2024 Advocacy Priorities

Leveraging the strength of Adventist Health – including its leaders, geographic footprint, and delivery system innovations – our advocacy program will effectively influence public policies to protect and build the safety-net and rural health system.

Priority	Healthcare Workforce Crisis	Safety-Net & Supplemental Funding	Access & Sustainability	Improve Community Health & Equity	Preserving Rural Health
	• Support Growth and Pipeline programs • Remove Barriers to practice • Address Violence • Invest in safety-net residency programs	• Fair and Adequate Medicaid and Medicare payments and coverage • Protect CA Hospital Fee • Preserve DSH • Protect the 340B	• Payment Innovation/ Delivery Reform • Commercial Payor Fairness • Remove Barriers to Integration & Clinical Networks of Care	• Equity Promoting Strategies • Social Determinants of Health • Improve access to mental health • Uninsured and Underinsured	• Preserve Critical Access Hospitals • Stability and expansion of RHC's • Promote new rural health models • Support physician residency programs in rural health • Bolster rural pipeline programs

Adventist Health

Priority: Address the Healthcare Workforce Crisis

Solution: Support Growth and Pipeline Programs

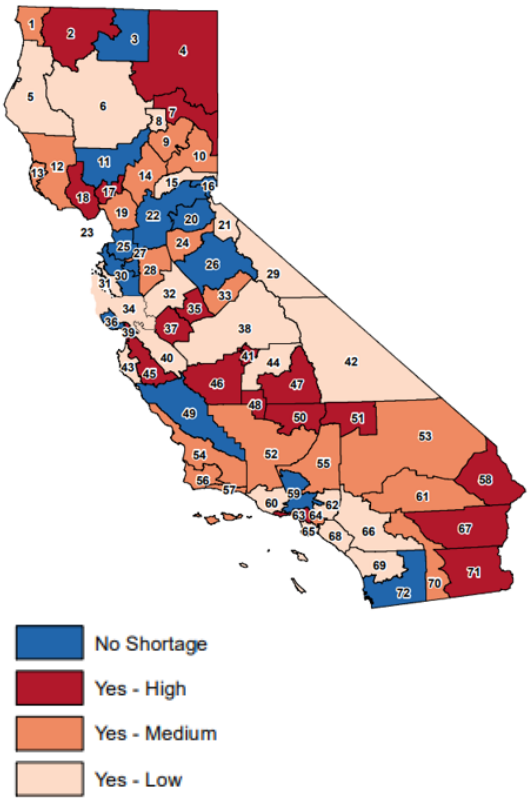
Adventist Health supports policies that address healthcare workforce shortages through growth and pipeline programs particularly in rural and underserved areas.

Before the pandemic, our communities were facing healthcare provider shortages caused by an uneven distribution of workers. Rural and underserved communities tend to have fewer physicians, nurses, specialists and other healthcare workers, while also facing higher rates of chronic disease, mental illness and obesity than their urban counterparts. Of the 35 counties in which we operate, 17 are in Medically Underserved Areas (MUA) or a Health Professional Shortage Area (HPSA). According to the "Supply and Demand Projections of the Nursing Workforce: 2014-2030, a report produced by the U.S. Department of Health and Human Services' Health Resources and Services Administration, California is facing a deficit of 40,567 RNs, which is nearly three times the deficit in several states suffering from a shortage like Texas, New Jersey and South Carolina.

What We Are Doing:

Adventist Health has created a comprehensive 10-year workforce strategy including pipeline, development and training programs to counteract and aid the workforce shortage. The goal of these programs is to reduce turnover and turnover costs, increase workforce to accommodate growth, improve workforce diversity to reflect local communities and form partnerships with community-based organizations and state and local agencies to support value-based care.

According to a 2018 Nursing Workforce Study by the U.S. Department of Health and Human Services' Health Resources and Services Administration, by 2030 **California will be facing an estimated deficit of 44,500 RNs.**



Policy Recommendations:

- Assist nursing workforce development programs to support recruitment, retention and advanced education for nurses and other allied health professionals.
- Direct funding to colleges to increase faculty in nursing and other clinical programs. Early identification and mentoring of highly prospective candidates to serve in rural and HPSAs.
- Reserve enrollment seats in nursing programs and allied health programs for local students in HPSAs.

Adventist Health

Adventist Health continues to advocate expansion of scope of practice for health care professionals and reduce the barriers of licensure in multiple states.

Many healthcare professionals are unable to practice at their highest level of training due to strict scope-of-practice laws (SOP). SOP laws are created by state legislatures, and then enforced by state governing boards. SOP laws determine what tasks a nurse, nurse practitioner, physician's assistant, pharmacist, or other healthcare provider is able provide to patients. Limiting tasks that these healthcare professionals are capable and trained for creates more stress on the healthcare system. Redefining the SOP laws can greatly decrease wait times, lower prices and improve access to healthcare.

The other large barrier to practice is medical licensure reciprocity which allows a licensed individual to practice in multiple states. The Interstate Medical Licensure Compact (IMLC) became operational in 2017 and thirty-five states are participating in the compact. However, the states in which Adventist Health provides services are not a part of the compact.

Participating in IMLC does not provide a compact license, but it does streamline the licensing process for applying to multiple states. States that are not a part of the compact have varying regulations and processing of the licensing application, leading to long wait times for license approval. Because the states in which Adventist Health operates are not members of the compact, the process to become licensed in more than one state can be timely and deter qualified physicians.

Within IMLC participating states:

51% of reciprocity licenses are available within a week.

80% of applicants use the compact to obtain one or two licenses.

Use of the compact has grown **47%** during the pandemic.

Policy Recommendations:

- Advocate for change of SOP laws to create more opportunities for qualified healthcare providers, which releases some of the burden from healthcare providers who are over tasked.
- Advocate for medical licensure reciprocity between all states Adventist Health provides services in.
- Continue licensure and scope of practice flexibility beyond the public health emergency to allow time to rebuild the pipeline and allow flexibility for hospitals to maintain access to care.

Adventist Health

Priority: Address the Healthcare Workforce Crisis

Solution: Address Violence

Adventist Health strives to create a safe workplace for all staff, patients and visitors through continuous advocacy regarding a need to decrease healthcare workplace violence.

While workplace violence can be found anywhere, healthcare professionals are more likely and have been experiencing an increase in minor and major verbal and physical abuse and violence when performing their daily duties. There has been an increase in violence during the pandemic compared to the three months prior to the onset of the pandemic. Violence inflicted on hospital personnel increases the stress on the already overburdened and understaffed workforce. If violence is left unaddressed, there will be a large resignation of individuals who do not feel safe in their work environment, leading to more complications in the healthcare system due to being understaffed. To ensure retention of the healthcare workforce, thehosptial must have precautions and training set up for employees' safety.

What We Are Doing:

Adventist Health Workplace Violence Prevention Task Force is responsible for researching, identifying, developing and deploying best practices. Through innovative systems and tactics, equipment and policies and procedures, the task force is an important part of improving patient and associate safety through the reduction or prevention of incidents of workplace violence throughout the entire Adventist Health system.

There has been an increase in violence during the pandemic compared to the 3 months prior to the onset of the pandemic. In 2023, there was a total of **2,402 incidents** at AH locations.

Violent assaults on associates rose **19.98%** from 2022 to 2023.

More than **8 in 10** healthcare workers reported experiencing at least one type of violence in the workplace, most likely due to the increase of restrictions, or longer wait times and other issues caused by lack of staffing.[ii]

Policy Recommendations:

Pursue legislation that protects healthcare workers through various forms including:

- Protect all hospital departments and healthcare workers. Apply penalties to individuals involved in violence.
- Make assaulting a healthcare worker the same penalty as assaulting flight crew and airport workers under federal law.

Support of Staff and Staff Protection:

- Encourage reporting and pressing charges on persons who assault healthcare workers.
- Provide resources and support programs to help employees cope with violent incidents.
- Allow healthcare workers to use only first names on identification badges.

i. (US DEPT OF LABOR – OSHA HEALTHCARE)

ii. (NATIONAL NURSES UNITED, 2021)

Adventist Health

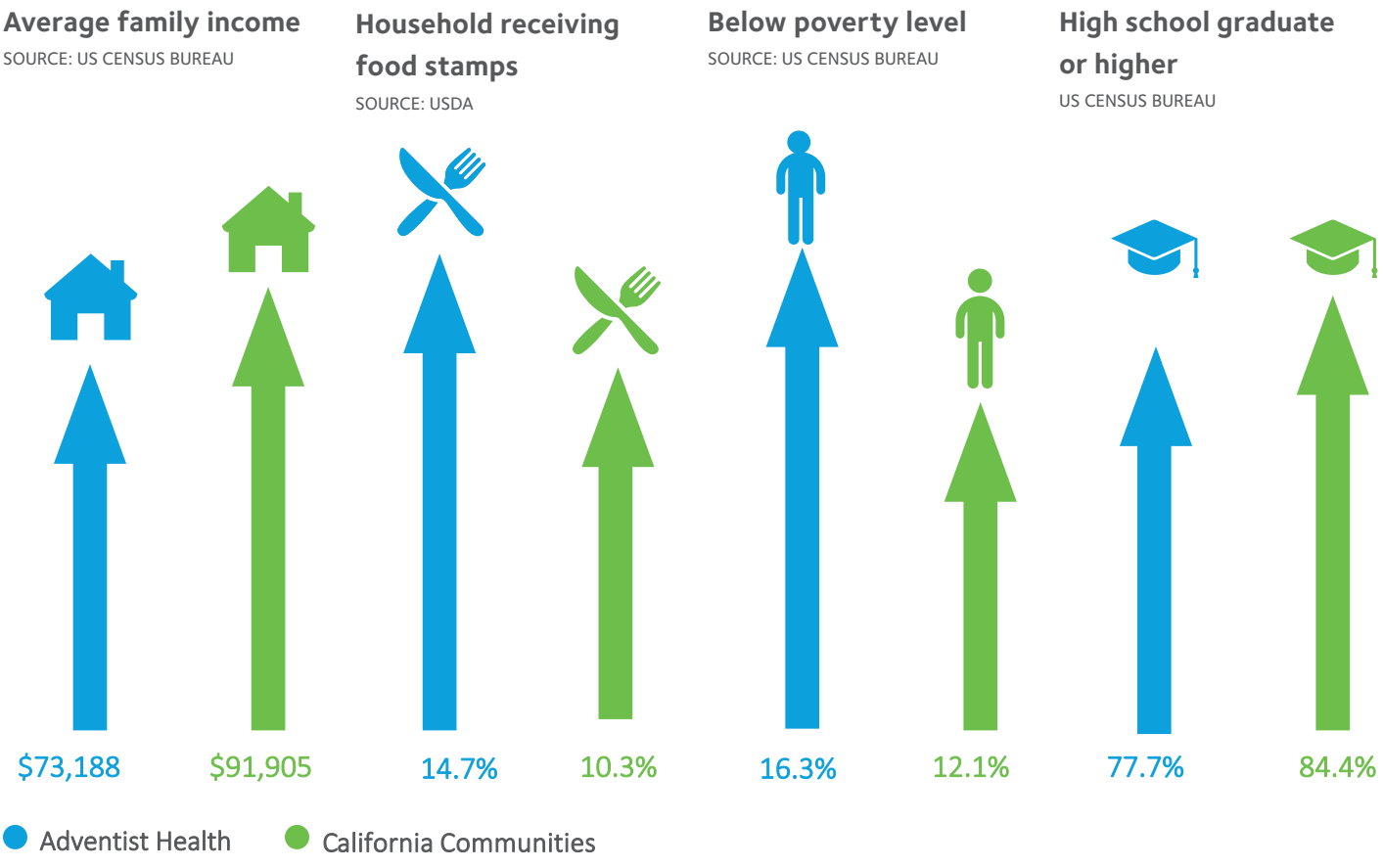
Priority: Sustain and Enhance the Safety-Net

Solution: Fair Medicaid and Medicare Payments and Coverage

Adventist Health continues to advocate for fair and adequate Medicaid and Medicare payments and coverage to protect and provide care for our most vulnerable populations.

Medicare and Medicaid are lifelines for the communities we serve. These programs ensure that elderly, medically frail, low-income, minority and other vulnerable populations can access the health services they need. Medicare and Medicaid account for about 75 percent of all care provided by Adventist Health hospitals. A strong Medicare and Medicaid program is key to much of the work we do for our patients and communities.

Adventist Health & California Communities Stats 2023



Policy Recommendations:

- Stop Site-neural cuts to safety-net hospitals.
- New safety-net definition take into account Medicaid care provided by hospitals.
- Increase Medi-Cal rate in California to align with inflation.

Adventist Health

Priority: Sustain and Enhance the Safety-Net

Solution: Preserve DSH

Adventist Health continues to advocate to preserve supplemental funding like DSH to continue providing necessary care to vulnerable populations.

Disproportionate Share Hospitals (DSH) are hospitals that receive federal and state funds to subsidize the costs associated with providing care to indigent and very low-income people. Adventist Health has 21 DSH hospitals in its system. Even with this critical supplemental funding, hospital costs for providing care to vulnerable populations are not fully met. On average, Medicaid, covers only 88 cents of every dollar spent treating Medicaid patients. And in 2019, hospitals provided $41.6 billion of uncompensated care.

Adventist Health has **9** designated Medicaid DSH hospitals and **12** designated Medicare DSH.

The Medicaid DSH cut for FY 2024-2027 is $8 billion each year, totaling to **$32 billion**

Policy Recommendations:

- Support a two year delay of DSH cuts. Any change to DSH distribution needs to take into account Medicaid provided by hospitals.

Adventist Health

Priority: Sustain and Enhance the Safety-Net

Solution: Protect 340B

Adventist Health understands that protecting 340B is necessary to provide care for uninsured patients and to support community health programs.

340B is a drug pricing program that came out of the Medicaid drug rebate program and requires pharmaceutical manufacturers participating in Medicaid to sell outpatient drugs at discounted prices to health care organizations that care for many uninsured and low-income patients. As a safety-net provider, Adventist Health will work to ensure the 340B program is protected so the most disadvantaged populations, which include low-income and severely isolated individuals, can still receive the care they need.

340B Adventist Health Hospital Stats 2023

19 Adventist Health hospitals enrolled in 340B

340B revenue
$18,4389,065.75

Cost Avoidance
$70,971,311,.37

Total Benefit
$89,360,377.12

Policy Recommendations:

- Begin assessing civil monetary penalties on manufacturers that deny 340B pricing to covered entities in violation of their obligations under the 340B statute.
- Ask that the 340B program remain whole and that no further cuts are passed onto hospitals.

Adventist Health

Priority: Access and Sustainability

Solution: Payment Innovation/ Delivery Reform

Adventist Health promotes integrated, comprehensive strategies to reform care delivery and payment to bring down the cost to health systems and improve the wellbeing of our communities.

Our current national health investment focuses heavily on medical interventions rather than on strategies that address disease prevention or social and environmental conditions that affect the health of a population. The traditional "fee-for-service" reimbursement system pays physicians and hospitals for each procedure performed on a patient, financially rewarding quantity over quality of the care provided. Since 2018, industry experts and researchers found that underutilization of preventative services is not the result of an information gap but rather that of an implementation gap. That is, most providers in the healthcare system understand the benefits of preventing chronic diseases, but do not prioritize them because financial incentives do not align with a focus on preventative care. According to the researchers, "currently, most providers, including hospitals and physicians, are paid to treat rather than to prevent disease." As risk-bearing entities that provide payment models and incentives, healthcare payers (commercial health plans, Medicaid and particularly Medicare) have influence that can affect the uptake of chronic disease preventative services.

It is essential that we change provider reimbursement from one focused on volume toward one focused on accountability for overall cost and quality. Many valuable services - such as patient education, effective preventative care and coordinated post-hospital care - are generally underprovided because doctors and hospitals do not have adequate financial or other resources to provide them. A reformed system should support providers who provide primary care and reward value, quality and organized delivery of care.

Healthcare **costs continue to grow at an unsustainable pace** of at least **2-3 times the rate of inflation.**

Policy Recommendations:

- Modernize provider reimbursement by moving away from volume and intensity and toward quality and value of services.
- Promote integrated, comprehensive strategies to reform care delivery and payment to bring down the cost to health systems and improve the well-being of our communities.

Adventist Health

Priority: Access and Sustainability

Solution: Commercial Payor Fairness

Adventist Health supports policies that make care more accessible and sustainable leading to adequate medical care for all individuals.

Health plans are increasingly shifting administrative burdens to providers, requiring their workforce to spend more and more time on the phone with insurers resubmitting claims, seeking prior authorization and more. The more time that doctors and providers must spend writing appeals and gaining prior authorization takes time away from much-needed patient care and drives up healthcare costs for every individual, further contributing to provider burnout. Requiring providers to file multiple appeals to get reimbursed is not an infrequent process, with the annual value of challenged claims ranging from $11 billion to $54 billion annually. Insurance companies often drag out the prior authorization process required to transfer patients to skilled nursing facilities and rehabilitation facilities, leaving patients in limbo and delaying their transfer to a facility that is best suited to handle their needs. At the same time, patients are often left in the middle to wait and wonder, “Is my insurance company going to pay for this?” In addition to generating stress for patients, administrative burdens also increase costs. More than one-third of all health care costs in the U.S. are due to insurance company overhead and resources to deal with billing.

Physicians and their staff spend an average of **almost two business days (14 hours) each week completing prior authorizations.**

24% of physicians report that prior authorizations have led to a patient’s hospitalization.

Physicians report that on average, **almost 1 in 5 prescriptions require prior authorization.**

Policy Recommendations:

- Standardize prior authorization requirements and processes.
- Standardize communication services and process requirements.
- Increase oversight of health plans to stop unnecessary denials or payment delays.

Adventist Health

Priority: Access and Sustainability

Solution: Remove Barriers to Integration and Clinical Networks of Care

Adventist Health wants to remove barriers to integration and clinical networks of care, to create a better patient experience and effectively utilize resources.

Clinically integrated networks, such as Adventist Health, encompass hospitals, clinics and other provider facilities that work together across different settings of care. Such networks have the benefit of improving patient experience through greater collaboration between providers, service lines and care settings. Health systems with clinically integrated models are able to establish more consistent practices in utilization review, quality assurance, protocols and guidelines and medical records access. It also ensures that struggling hospitals can remain open, access resources necessary to comply with costly regulations, pay for new technology that improves patient safety and the quality of care, and support outreach programs that keep people healthy and active.

The pandemic also has highlighted the essential role that hospital partnerships can play in managing scarce resources amid a public health crisis. Integrated systems have been able to seamlessly shift supplies and staffing to areas hard hit by COVID-19. And, in an example cited in a Kaufman Hall report, hospitals that have integrated with academic medical centers have been able to bring new COVID-19 treatment protocols and vaccine trials to their patients.

Policy Recommendations:

- Remove barriers to integration and clinical networks of care.
- Create policy solutions that help rural providers affiliate with other health systems to ensure care stays local.

Adventist Health

Adventist Health advocates for whole person care, which includes ensuring our communities have equitable opportunities not only for healthcare, but to housing, education and other needs.

Adventist Health advocates for whole person care, which includes ensuring our communities have equitable opportunities to access not only for healthcare, but to housing, education and other needs. It is widely known that access to healthy foods, quality schools, stable housing and other social needs shape the environments where people live, work and play. Research shows that medical care accounts for 20% of health outcomes, whereas 80% can be traced back to these conditions, referred to as social determinants of health (SDoH). Equity promoting interventions that address SDoH can improve health outcomes, especially for those experiencing inequities. Our goal is to decrease disparities that influence individual health-related social needs so people can live happier, healthier lives.

Adventist Health promotes approaches to account for health-related social needs in quality measurement and value programs where appropriate to ensure equitable performance comparisons and payment adjustments. We also promote alignment and standardization of approaches to collecting, analyzing and exchanging demographic and health-related social need data across federal agencies.

An increase in Community Health Workers (CHWs) is one way to help bridge the gap between social determinants of health. CHWs are frontline public health workers who are trusted members of the community and/or have a particularly close understanding of the community being served. Individuals are able to trust CHWs who can then link them with health and social services in the community, as well as facilitate access to those services.

Policy Recommendations:

- Support workforce development programs in low-income communities.
- Support policies that address societal barriers to working.
- Support policies that improve the nutritional quality of school lunches.
- Provide access to healthy food opportunities for low-income neighborhoods.
- Expand funding for low-income, affordable housing and rental assistance.
- Influence state and federal policy makers to support policies that grow the CHW workforce through a combination of direct investments and policies that incentivize payors and government to deploy them.

Priority: Improve Community Health and Equity

Solution: Address Social Determinants of Health

Adventist Health patients and communities deserve to live the healthiest lives possible. We continue to advocate for a focus on addressing SDoH so our patients need to overcome less challenges.

While access to healthcare is an essential part of our health, the environment, socioeconomic conditions and our habits play a large role as well. These other factors other than health are called social determinants of health (SDoH). Policy changes are essential in solving these SDoH challenges to create more opportunities for quality education, employment, livable wages, affordable housing and safe communities. When social determinants are addressed, an improvement in health outcomes will be seen and medical costs more controlled.

Disparities resulting from SDoH often disproportionately impact historically underserved communities. Individuals who have been subjected to these inequities are shown to have an increased risk of early mortality and higher healthcare expenditures (KFF). With the focus of eliminating health disparities and improving the nation's overall health, changing the reimbursement models to focus on quality of care rather than quantity is needed. Fee-for-Service (FFS) models do not create the proper incentives to address non-medical factors since they do not adequately reimburse providers for extending care beyond the provider's walls. Focusing on eliminating these disparities that have been present for generations will lead to a healthier future for our communities and the nation.

Social determinants of health affect many health outcomes like mortality, morbidity and life-expectancy.

https://www.cdc.gov/visionhealth/determinants/index.html

Policy Recommendations:

- Promote reimbursement models that take SDoH into consideration.
- Standardize SDoH data collection and maintain a robust data exchange infrastructure at a local and state level to help identify who will need future services and intervene early.

Adventist Health

Priority: Improve Community Health and Equity

Solution: Improve Access to Mental Health

Unless addressed, mental and behavioral health challenges will only become more prominent for individuals in our communities. Adventist Health continues to advocate on improving mental health access so our communities know we value a whole-person approach to health care.

Individuals seeking mental health care often discuss the large number of barriers that must be overcome in order to receive care for their concerns. Improving access to mental health services can be done in many ways.

1. Integrate mental health into medical care while improving access in community-based settings by addressing barriers, workforce shortages and mental parity. The stigma of mental health is still relevant and often leads to people shying away from receiving care. Cultural ideations also have an impact on who may seek treatment for behavioral health concerns. Studies show individuals with serious mental illness have higher rates of morbidity and mortality of chronic health conditions, which is why it is important to address any mental health concerns as soon as possible (CHCF Behavioral Health Integration Blueprint). Integrating mental health into primary care settings will increase the number of individuals reached, so they do not have to continue to suffer alone. Ensuring individuals have access to mental health services throughout the community will directly impact the number of individuals who present themselves in mental distress at emergency departments.
2. More funding for long-term care to help institutionalize patients. Often patients will present themselves in the emergency room (ER) in mental distress. These patients are then stabilized and released and are not set up with a long-term treatment plan. Unless there is more funding for long-term care options, the cycle will continue and these same patients will continue to present themselves in the ER, resulting in less time for providers to care for others in critical conditions.
3. Increase the amount of behavioral health providers covered by insurance plans. Individuals will go without treatment because they cannot find a provider that will work with their insurance, or the wait times for providers are months out. The option to pay out-of-pocket is usually not available because the costs are so high.
4. More community-based resources and education is needed, in addition to addressing barriers to outpatient treatment for people with serious mental illness. An increase in resources for these individuals while they wait to receive services is needed to provide some relief and help.

Policy Recommendations:

- Invest in more community-based resources for those with serious mental illness.
- Encourage primary care practices to identify community-based resources to help patients address toxic stress.
- Keep waivers in place that allow providers to use telehealth to deliver mental health services.
- Integrate mental health services into primary care settings and support decreasing stigma.
- Repeal the Medicaid Institutions for Mental Disease exclusion, which prohibits the use of federal Medicaid funds to cover inpatient mental health services for patients aged 21 to 64 in certain freestanding psychiatric facilities.

Adventist Health

Priority: Improve Community Health and Equity

Solution: Uninsured and Underinsured

Adventist Health supports policies that make caremore affordable and accessible, especially policies thatfocus on uninsured and underinsured individuals.

Individuals who have a regular source of primary care receive more preventive services, are more likely to comply with prescribed treatments and have lower rates of illness and premature death than their uninsured or underinsured counterparts. People who lack health insurance are significantly less likely to have a regular source of primary care and are hence less likely to receive not only preventive care, but also treatment for major health conditions and chronic diseases. “Underinsured” people with substantial out-of-pocket costs are likely to forgo both necessary and elective care. These people often use hospital emergency departments as a primary care setting, which drives up costs for businesses and other patients.

In 2022, California had an uninsured rate of **6.5%.**

3.5% of Hawaii's population was uninsured in 2022.

6% of Oregon's population was uninsured in 2022.

Policy Recommendations:

- Establish a Framework for the Integration of Medicare and Medicaid Services for Dual Eligible Individuals
- We urge the consideration of health benefit designs that encourage patients to access and use cost-effective primary care, especially health services shown to delay or prevent the onset of chronic conditions.
- We support policies that achieve universal coverage with a lens of equitable access to care, especially for populations that have endured far too long without care.

Adventist Health

Priority: Preserving Rural Health

Solution: Preserve Critical Access Hospitals

CAH designation protects and ensures access to healthcare services so Adventist Health can continue providing care in rural communities.

On average, rural residents are older, poorer and generally have worse health conditions than urban residents. Requiring more medical attention and care, they also have more limited access to health services.

Adventist Health has multiple designated critical access hospitals (CAHs) in California and Oregon including Mendocino Coast, Howard, Tehachapi, Clear Lake and Tillamook. CAH designation status comes from the Centers for Medicare & Medicaid Services (CMS). In order to be eligible for the CAH designation, the hospital must be a currently participating Medicare hospital, ceased operations on or after November 29, 1989, or health clinic or center that previously operated as a hospital before being downsized to a clinic or center.

The CAH program helps rural hospitals serve their communities by providing increased revenues through the cost-based reimbursement Medicare Program. Designated CAHs have a different set of eligibility rules called Medicare Conditions of Participation. These eligibility rules protect and ensure the health and safety standards of the organizations.

Adventist Health has **5** Critical Access Hospitals.

Policy Recommendations:

- Re-define “reasonable” or “allowable” costs for CAHS to include additional patient centered costs.
- Remove the 96 hour Condition of payment for CAHs

AdventistHealth

Priority: Preserving Rural Health

Solution: Stability and Expansion of Rural Health Clinics

Rural Health Clinics are vital to increasing access to our rural patients, are often the main source of primary care in their communities.

Signed into law by President Jimmy Carter in 1977, the rural health clinics (RHC) program was designed to improve access to health care in rural, underserved areas. Over forty-five years later, we are pleased to report that there are over 5,300 RHCs providing quality care to rural and underserved patients. However, as healthcare evolves, several program policies are in need of modernization to reflect the changing world. The Rural Health Clinic Burden Reduction Act would accomplish this through the following provisions:

- Modernizes RHC physician supervision requirements by aligning them to state scope of practice laws governing PA and NP practice.
- Removes the requirement that RHCs must "directly provide" certain lab services on site and allows RHCs to instead offer "prompt access" to these services.
- Allows RHCs the flexibility to contract with or employ PAs and NPs.
- Maintains status quo location eligibility, allowing RHCs to be located in an area that is not in an urban area of 50,000 or more, given that the Census Bureau no longer utilizes the term "urbanized area."
- Removes a regulatory barrier that limits RHCs provision of behavioral health services in areas experiencing a shortage of such services.

Adventist Health has over **65 Rural Health Care Clinics** throughout California, Oregon, and Hawaii.

More than **20%** of the Rural Health Clinics in California are part of the Adventist Health System.

Adventist Health

Priority: Preserving Rural Health

Solution: Promote New Rural Health Models

As health care evolves, implementing new models for rural health will ensure financial sustainability.

Rural hospitals often struggle to keep their doors open due to declining financial performance, geographic isolation or low patient volume. Since 2010, 136 hospitals have closed their doors, with many more decreasing service lines, leading to a lack of access for people in rural communities. Because of this, rural residents have higher rates of mortality, chronic diseases and disabilities as compared to urban residents. The hospital closures emphasize the importance of these hospitals in their communities, as as well as the need for financially viable rural health models. Participation in innovative payment models that provide additional investment and flexibilities can be a helpful resource.

Rural Hospitals make up about **35%** of all hospitals

Approximately **43%** of rural hospitals operate at a financial deficit.

Policy Recommendations:

- Test new payment models of care in rural areas and sustainable system design.
- Provide stabilizing relief for rural providers to abate the rural hospital closure crisis exacerbated by COVID-19.
- Identify models of care to better support the safety net needs of frontier and isolated rural communities.

Adventist Health

Priority: Preserving Rural Health

Solution: Support Physician Residency Programs in Rural Health

Maintaining healthy rural communities depends on a strong healthcare workforce, which includes professionals living and working in rural communities.

Rural hospitals face significant staffing shortages with only ten percent of physicians practicing in rural communities despite 20% of the United States population living in rural areas. Rural areas struggle to recruit and retain an adequate health care workforce. Seventy-seven percent of rural counties are Health Professional Shortage Areas, and nine percent have no physicians at all. With far fewer physicians per capita, the maldistribution of health care providers between rural and urban areas results in unequal access to care and negative impacts to rural health.

Policy Recommendations:

- Remove barriers that limit rural resident training and grow training opportunities through vehicles like rural training tracks.

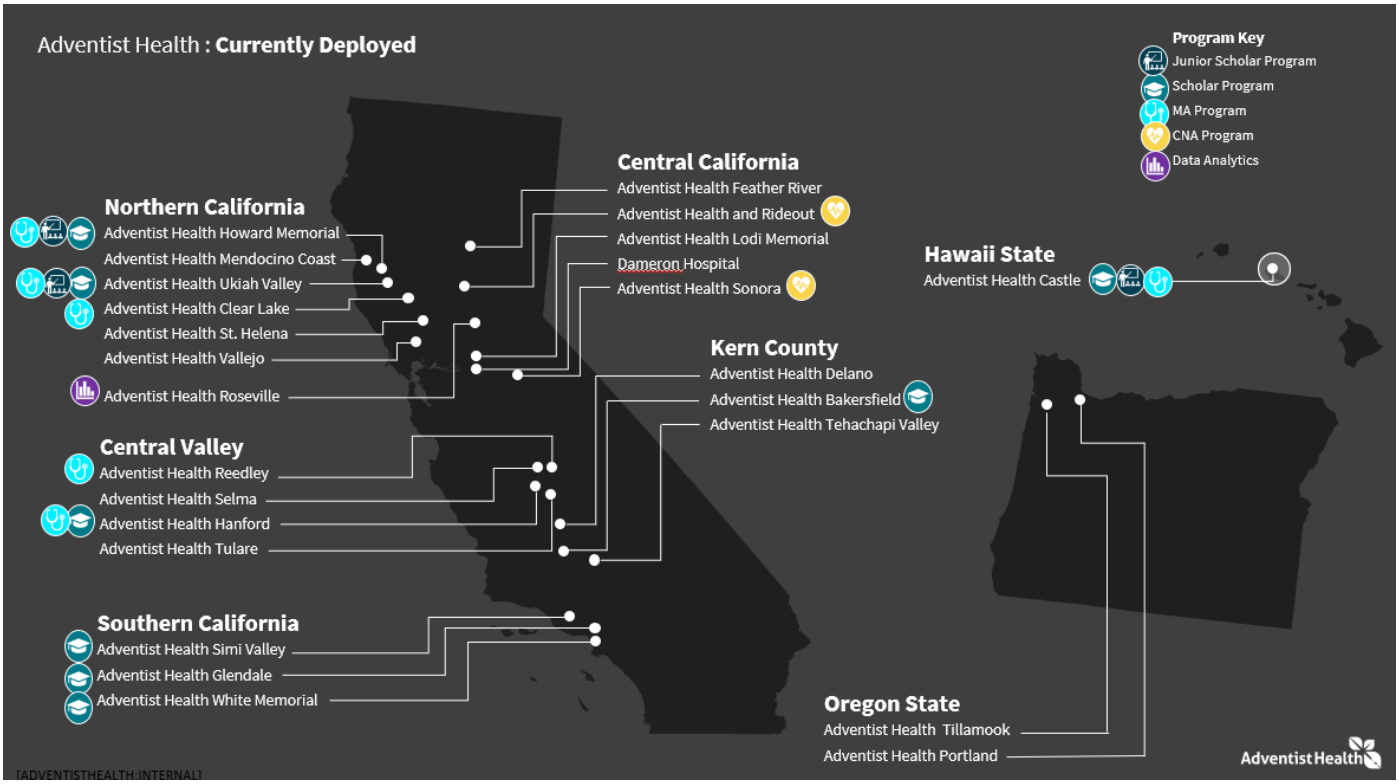
Adventist Health

Pipeline programs are a proven solution to address critical health professions shortages.

Workforce shortages and increasing labor expenses have pushed hospitals to utilize expensive contract labor firms to bolster staffing. For rural hospitals, the rising costs for labor is especially challenging when close to half of rural hospitals already have negative operating margins. To avoid expensive contract labor and the underlying workforce shortages, pipeline programs that incentivize clinicians to work in rural areas can alleviate the strain in rural health.

Policy Recommendations:

- Implement the National Healthcare Workforce Commission, which was authorized in the Affordable Care Act but never funded.
- Address the shortages rural providers face in maintaining an adequate workforce through programs like the National Health Service Corps (NHSC), Nurse Corps Loan Repayment Program (NCLRP), and Title VII and VIII workforce training programs.
- Test new models of team-based care to maximize the capacity of the rural workforce to serve people living in rural areas.
- Allow policies that allow trained professionals to work at the top of their licensure.



AdventistHealth