Testimony
for the
Committee on Health, Education, Labor and Pensions
of the
U.S. Senate

"Examining Our COVID-19 Response: An Update from the Frontlines"

March 9, 2021

Chair Murray, Ranking Member Burr, and members of the Committee, I am honored to represent our many frontline staff and other team members who have worked tirelessly to care for all of our patients, including those suffering from COVID-19. I am Mary Ann Fuchs, Vice President of Patient Care & System Chief Nurse Executive at Duke University Health System and Associate Dean of Clinical Affairs at the Duke University School of Nursing. I also serve as the current president of the American Organization for Nursing Leadership (AONL), which is the national professional association of more than 10,000 nurse leaders who manage and facilitate patient care in all settings across the care continuum. AONL is the voice of nursing leadership and a subsidiary of the American Hospital Association (AHA). Thank you for the opportunity to testify.

Duke University Health System is comprised of a hospital and health care network supported by outstanding and renowned clinical faculty, nurses, and care teams. This network is dedicated to providing high-quality patient care, educating tomorrow's health care leaders, discovering new and better ways to treat disease through biomedical research, and partnering with our community to improve health everywhere. Duke's services span the full continuum of care, from primary care to medical and surgical specialties and subspecialties, all dedicated to putting our patients at the forefront of everything we do.

Founded in 1998 to provide efficient, responsive care, the health system includes three hospitals – Duke University Hospital on our Duke University Medical Center campus in Durham, North Carolina, Duke Regional Hospital, and Duke Raleigh Hospital. In addition to our hospitals, Duke Health has an extensive, geographically dispersed network of outpatient facilities that include primary care offices, urgent care centers, multi-specialty clinics, and outpatient surgery centers. Duke Primary Care is the largest primary care network in the greater Triangle, North Carolina area with family and internal medicine providers and pediatricians in more than 40 locations throughout the region. Duke Connected Care, a community-based, physician-led network, includes a group of physicians, hospitals, and other health care providers who work together to deliver high-quality care to Medicare Fee-for-Service patients in Durham and its surrounding areas.

The Private Diagnostic Clinic (PDC) is the faculty physician practice for Duke Health. It is one of the first and largest academic multi-specialty group practices in the United States. The PDC owns and operates more than 140 primary and specialty care clinics throughout central and eastern North Carolina. Through a diverse and integrated network of Duke providers, patients have convenient, accessible, and high-quality primary and specialty care close to home.

Duke HomeCare & Hospice offers hospice, home health, and infusion services. Hospice care is offered to terminally ill patients in their home, skilled-nursing facilities, assisted-living facilities, and at our two inpatient facilities located in Hillsborough and Durham, North Carolina. Home health services are available to patients who are homebound and in need of nursing services, physical therapy, speech therapy, or occupational therapy. Infusion services are provided at home or at work for individuals who need intravenous therapy.

We appreciate the Committee's leadership in addressing the current COVID-19 pandemic. On behalf of Duke Health, thank you for the support Congress has provided to hospitals, health systems, and all providers over the last year. The CARES Act and subsequent legislation established and added to the Provider Relief Fund, which provided critical resources to better prevent, prepare for, and treat COVID-19.

As a tertiary and quaternary care center, we put the person who needs our care at the center of everything we do. Since well before the arrival of the COVID-19 pandemic, the safety of our patients is and always has been our first priority. Our hospitals safely manage infectious diseases every day. And we will continue to provide safe, effective, patient-centered care in our facilities.

Over the last year, COVID-19 has posed persistent challenges for the communities we serve, our patients, and our team members on the frontlines. Below, I address the many ways in which we adapted care for our community and our patients, many of whom are very sick and require complex, coordinated care. I will also share our experience standing up a robust testing program and rolling out a successful vaccine campaign. I also share some perspectives on the challenges ahead and how to apply lessons learned to future public health threats.

A view from the frontlines: Provider care and COVID-19

As the chief nurse of our health system, and on behalf of the many nurse leaders on the frontlines of this pandemic, I know firsthand the issues facing our patients, our nurses and other provider colleagues, and our health care organizations. At Duke, we provide tertiary and quaternary services and serve the highest acuity patients. In order to meet our mission, we need appropriate staffing (nurses, respiratory therapists, physician staff, others) and equipment (personal protective equipment (PPE) and other intensive equipment) to best care for our patients, their loved ones, and each other.

I worked with multiple teams comprised of nurse, physician, and administrative leaders to create new strategies to meet patient care needs; reallocated internal resources to adapt to influxes of patients; and quickly pivoted when circumstances changed. Specifically, our team developed appropriate staffing models; new policies and procedures in support of infection prevention for patients, visitors, and staff and appropriate use and reuse of PPE and supplies; new care models and patient care practices; established new testing and treatment sites; and stood up multiple vaccination sites for employees and patients, among many other things. We also worked in our community in a variety of ways, including serving as a major transfer center for the sickest patients, and providing resources to skilled nursing facilities in the form of COVID testing, staffing, and training to care for that patient population.

As a team, we responded to the ever-changing information by regularly updating our policies and procedures, holding weekly town halls for employees, convening virtual community forums with our experts to learn more about testing and vaccines, and providing other outreach – including through print materials and online communications – to inform our workforce and community about our pandemic response. Like many health systems, we were the hub of the COVID-19 response in the community. The vital role health systems played in the response is something I hope this Committee will consider when drafting future policy.

At Duke, we are extremely committed to protecting all of our workforce and have learned so much about this coronavirus since it first emerged in the United States in early 2020. In the beginning, we had too little information about the virus and how it is transmitted, uncertainty that was compounded by a real and global shortage of N95 masks and other PPE, as well as stockpiles that contained expired PPE. We know that the same challenges were impacting hospitals all over the country, including those facing additional resource challenges and workforce shortages.

Very early in the pandemic, we made a commitment at Duke to universal masking for all our team members, and we later expanded that to require masks for patients and visitors. Our Supply Chain team worked around the clock sourcing from around the globe to ensure we had adequate safe and effective PPE – including surgical masks, gloves, and gowns – for our teams. Given these challenges, I am proud of our Duke community and the partnerships across both the health system and university to help address some of our most pressing needs.

Over a year ago, facing a critical shortage of N95 face masks of our own, Duke Health research and clinical teams confirmed a way to use existing vaporized hydrogen peroxide methods to decontaminate the masks so they can be reused. The process uses specialized equipment to aerosolize hydrogen peroxide, which permeates the layers of the mask to kills germs, including viruses, without degrading the mask material. As a result, the decontamination process allowed for thousands of N95 masks to be reused at all three of our hospitals, easing some of the shortage and curbing the need for other alternatives using unproven decontamination techniques. Our experts also provided guidance to other hospitals and health systems across the country so that they could develop and implement such procedures.

Recognizing the mental health needs of the front-line workforce

<u>The impact</u>

The pandemic has profoundly affected our health care teams and clinician leaders, emotionally and physically. Caring for critically-ill patients, comforting families of loved ones suffering in isolation, and fearing bringing the virus home to our families has taken a significant toll on the mental wellbeing of our workforce. The unfortunate reality is physicians and nurses already suffered from high rates of depression, burnout, addiction, and suicide before the COVID-19 pandemic.

Early on in the pandemic, in my role as president of AONL, we joined leadership from other national nursing organizations to meet with the Coronavirus Task Force to collectively advocate for three priorities: keep our nurses safe; allocate nurses so we have enough staff to care for our

patients and communities; and ensure nurses have the supplies and equipment they need to treat patients. While we continue to advocate for resources to protect the physical health of clinicians and staff, we are also advocating for resources to support their mental health.

To help shed light on nurse leaders' primary challenges, leading practices, and areas of support during this pandemic, AONL fielded a pulse check study of more than 1,800 nurse leaders in July 2020. Participants included nurses at all leadership levels, mainly in the hospital and health system setting. The primary challenges identified were access to PPE and other supplies, communicating and implementing changing policies, surge staffing, reallocation and training, and emotional health and well-being. AONL fielded a follow up study last month, and while the report is still in development, we do know that the availability of health care workers is still a major issue along with addressing burnout and building resilience. These issues are not specific to nursing and also extend to physicians, respiratory therapists, transport specialists, and environmental service staff.

I am proud of all our Duke Health team members for their commitment to our patients and support of their colleagues during unthinkably challenging professional circumstances, but none of us are immune to the burdens the pandemic has placed on our mental health. We are seeing the exhaustion among nurses, first and foremost, followed by the feelings of being overwhelmed and anxious and having difficulty sleeping, as many nurses also face challenges of managing other responsibilities for their families and conducting virtual school at home. This fatigue and strain, which at times presents as post-traumatic stress disorder, has been dramatically exacerbated over the last year.

As a result, we are starting to see more of our skilled workforce leave or planning to leave, which is also being reported in recent surveys conducted nationally. This kind of high turnover will have a significant impact on the future of delivering health care. Compassion fatigue is just as real and consequential as physical exhaustion, and while the COVID vaccines bring hope, we are seeing the respect for frontline workers dwindle as the public tires of this pandemic. Unfortunately, we also are starting to see an increase in inappropriate and violent behaviors as a result of the incredible toll this pandemic is taking on those seeking care in our hospitals and clinics, which is another complicating factor for our workforce.

Our response and proposed solutions

The constant challenge of caring for COVID patients – by serving as their family and managing death and dying in addition to intensive care – means our workforce must be cared for and offered respite. We provide mental health resources through Duke's Personal Assistance Service (PAS), which provides assessment, short-term counseling, and referrals by a staff of licensed professionals to help resolve a range of personal, work, and family problems. PAS services are available at no charge to benefit-eligible Duke faculty, staff, and their family members. Duke also sponsors an emotional support and well-being hotline and online resources conveniently available to staff, faculty, and our broader community. In addition, our chaplains provide needed support to frontline staff in their care settings across the health system.

In addition to supporting the National Academy of Medicine's *Action Collaborative on Clinician Well-Being and Resilience,* the AHA and AONL have developed a number of resources to

address burnout and promote resilience, especially during the COVID-19 pandemic. These include guides on grieving when there is no time to grieve, embracing mindfulness, and addressing moral distress. The AHA also created the *Caring for Our Health Care Heroes During COVID-19* resource, which outlines the ways hospitals and health systems are helping to care for and support the health care workforce during this crisis. The document focuses on three areas – mental health, food, and housing – and features case examples from across the country. It also provides a list of national well-being programs and resources developed for healthcare workers.

Further, Duke Health joins other organizations, including the AHA and AONL, in supporting the Dr. Lorna Breen Health Care Provider Protection Act, which aims to reduce and prevent suicide, burnout, and behavioral health disorders among health care professionals. Named for a physician who led the emergency department at New York-Presbyterian Allen Hospital, the bill would authorize grants for providers to establish programs that offer behavioral health services for front-line workers. In addition, the bill would require the Department of Health and Human Services to study and develop recommendations on strategies to address provider burnout and facilitate resiliency, and it would direct the Centers for Disease Control and Prevention to launch a campaign encouraging health care workers to seek assistance when needed. Thank you to Senator Kaine and Senator Cassidy for leading this effort. I hope this Committee will give the legislation swift consideration.

Moving forward: Planning for the future from lessons learned

This past year has offered us many lessons learned to better care for our patients during and after public health crises. We continue to treat patients who suffer from chronic conditions as a result of COVID-19 and who will need long-term care in the community. From the early phases of COVID-19 through recent surges and into the future, we will continue to see adaptation in the care we provide our patients and the safety we ensure for our workforce.

The pandemic created regional collaboration between (historically) competitor health systems, who pulled together above and beyond the connections that exist in NC, and the state emergency management collaboratives (RACs) that are in place to address natural disasters and other emergencies. Health systems like ours began weekly coordination of our response, sharing supplies and resources and ensuring access to care and an equal sharing of the burden of COVID cases. Lessons learned through these efforts could be translated into mutual aid expectations for any future similar public health crises.

The Hospital at Home program allows us to care for patients at home. We recently launched this initiative at Duke Raleigh Hospital and have seen firsthand the benefit of allowing acute healthcare services to be provided outside of a hospital setting in response to the surging COVID-19 pandemic. At Duke University Hospital, we are providing enhanced home care services to COVID-19 positive patients who can be treated at home and thus provide better access to hospitalization for more acutely ill patients.

Thanks to a $7.4 million grant from the North Carolina Department of Health and Human Services (NC DHHS), Duke Health's COVID-19 Support Services Program has been able to assist individuals and families required to isolate or quarantine due to COVID-19. The program,

which initially covered three counties and has expanded to nine, has served approximately 30,000 people through relief payments, food boxes, meals, COVID supplies, transportation, and medication delivery. Duke has partnered with 15 minority-led community-based organizations to provide these much needed services in our community.

At Duke Health, our top priority remains the health and safety of our patients, their loved ones, and each other. Our planning team has been diligently coordinating with our state leadership and developing the proper preparations for administering all three COVID vaccines now currently available. At Duke Health, we see the vaccine working to protect our team – with over 70% of our team members having been vaccinated – and in recent weeks we have not seen any COVID-19 infections in vaccinated team members.

As part of our commitment to getting vaccine to those most impacted by COVID-19, we have established a system-wide Vaccine Equitable Distribution Committee to better understand our data and reach historically marginalized populations, including those who are disproportionately impacted by COVID-19. We have dedicated appointment blocks and allocation for these populations, and we partner intentionally with community organizations.

We continue to partner with the community to pilot "pop-up" vaccine clinics. Recently, we joined with the Latino Community Credit Union, La Semilla, El Centro Hispano, Greenlight, and Immaculate Conception Church through the LATIN-19 initiative to create a vaccine clinic geared toward the Latinx community. We also have partnered with the Durham Recovery & Renewal Task Force's Faith Leaders Round Table to hold an event at Nehemiah Christian Center in downtown Durham. We continue to collaborate with the African American Covid-19 Task Force and Community Health Coalition, Meals on Wheels, Lincoln Community Health Center, and additional faith communities to provide vaccine allocation and transportation for vulnerable communities.

As supply increases and eligibility categories expand, we will continue to build on the above efforts and develop additional strategies with the communities we serve. Through this work, the health system has improved the rate of African Americans vaccinated from 8.8% on February 1, 2021, to more than 15% today. While we are still not where we need or want to be, we are making progress and will continue to do so. All combined, this outreach is just one way to address the enormous health equity gaps that COVID-19 has exposed. Our nation's health policies must prioritize addressing these health disparities so that they are no longer systemic impediments to patient care and access.

We are following the guidance and direction of our public health experts, including our infectious disease and infection prevention colleagues, closely monitoring and adopting new findings, and following clinical protocols developed by expert scientists and clinicians in every discipline of care. We will continue to manage the pandemic's impact on everything we do, while also seeing to the important challenge of maintaining resilience within our workforce.

Preparing for future health emergencies now means doing all that we can to ensure a strong, deep, and viable health care workforce in the future, including our physicians, physician assistants, and especially our nurses. Even before the COVID-19 pandemic, our nursing

workforce needs outpaced our supply. We are grateful for the leadership of Senator Burr and Senator Merkley in advancing the reauthorization of Title VIII Nursing Workforce Development Programs. We were pleased its reauthorization was included in the CARES Act enacted last March and thank Congress for supporting legislation to update and improve programs that help to grow and support the nursing workforce in the United States.

We continue to advocate for increased funding to the Title VIII Nursing Workforce Development programs to increase the nursing and nursing educator workforce. Each year, nursing schools must deny admission to thousands of potential students because they do not have enough faculty to teach these aspiring nurses. The Title VIII programs support nursing schools but also seek to add diversity to the nursing profession and improve access in health shortage areas. Along with the broader nursing community, we support the Future Advancement of Academic Nursing (FAAN) Act, which would make critical investments in our nursing infrastructure, including underserved areas by supporting the needs of nursing students, helping retain and hire diverse faculty, providing resources to modernize nursing education infrastructure, and creating and expanding clinical education opportunities. These legislative efforts are essential and will help prepare nursing students as they transition from the classroom to the frontlines of patient care. Thank you to Senator Merkley for his leadership introducing the FAAN Act.

COVID-19 has served as a blunt reminder that we cannot afford to overlook our public health infrastructure and workforce. At a state level, and in the absence of a coordinated and consistent public health infrastructure with sufficient resources, communities, long-term care facilities, and public health officials turned to health systems and hospitals to support testing, case identification and contact tracing, facility interventions in long-term care and communal living facilities, assistance for historically marginalized communities, and most recently vaccination at scale in our communities. While health systems including Duke Health have stepped forward to do this work, these additional responsibilities have substantially added to the burden and burnout of our teams and increased financial losses and challenges. Further ongoing investment in public health infrastructure is critical.

We appreciate the tremendous and ongoing coordination with our Governor's Office and NC DHHS to develop a statewide plan to respond in lockstep to the current pandemic. But because our public health infrastructure is resourced differently in every county, the local-level capacity to respond to public health threats varies significantly across our state. The pandemic has highlighted a critical need to narrow these gaps in pursuit of a stronger and more coordinated public health system. In follow-up to legislation enacted by Congress in December, we are grateful the North Carolina General Assembly approved a bill last week that will provide $84 million to local health departments across our state.

As the Trust for America's Health notes[1], public health departments must respond quickly to emergencies while maintaining the day-to-day work they already do to support healthy communities, including managing chronic disease and substance misuse. We echo the TFAH's call for robust funding "to ensure that all communities are served by health departments with comprehensive capabilities" and to minimize the vulnerabilities recently exposed. We are

[1] https://www.tfah.org/wp-content/uploads/2021/03/Public-Health-Infrastructure-Fact-Sheet-3-1-21-1.pdf

grateful for Chairwoman Murray's leadership on legislation that would strengthen the state and local public health infrastructure. Thank you to this Committee for its attention to these issues and for seeking policy solutions that will address workforce needs and provide access to care for all patients.

As president of the AONL, I served on an AHA task force that developed a *Pathways to Recovery* compendium of resources to help inform hospitals and health systems' work to respond to and recover from the pandemic. It spans 11 areas, including workforce, testing/contact tracing, communications (both internal and external), supply chain, ancillary/support services, plant operations, financial management, governance, patient experience, transitions in care, and risk management. It is intended to help hospitals align with where their own communities are in the pandemic.

COVID-19 highlighted the disparities in care and the need for health equity. In addition to addressing systemic racism within health care, we recognize the importance of recruiting and retaining a diverse health care workforce, reflective of the communities we serve. The AHA and AONL developed resources to help health leaders implement and foster workforce diversity and inclusion within their organizations. These tools also address bias and examine how institutionalized and systemic racism result in inequities in care.

I must also note the impact of the unprecedented expansion of telehealth services and access to telehealth resources since the start of the pandemic that has helped us stay connected to our communities. Our experience, and that of fellow health systems across the country, has demonstrated the efficacy of telehealth in delivering care in a public health emergency, and we want to ensure that it will remain beneficial, acceptable, and accessible to more patients when applied in the appropriate ways on the other side of the current crisis.

We are grateful that the Centers for Medicare and Medicaid Services (CMS), through emergency waiver authority, have provided numerous telehealth flexibilities, and we urge further action by Congress and CMS to make many of these flexibilities permanent after the pandemic. In the near term, we support the Temporary Reciprocity to Ensure Access to Treatment (TREAT) Act (S.168), introduced by Senator Chris Murphy and Senator Roy Blunt, that would create federal uniform licensing for the duration of the COVID-19 pandemic. We also support changes to Section 1834m of the Social Security Act to allow more medical professionals, including, occupational therapists, physical therapists, and speech-language pathologists, to be able to be reimbursed by Medicare for their services after the public health emergency ends. Finally, we urge Congress to address technological, broadband, and other gaps to access along with any further telehealth expansion efforts so that the digital divide is not a barrier to quality care.

The substantial financial impacts of COVID-19 on hospitals and health systems will also have lasting impacts. Systems now face difficult decisions to reduce costs, potentially limiting support to health care professionals, further development of needed infrastructure, and support for their communities. The economic impacts for patients and those who have lost health care insurance or cannot afford patient financial responsibilities are further impacting providers facing financial challenges now due to the COVID-19 pandemic. Additional support is needed, including

eliminating further reductions in payments through federal programs including Medicare and Medicaid to maintain access to care for patients.

In closing, nursing has been ranked the most trusted profession by Americans for decades, with a large majority of survey respondents rating the honesty and ethical standards of nurses as high or very high. Nurses have the skills, expertise, creativity, and unique ability to problem solve and lead while putting the patient's whole health at the middle of everything we do. As the spring and summer bring an increasing number of vaccinations per day, in combination with continuing to mask and practicing healthy behaviors after receiving the vaccine, we need to acknowledge pandemic fatigue, be patient with each other, and work together in being innovative to provide highest quality care in the safest manner possible. In my role at the AONL and with the AHA, we will continue to support state efforts to expand scope of practice laws, allowing non-physicians to practice at the top of their licenses.

Thank you for the opportunity to serve on the witness panel for this important conversation. At a recent HELP Committee hearing, Ranking Member Burr, who has been a great partner for Duke Health and health systems across North Carolina throughout the challenges of COVID-19, commented that it would be "devastating" if we do not learn from the lessons of the current pandemic. I wholeheartedly agree. Our collective weaknesses and failures have rarely been so important to understand or on such public display – but we have also seen our nearly unlimited capacity for resilience, innovation, and responsiveness. We look forward to working with you to apply those lessons, cement our strengths, and create an even more robust health care infrastructure to address future challenges.