mandates and political reasons too. She added that as much as companies are trying to address these challenges, it isn't getting through.

Ms. Kelly then asked the panelists whether what they have learned earlier this year has changed their response to the most recent surge in cases related to the Delta variant. Ms. Somers replied that they learned and have gotten used to it, and that the sense of family between employees makes all the difference. Staff don't have as many questions, and they touch base and ask what they can do to make it easier to come to work. Staff have said that they want to be recognized and told that they are doing a good job.

Ms. Neilson shared that it is more frustrating now, and the empathy meter seems lower. She added that one of the hardest parts is trying to find avenues to get patients to listen, and that pay rates are often too low to make the challenges of the work sustainable or manageable. It has been hard to navigate the challenges of hospital capacity.

Ms. Kelly asked the panelists how some of the barriers could be addressed to bring us out of this pandemic, and what they would change if they could. Ms. Stephens replied by emphasizing more staff, higher pay, and more continuity of care. She finds it harder to remain optimistic because it often feels like the other shoe is about to drop. She shared that if health care workforce retention is important, there needs to be a focus on who they are as people and individuals. She would love to see peer-to-peer support services available so health care workers have someone to talk to who understands their experiences. She added that we are going to lose a lot of good people, and not just at the bedside, but who they are in themselves.

Ms. Neilson shared that she is nursing because she wants to be in nursing, and she stays at the bedside because she feels that it is where she can truly help people, but it has been hard. She emphasized Ms. Stephens' comment about peer-to-peer support services because it is so important to have someone who understands.

Ms. Somers shared that she wishes she knew all of the solutions. She shared that taking time off is challenging for staff because people need them to hold their hands, feed them, and wash their faces.

IV. <u>Health Care Workforce Synthesis Groups</u>: 1:20 – 1:45 PM

The task force is split into synthesis groups to address the following questions:

1. What problems were raised during the key perspective discussion?

2. Which problems may have been preventable in hindsight?

3. What are some potential short and long-term consequences if the identified problems are not addressed?

4. What policy solutions have been put into place since the initial outbreak that you are finding helpful in addressing the current circumstances?

Key takeaways from the synthesis groups:

- We knew that staffing shortages and burnout among clinicians were problems even before the COVID-19 pandemic.

- If we are going to recruit new talent, we need to give them a reason to join and understand that the current challenges in the health care workforce are not going to be attractive to younger people. We need to shift the narrative around that to attract more people to the field, and health systems will need to be clear and intentional about addressing pay gaps, staffing models, and benefits to recruit and retain talent.

- There are severe consequences when elected officials, the media, national health representatives, etc. send mixed or confusing messages related to the pandemic in terms of vaccine uptake, and clinical care and staff morale.

- We should consider reporting requirements and other things that take up time. Why are we doing what we're doing, and are these processes taking time away from providing care?

V. <u>Break</u>: 1:45 – 1:50 PM

VI. <u>Achieving Health Care Workforce Stability and Resilience</u>: 1:50 – 2:40 PM

Hilary A. Campbell, PharmD, JD
Director, Sheps Health Workforce NC & Health Professions Data System
UNC Sheps Center for Health Services Research

Ciara Zachary, PhD, MPH
Assistant Professor
Department of Health Policy and Management
UNC Gillings School of Global Public Health

Jill Forcina, PhD, RN
Associate Director of CPD, IPE, and Nursing
North Carolina Area Health Education Centers

Hugh Tilson, JD, MPH
Director, North Carolina Area Health Education Centers
Associate Dean and Assistant Professor of Family Medicine, UNC School of Medicine

The task force heard two presentations from Hilary A. Campbell and Ciara Zachary, which focused on the current health care workforce landscape, what is needed to achieve workforce stability and resilience, and potential areas of action. Presentation slides are available on the NCIOM website. Jill Forcina and Hugh Tilson then moderated a brief discussion with the two presenters. Key takeaways are provided below.

Most pressing equity concerns illuminated or exacerbated by pandemic:

- Some of the most pressing equity concerns illuminated or exacerbated by the pandemic include wages and medical leave. Consider what supports and policies could be implemented to allow the healthcare workforce to be as healthy and safe as possible. People are often stuck between receiving a paycheck and staying safe.

- The health care workforce also includes members of communities. Home health aides, for example, include a lot of underrepresented minority populations that are doing health care work without resources or job benefits to keep themselves and their patients healthy. The more we talk about burnout, the more organizations need to be thinking about retention.

Would addressing inequities in the workforce address inequities in communities?

- To address workforce inequities in communities, we need to think about affordable housing, safe transportation, and other drivers. It can be hard to separate which policies or programs would work best. If we are going to see opportunities to address inequities, we can't parse out these issues separately.

As we think about the conversation earlier today with several health care workers, what are two priority areas that should be addressed to improve stability and resilience in workforce?

- Everything is interconnected and you can't address a piece of a problem separately. It looks like we need more nurses in NC now, over the next decade, and beyond, but it is not as easy as opening schools or enrolling them in schools we already have. There will be increased competition with other states that also need more health care workforce. One approach is to think about all the needs, possible priorities, and goals, and think about them in strategic ways.

- We need to make affordable health care more available and prioritize that in NC. One provision in Build Back Better relates to education, so thinking about workforce pipeline and how that could help certain groups who aren't well-represented in the workforce.

VII. Synthesis Groups: 2:40 – 2:55 pm

Attendees were then moved into small groups to answer targeted questions and brainstorm concrete next steps with the goal of moving toward recommendations using Jamboard.

1. What steps could be taken in the next year to improve workforce stability and resilience? What steps could be taken in the next five years?

2. What resources would be needed for the proposed changes to be effective?

3. Who would be responsible for implementing the proposed changes?

4. How would we measure progress over time? What would represent success?

The Jamboard results are linked here: Room 1, Room 2, and Room 3.

VIII. Next Steps and Closing: 2:55 – 3:00 PM

Alison Miller, MA, MPH
Project Director
North Carolina Institute of Medicine

Ms. Alison Miller brought the meeting to close by thanking the task force members for their participation and providing an update on next steps.

Adjourned 3:00 PM