



HEALTH CARE

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A BIENNIAL JOURNAL ON HEALTH AND COMMUNITY WELL-BEING

Fighting *for* Our Patients *and* Each Other

When we work together, we can
turn our aspirations into actions

In this issue:

- + Overcoming vaccine hesitancy page 4
- + Tackling the staffing crisis page 11
- + Organizing and mobilizing page 16
- + Exploring partnerships page 22
- + Countering environmental injustice page 31



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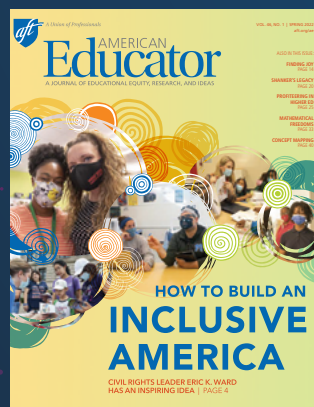
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Aspiration to Action

Patient and Clinician Safety Is a Labor Movement Issue

RANDI WEINGARTEN, AFT PRESIDENT

AT THE AFT, we have a saying: we care, we fight, we show up, and we vote. Our goal: turn aspirations for a better life into reality. And frankly, working people can only do that when we work together in solidarity.

How? Whether striking for safe staffing, negotiating decent wages and retention policies, or electing leaders who prioritize accessible, affordable healthcare, we fight for solutions to the problems that keep you up at night. But because hospital management often puts profits over patients and clinicians, healthcare is full of keep-you-up-at-night issues.

In this *AFT Health Care*, Bill Garrity, the president of University Health Professionals in Connecticut and an emergency department nurse, explains that one of his members recently worked an 18.5-hour shift. That's deplorable—and dangerous. Nurses and other health professionals are routinely forced to work overtime with high patient loads; as exhaustion sets in, they fear for their patients' safety. "Many of our members just cannot handle it anymore. I have actually had suicide prevention talks with my own members," Garrity says.

Stephanie Gapper, a registered nurse and member of the Oregon Nurses Association, warned her family and friends to stay out of the hospital during COVID-19. Patients were being treated in hallways, while experienced nurses who felt devalued and overwhelmed walked out the door.

These are issues for everyone—not just hospital staff. And our union confronts these issues head-on.

We are in a moment like no other. The global pandemic should have unified the country in fighting the virus, but instead our political environment is as toxic as I have ever seen, with extremists preying on anxieties to stoke divisions.

Our movement, the labor movement, helps confront this uncertainty and anger. The labor movement offers a pathway to dignity, respect, and being able to sleep at night—having a secure job with good wages and benefits, a reasonable workload, and voice at work. This path creates opportunities to build a better future, particularly for the next generation.

In healthcare, this pathway begins with solving the staffing crisis. The AFT Healthcare Task Force, which I convened in January, is bringing together AFT leaders, representing the voices of rank-and-file members, and the nation's top healthcare researchers. Later this spring, they will make recommendations on recruitment and compensation, with an emphasis on increasing diversity, career retention and advancement, and trust and voice in the workplace. That means a focus on salaries, working conditions, and staffing levels, including safety concerns and resources, and confronting industry trends that are undermining healthcare workers' jobs.

The healthcare work you do is essential. So is your union work—creating communities, building power, and setting an agenda of fairness, opportunity, and justice for working people. Our country is at a crossroads; our union movement is a vital force in moving from anger to aspiration, from fear to hope.

We are, collectively, perhaps the best vehicle for everyday folks to improve their lives. That happens at the bargaining table, but it also happens at the ballot box. It happens when we take the last-resort step to go on strike for the resources to do our jobs safely. It happens with the new organizing at Amazon, Planned Parenthood, and Starbucks, and also with legislative victories.

But let's not kid ourselves. Corporate and other wealthy elites—including hospital CEOs and investors—have spent the last four decades waging war on working people. I believe in capitalism, but capitalism works better when there's a check on that power—when the people doing the work have a say in who benefits, rather than this obeisance to the market, which is why gas prices, prescription drug costs, and insurance rates are sky high.

Let's rewrite the economic rules so we have a system that rewards work, not wealth.

That's part of what unions do—turning our aspirations into reality—and Americans see that value. The Gallup approval rating for unions is nearly 70 percent, the highest in six decades. We are there, shoulder to shoulder, in hospital break rooms, in churches and synagogues and mosques, in community centers, and on factory floors.

When we connect with people on the issues that matter, the things that create the freedom to thrive, we build a better life for ourselves, our families, our patients, and the next generation, too. That's what unions do. +



We fight for solutions to the problems that keep you up at night.

Moral Injury Research

We Want to Hear from You

For far too long, the failings of our nation's healthcare system have fallen on nurses' shoulders—and hearts. More than two years into the COVID-19 pandemic, the strain has only worsened, and the consequences for nurses are devastating.

The AFT is sponsoring a research project to better understand, address, and prevent moral injury. Nurses across the country are sharing their experiences with researchers:

"We are board-certified health professionals, and nothing cuts us down like the constant feeling of providing inadequate care. Before, I would attempt to build a strong rapport with these patients during their scariest times.... Mentally exhausted, I now limit my time in the room no matter if the patient is recovering or preparing for hospice.

"Being the ones primarily going into rooms, the nurses were the first ones to see the effect of insufficient PPE. As of this week, my N95 mask is three months old and has been Surfacided five times.... Welder's shields are taped together, cleaning wipes are sometimes unavailable, and periodically, new brands of gowns don't have arms."

+ + +

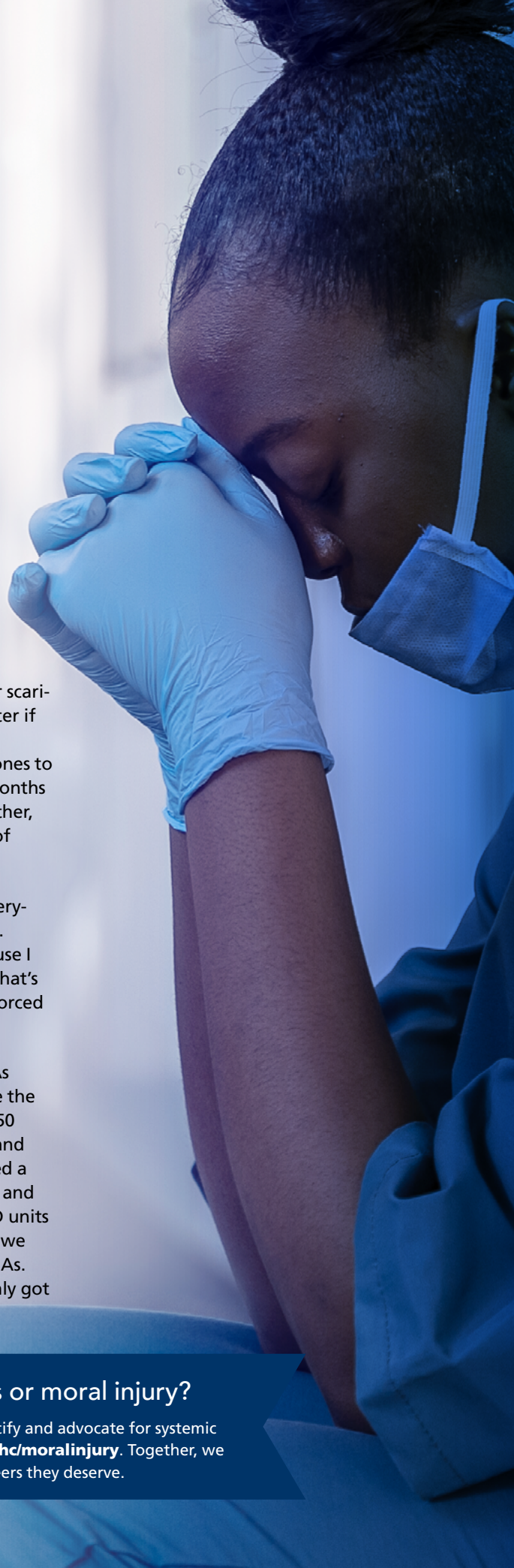
"There were many, many situations where, as the bedside nurse, I was everything for a patient. I was the nutritionist. I was the respiratory therapist.... Physicians would send me into the room to ask a patient a question because I had to be there anyway, and they didn't want to increase their risk.... So that's really demeaning. But I also think it is dangerous.... It feels like we were forced to take on roles that were not ever supposed to be part of our role."

+ + +

"Right now, staffing is the worst it has ever been. I kept stats on myself. As the charge nurse, I was supposed to be out of staffing in order to manage the complex 36-bed unit, [but] I would be in charge with six patients ... from 50 to 83 percent of the time. It was so difficult to do two jobs so frequently and have to deal with all of the daily issues; it was demoralizing.... I also carried a tremendous amount of guilt because I was unable to help any other staff and we were all working like dogs.... COVID struck, and the designated COVID units took our staff every day, so they could be 4:1 with numerous CNAs, while we took on their heavy medical patients and worked 6:1 with one or zero CNAs. 'Merit raises' were incredibly insulting, as I was working like a dog and only got 68 cents, the worst raise of my 17-year career."

Are you a nurse who has experienced moral distress or moral injury?

Please share your story by visiting gwhwi.org/moralinjury.html so we can identify and advocate for systemic solutions. To read more from a few of the stories already submitted, visit aft.org/hc/moralinjury. Together, we can ensure that patients get the care they need and nurses have the fulfilling careers they deserve.



FIGHTING FOR OUR PATIENTS AND EACH OTHER

Through collective action, healthcare workers can improve patient care, staff working conditions, and community well-being.

4 Become a Vaccine Champion

With Kindness and Respect, We Can Help Others Choose to Be Vaccinated

BY MARY KOSLAP-PETRACO

11 Fighting for Our Patients and Our Profession

Two Experienced Nurses on the Staffing Crisis

16 Organizing on the Frontlines

Improving Patients' Care and Workers' Conditions

BY REBECCA KOLINS GIVAN

22 Improving Working Conditions in Turbulent Times

Expanding Unions' Toolkits

BY PETER LAZES AND MARIE G. RUDDEN

24 Boxing and Dancing at the Same Time

BY DEB SNELL

28 Partnership in Flux

BY KATIE EKSTROM

31 Environmental Justice

How Pollution Is Ruining Our Planet and Our Health—and What We Can Do About It

BY NA'TAKI OSBORNE JELKS



 **Union Highlights: aft.org/hc/spring2022/uh**

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The **American Federation of Teachers** is a union of professionals that champions fairness; democracy; economic opportunity; and high-quality public education, healthcare and public services for our students, their families and our communities. We are committed to advancing these principles through community engagement, organizing, collective bargaining and political activism, and especially through the work our members do.

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Pictured:
AFT MEMBER REFYND DURO, RN-BSN

Become a Vaccine Champion

With Kindness and Respect,
We Can Help Others Choose to
Be Vaccinated

A few years ago, I was chatting with a mom in our church parking lot. When she told me her oldest child was getting ready to go to college, I shared in her excitement. As a parent, I know what a wonderful experience it is to give children wings to fly out of the nest. Everyone at church knows I'm a nurse and a passionate advocate for vaccines, so my next question was no surprise.

"Have you gotten your child the meningitis B vaccine yet?"

"Oh sure," she said. "We got the meningitis vaccine that's required for school." She'd wanted to be sure her child was protected.

"I couldn't agree more, and I want the same thing," I replied. "That's why I asked about meningitis B."

The mom had never heard of the meningitis B vaccine, so she thought it couldn't be that important. And anyway, meningitis is meningitis, right? With all the other vaccines children already receive, why was this one necessary?

"Those are excellent questions," I said. "I know you're really just trying to sort all of this out and do what's best for you and your family. May I have permission to answer your questions?"

When she nodded, I told her about my background—that I've spent most of my career learning about and giving vaccines. I've taken several courses from the Centers for Disease Control and Prevention (CDC), the Vaccine Education Center at Children's Hospital of Philadelphia, and other places, and I read more on vaccine topics every day



to stay current. I told her that in my research, I'd learned that the only strain of meningitis seen on college campuses in the last 10 years is meningitis B—but the vaccine isn't mandatory because the disease is considered very rare.

"If it's so rare, why does my child need a vaccine?" she asked.

"It won't be rare if your child contracts it," I told her. "And the only protection against it is the vaccine."

I told this mom that a very dear friend of mine had lost her 17-year-old daughter—her only daughter—to meningitis B before there was a vaccine available. And more recently, an adolescent who lived not far from me had also died from meningitis B. I told her that I knew a few people who had survived it, but their lives had been changed forever because of lost limbs or permanent organ damage.

"May I have your permission to discuss the vaccine further and tell you what I've learned?" I asked.

When she agreed, I asked her what questions she had about the vaccine. She asked if it was safe. I told her the meningitis B vaccine was tested very vigorously in thousands of people before it was licensed, and it was found to be safe and effective. The most common side effect is a sore arm.¹ I told her that I believe so strongly in the science that I'd convinced my nieces and nephews to get the vaccine for their children. The mom found this very reassuring.

"Have I answered all your questions?" I asked. She said I had, and that I'd given her a lot to think about.

I left her with a final thought: "I hope you decide to ask your healthcare provider about the meningitis

By **Mary Koslap-Petraco**

Mary Koslap-Petraco, DNP, PPCNP-BC, CPNP, FAANP, is an adjunct clinical assistant professor at the Stony Brook University School of Nursing and the owner of Pediatric Nurse Practitioner House Calls. She chaired the National Association of Pediatric Nurse Practitioners' Immunization Special Interest Group and has served on the National Vaccine Advisory Committee.

ILLUSTRATIONS BY FRANCESCA GASTONE

B vaccine before your child leaves for school. I know I wouldn't let my child leave home without that potentially lifesaving vaccine."



I have conversations like this all the time. They have been part of my career in public health for more than 30 years. I'm a nurse with expertise in immunizations, and in my work communicating the importance of vaccines to the public, I've seen a range of emotional responses to the topic of vaccines. Vaccination is an emotional issue for me, too. It's the reason I became a nurse.

I grew up in a family suffering the ravages of diseases that are now vaccine preventable. One summer Sunday morning in 1923, my mother, Mildred Bliss Koslap—then just 3 years old—woke up to find that her right arm and leg were numb and she could not get out of bed. She was terrified. Her parents were distraught. After some effort, my grandfather was finally able to locate a kindly physician to make a weekend house call to the guest house in upstate New York where they were staying on vacation. The physician took one look at my mother and announced that it was polio. My mother had no idea what that meant, but she clearly remembered the fear in her parents' faces.

The guest house was thrown into chaos. Not much was known about polio in those days, but none of the other guests wanted to be near a sick child. Everyone else left, and the owner of the house insisted that my grandparents pay for all the lost business. For three weeks, my mother was quarantined there until the physician deemed her able to travel back home to continue her isolation. She spent months confined to her bed, unable to move her right side, feed herself (she was right-handed), or see her siblings.

The treatment for polio at that time was hot wet packs applied to the limbs to relieve the painful muscle spasms. My mother hated them because they made her even hotter in the summer heat—but she really hated the strengthening exercises she had to do when the packs came off. The packs continued for over a year, and the strengthening exercises lasted for years after that.

My mother recovered, but life was different for her. She learned to write again, this time with her left hand, because polio had changed her dominant hand. By the time she was able to walk by herself again at 6 years old, her right leg had become shorter than her left, giving her a slight limp. She went to school, grew up, and had children, but being a polio survivor colored my mother's entire life. She would not allow my sisters and me to go swimming in the summer, and she limited the number of other children we were allowed to play with—she was always afraid one of us would get polio, too. When the Salk vaccine was approved in 1955,² my mother could not get us vaccinated fast enough. She wasn't alone; every parent she knew was just as anxious to get their children protected.

At that time, I was attending Catholic school in the village where I was raised. While we children weren't

excited about getting a shot, we knew what contracting polio would mean for us. I clearly remember sitting in my second-grade classroom the day our teacher told us one of our classmates had been hospitalized with polio. I asked if they'd been put in an iron lung. Pretty heavy stuff for a 7-year-old. So when it was time to get vaccinated, I walked with the nuns and 400 other schoolchildren the mile up the hill to the public elementary school where the shot was being administered. We marched into the auditorium and, one by one, made history. After that, summers were very different. We could swim and play with our friends as much as we liked. Polio became a distant memory for everyone except those of us who lived through it.

Once we had the vaccine, we were done with polio—but it wasn't done with my mother. Her right side began to weaken in her 40s, and by her mid-70s she could no longer grasp things with her right hand. Her physicians had no idea why this was happening. I was a nurse by then and had started working in my local health department with vaccines. There, I learned that physicians at the CDC and the National Institutes of Health had been studying a new polio complication in which spasms and paralysis returned in many survivors over time. The complication became known as post-polio syndrome.³ I was sure my mother had it. When I finally convinced her physicians to read the published article on post-polio syndrome, they agreed with my diagnosis. By the time my mother died at age 98, polio had robbed her of the ability to walk independently and care for herself.

My mother's experience with polio was instrumental in my becoming a nurse advocate for vaccination, but my path was also shaped by my grandmother's experience with cancer. In 1955—the same year that the polio vaccine saved me and countless other children—Mary Skapura Koslap, for whom I was named, died of cervical cancer. My grandmother did not have the same access to medical care that we enjoy today. She had no annual Pap smear because a simplified test wasn't routinely given until 1957.⁴ When she was finally diagnosed, it was too late; cancer had taken over her body, causing necrosis and pain. My aunt, who lived with and cared for my grandmother, worked tirelessly to keep her clean and comfortable. She changed and disinfected bed linens multiple times a day, but all the bleach in the world could not cover up the smell as my grandmother rotted to death.

My grandmother died from a disease that is largely preventable today thanks to a vaccine. Human papillomavirus (HPV) causes cancer of the cervix, oropharynx, anal canal, vulva, vagina, and penis, but the HPV vaccine could prevent 90 percent of these cancers.⁵ The data are compelling. I can only imagine the additional time my family might have had with my grandmother—and the suffering she might have been spared—if this vaccine had been available in her lifetime. That's why I tell her story every time I give

Vaccination is an emotional issue for me, too. It's the reason I became a nurse.



an adolescent the HPV vaccination. I never want them to have to face what my family experienced.

Vaccines are the number one public health achievement of the 20th century.⁶ Research shows that vaccines have saved countless lives, and they increase our longevity. And they're not just for babies; vaccines are important at various times along the lifespan. But fear and misinformation can cloud the evidence that vaccines work. This has become more obvious during the COVID-19 pandemic, which has for the first time in many years interrupted our country's increasing longevity with its disproportionate impact on Black

and Latino communities.⁷ We now have vaccines that can reverse this disturbing trend and make real headway in keeping our communities safe, not just from COVID-19 but from other serious illness and disease. What we need are nurses to be vaccine champions and empower others to follow the evidence.

Nurses as Vaccine Champions

I often describe myself as a “dinosaur” when relating my nursing experiences because I've been doing this for so long. But my passion and conviction for this work are just as strong today as they were on the day I took the Nightingale Pledge at graduation in 1969. In the final line of the pledge, I promised to “devote myself to the welfare of those committed to my care.”⁸ To me, that means doing all I can to protect my patients—not only encouraging them to get vaccinated, but also setting an example for them by getting vaccinated myself. I see it as a moral responsibility. I start every day with an unspoken promise to my patients: “As I care for you, it is my job to protect you from all harm. That means any harm from your illness or its symptoms, from outside forces including the care environment, and from other people if necessary.”⁹

I have never met a nurse who took the Nightingale Pledge for granted. We consider caring for others in their time of need personally and professionally rewarding and one of our most sacred responsibilities. We are born leaders and take-charge people. We don't stand on ceremony; we jump into action during emergencies. We save lives on airplanes and stop to help with motor vehicle accidents. And all this is in addition to the work we do daily to keep our patients safe with our excellent assessment skills. We are singularly well suited to the work of vaccine advocacy.

By virtue of our profession, nurses have a head start in championing vaccines for ourselves, our patients, and our communities. Ours is the most trusted of all professions.¹⁰ We are rated highly because we're seen as honest and ethical. The public trusts that we put our patients'

needs ahead of the interests of others. Our voices are heard and our opinions are respected because of what we do. No matter what field of nursing we practice, we all spend much of our time educating patients. We have a way of speaking that makes complicated material understandable without talking down to patients.* We need to use that influence to clarify misinformation about vaccines, reassure each other and the public that the science behind vaccines is solid, and encourage everyone to get vaccinated. I truly believe that every nurse should be a vaccine champion and that every nurse *can* be a vaccine champion. It all starts with conversations with fellow nurses who may be hesitant about vaccines.

The reason to start these conversations with our colleagues is simple: our patients depend on us to protect them from harm, and this includes the harm we can inadvertently cause them ourselves. The medical literature has clearly demonstrated that healthcare workers can be vectors of highly transmissible pathogens like influenza and measles.¹¹ Not surprisingly, one of the best ways to protect patients from pathogens we are carrying or come into contact with is vaccination.¹²

I would never expect a nurse colleague to do something that I wouldn't do or something that is not supported by the best available evidence. And the evidence clearly indicates that vaccines are safe and effective. Obviously, no vaccine is 100 percent effective or guaranteed; there is always a small risk of infection or negative reaction. But there is also risk in daily activities like driving a car or walking across a street. We do those things as safely as possible because we understand that the benefit of getting where we need to go far outweighs the risk.

So I start with me. I ask for permission to have a conversation, and I approach the conversation from the perspective that being vaccinated myself—and getting my family vaccinated—is the right thing to do for everyone I care about, including my patients. It is never about yelling or belittling a colleague who disagrees with me. It's about building trust: I listen to my vaccine-hesitant nurse colleagues and address their concerns one by one in a way that I believe may persuade them to trust the evidence and realize that being vaccinated is part of our responsibility to protect each other and our patients.

The CASE Model

I have found that it's much easier to have these conversations when there is a paradigm to follow. The paradigm that I have taught to countless colleagues is the CASE model for addressing vaccine hesitancy and communicating science. This model was developed by Alison Singer, president of the Autism Sci-

*For tips on speaking with patients, see “Improving Communication and Care: How Clinicians Can Increase Health Literacy and Equity” in the Spring 2021 issue of *AFT Health Care*: aft.org/hc/spring2021/roberts.

ence Foundation, who believes that high-emotion conversations like those about vaccination must be approached from a place of shared beliefs and a desire to find common ground.[†] The model has four steps: Corroborate, About Me, Science, and Explain/Advise. The rationale for patterning the conversation in this way is that people tend to make better decisions about vaccination when they receive relevant, credible, and comprehensive information about a topic; when they feel their concerns are heard; when they aren't belittled; and when they feel they have control over the decision.¹³

Corroborate: In this first step, you as the vaccine-committed nurse should acknowledge the other person's concern about vaccines and find something on which both of you can agree. This step is important because it sets the tone for a respectful, successful talk. We all have so much information coming at us from the news, social media, the internet, and other people, and it's all relayed with such conviction and passion that it's easy to get caught up in whether or not the information is actually based in science. But no matter what two people think about vaccines, there is always something both can agree on (for instance, you might agree that the amount of information is overwhelming!). And when you speak with kindness and genuine care and concern for the other person—as nurses are prone to do—barriers to successful discussions are often reduced.

About Me: Here, you describe what you have done to build your knowledge base and expertise to establish trust and credibility. In this step, I often mention that I have worked for a health department for 30 years and am very active in two national vaccine advocacy organizations: I am a nurse consultant for Immunize.org, and I'm on the Scientific Advisory Board of Vaccinate Your Family. I talk about the science-based news, journal articles, and studies that I have read and the many courses I have taken on vaccines. Because I believe personal stories are very powerful, I also tell the other person about my family history with vaccine-preventable diseases, and I disclose that I am vaccinated myself, along with my children and grandchildren.

Science: At this point, you've already centered your perspective in science, so in this step you describe what the science says. Talk about the studies conducted over time that have clearly shown vaccines are safe and effective and why you trust the science. I often mention here that I trust the science because I am a nurse scientist. Be careful not to overwhelm the other person by relying too heavily on scientific studies—it can be a turnoff for some. And remember that for every study you cite that supports immunizations,

they may cite a “study” that supports the opposite. If they do, discuss that study and be ready to talk about why its findings may not be scientifically supported or the best available evidence.

Explain/Advise: Finally, give advice to the other person based on the science. Explain that vaccines are critical to our health and well-being because they prevent diseases that cause real harm. Tell them that you want the same thing for them that you want for yourself: to be healthy and to protect yourself and others from vaccine-preventable diseases.

All conversations using this model should begin by asking the other person for permission to start a discussion. I often ask, “May I have your permission to tell you what I've learned about this vaccine?” When I have respectfully asked, I have never been refused. After each step in the model, I pause and ask, “Have I answered all of your questions?” I ask these questions using this wording because I believe they give the vaccine-hesitant person a sense of control in the conversation—and we all want to feel like we are in control and not being told what to do or believe. Some vaccine-hesitant people are already defensive, expecting to be told that they are wrong and that their fears and concerns will not be heard or addressed. Establishing respect and giving them control to steer the conversation helps remove these barriers to a successful discussion.

The CASE model can be used for conversations about any vaccine, but considering the COVID-19 pandemic of the last two years, this vaccine conversation is especially important. Here's how you could use the model to speak to a nurse colleague (or to a family or community member) who is hesitant about receiving a COVID-19 vaccine:

You [**Corroborate**]: I heard that you have some reservations about the COVID vaccines. I get it. These vaccines were made really quickly compared to other vaccines. Honestly, I was worried about it at first, too. I wasn't sure all of the usual testing was completed and all the right safeguards were followed.

Nurse Colleague: Yes! I'm really worried about how fast these vaccines were pushed through and the new technology. How do we know the science was done right?

You: We're worried about the same thing! We both want to make sure the science was done right. What other issues with the vaccine are concerning to you?

Nurse Colleague: Well, what about the testing? How do we know all of the safeguards were followed in testing the vaccine on people? And I'm also concerned the vaccines could cause damage and affect my ability to have a healthy baby.

You: Those are excellent questions. I know you're really just trying to figure out what's best for you. May I have your permission to answer your questions and tell you what I've learned about the COVID vaccines?

We need nurses to be vaccine champions and empower others to follow the evidence.

[†]Although the CASE model has not been empirically tested, it shares many features with promising approaches to patient-provider communication; for a review of these approaches, see “Communicating with Vaccine-Hesitant Parents: A Narrative Review,” which is available at go.aft.org/2v1.

Nurse Colleague: Yes, I'm interested in your perspective.

You [**About Me**]: I've read about all that had to happen for these vaccines to become available in the United States. I went to scientifically supported websites by the CDC and the Vaccine Education Center at Children's Hospital of Philadelphia and found that the COVID vaccines went through the same rigorous testing as every other vaccine. I searched for the best available evidence that COVID vaccines are safe and effective, and I found it on those sites.

I agree that the idea of "new technology" for the COVID vaccines can sound concerning, but I've learned that this technology has been around for more than 20 years.¹⁴ We haven't used it because it is expensive technology, and we had little need for it until now because we had vaccines that worked well and were cheaper to produce. But the testing process was not changed at all. The clinical trials were completed for this vaccine just as for all other vaccines. In fact, the COVID vaccines are being more closely monitored for safety than any prior vaccine.¹⁵

Nurse Colleague: OK. Maybe there's more to this than I thought. But I still have those other questions.

You [**Science**]: May I tell you another interesting thing I learned?

Nurse Colleague: *Nods in agreement.*



You: While COVID vaccines were certainly made available much more quickly than previous vaccines, this was only possible because massive financial and human resources were dedicated to this effort in response to the pandemic—but the vaccines still had to undergo the same safety testing as other vaccines. They were tested in tens of thousands of people, and the results of these tests were carefully reviewed. In the US, these reviews were completed by independent experts advising the Food and Drug Administration and the CDC. Billions of people have now received a COVID vaccine, and multiple systems are in place to make sure these vaccines keep being

safe.¹⁶ All the evidence points to the benefits of vaccination far outweighing the risks.

Nurse Colleague: OK, but what about the risk to fertility and pregnant women? I read on the internet that the COVID vaccines can cause infertility and damage fetuses.

You: I hear your concern about the effect an mRNA vaccine might have on fertility. I wanted to make sure I learned everything I could about that, too. To affect our bodies in that way, the mRNA would have to have access to our DNA. But I learned that doesn't happen. The mRNA never enters the cell where DNA is located, so it can't influence genes. And both the mRNA and spike

protein—the bit of coronavirus that helps it enter human cells—are only in our bodies temporarily.¹⁷ The CDC is currently studying the safety of the vaccines, and so far it has no evidence that they are problematic—in fact, the CDC advises pregnant people to get vaccinated.¹⁸ The most common side effect of the vaccine seen in pregnant people is a sore arm following injection. Have I answered all the questions you have about the vaccine and pregnancy?

Nurse Colleague: I think so. I didn't know all the science behind the vaccine.

You [**Explain/Advise**]: I didn't either, initially. But several of my friends and a family member suffered from COVID. With what we know about how serious this disease can be, I was excited to hear about vaccines being produced so quickly—but like you, I had concerns. Learning how rigorous the approval process was and how safe the vaccines are really calmed my mind. It's amazing that we have vaccines to help prevent this disease for those we love and care for. My family members and I have all gotten vaccinated. I hope you will, too.

Using CASE to Clarify Misinformation

As vaccine champions, we are empowered not only to share what we've learned about vaccines, but also to dispel myths and misinformation that could prohibit others from choosing to vaccinate. Myths about the COVID-19 vaccines abound; a few that have become widespread claim that they make our bodies magnetic, that they contain microchips to track our movements, and—as seen in the sample conversation above—that the vaccines alter our DNA and can harm pregnancies.¹⁹

The CASE model can be very effective when we hear another nurse mention something about vaccines that sounds incorrect. In this situation, we need to first be comfortable enough to ask where the nurse heard or read that information, and then go check out the source for ourselves. The rest of the conversation can begin from there. I believe that if nurses who are sharing misinformation can be engaged in an open, respectful conversation to discuss their fears about the vaccine, hearing about the best available evidence and receiving answers for their questions could make a difference in their thinking and stop misinformation in its tracks.

I experienced this recently, while I was volunteering to administer COVID vaccinations for my hometown's county health department. I was working with an obstetrics nursing colleague who had experience in the labor and delivery, newborn nursery, and postpartum units, in addition to being a childbirth educator. This colleague told me she'd seen a huge increase in infants with low birth weight since pregnant people had begun receiving the COVID vaccine, and she didn't think the number of pregnant people who had died from COVID could compare with the number of low birth weight infants.

“I’m very surprised to hear that,” I told her, “since so many people have lost their lives and/or their babies to COVID. But I hear your concern, and it would concern me, too. May I share with you what I’ve learned about pregnancy and the COVID vaccine?”

When she agreed, I mentioned that I daily monitor data that come directly from hospitals. I’d also read the CDC’s findings on this topic: those who contract COVID during pregnancy and have symptoms have a twofold higher risk of ICU admission and 70 percent increased risk of death compared with symptomatic people who are not pregnant.²⁰ What’s more, a very large study found no association between vaccination during pregnancy and preterm birth or low birth weight.²¹ In fact, the growing body of data shows just the opposite: the CDC’s COVID vaccine pregnancy registry, which tracks pregnancy outcomes of those who received vaccinations, has found no increased risk of miscarriage among those vaccinated before 20 weeks gestation and no safety concerns for those vaccinated later in pregnancy or for their babies after birth.²² Comparing these data against the known severe risks of COVID during pregnancy demonstrates that the benefits of pregnant people receiving a vaccine outweigh any known or potential risks.

“I believe the vaccine is safe and effective in pregnancy,” I told her. “I’m already vaccinated, but if I were

pregnant, I’d take it. And if my daughters-in-law were pregnant and had not yet been vaccinated, I’d recommend they get vaccinated as well. Have I answered all the questions you have?”

The nurse said that she’d never heard the evidence presented in that way, and our discussion had changed her thinking. I truly believe this was possible because we had a nurse-to-nurse conversation and she trusted me as a colleague. I also believe our conversation was a step in empowering this nurse to be a vaccine champion herself and make the case for vaccination with her colleagues and patients. This is what it’s all about!

Of course, not every conversation results in a changed mind or a decision for vaccination. If I can get the other person to even engage in a discussion, and if I can leave them with something to think about, that’s progress. But progress is impossible if I approach them as if they are crazy or intentionally trying to harm others with incorrect information. So instead of “Where on earth did you hear that? You’re wrong!” I tell them, “I’ve heard that, too. Can we talk about it?” Remember that we want a conversation, not a confrontation—and our vaccine-hesitant colleagues have the same good intentions for their families and patients as we do. Our goal is to listen to each other and find common ground from which to work together.

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Resources to Become a Vaccine Champion

Being vaccine champions means being fully stocked with resources and professional development opportunities to increase our knowledge and expertise. Many years ago, the CDC realized that no immunization program would be successful unless there was buy-in from nurses, who administer the overwhelming majority of vaccines.

My very dear friend, Dr. William Atkinson, a medical epidemiologist retired from the CDC—and known across the country for championing nurses as the managers of vaccine practice—developed a course in 1995 with Dr. Walter Orenstein, then director of the CDC’s National Immunization Program, to help nurses become vaccine champions. The Epidemiology and Prevention of Vaccine-Preventable Diseases course, known as the Pink Book course, was originally offered by the CDC through local health departments as a two-day onsite training. It is now available as a webinar series provided in one-hour increments (and continuing education credits are available through July 1, 2022). I believe every nurse should take this course. We never know when an immunization question will arise

from our colleagues, our family members, or others in our community, and we need to be prepared with answers. For more information, visit cdc.gov/vaccines/pubs/pinkbook/index.html; for the webinar series, go to cdc.gov/vaccines/ed/webinar-epv/index.html.

There are many other resources that provide excellent evidence-based information about vaccines. Here are some of my favorites:

- *National Center for Immunization and Respiratory Diseases (NCIRD)*. A division of the CDC, the NCIRD maintains a website with comprehensive information and resources on multiple vaccine-preventable bacterial and viral diseases: cdc.gov/ncird/index.html.
- *Immunize.org*. This easy-to-navigate site is the best place to find current training materials, patient screening questionnaires, translations of CDC-required vaccine information statements in multiple languages, and more. I think of it as the “nurses’ vaccine information depot”: immunize.org.

- *IZ Express*. This free weekly email by Immunize.org delivers timely immunization updates. It includes courses being offered, conferences, and a compilation of all the relevant information coming from the CDC and current published evidence-based data in an easy-to-read format: immunize.org/express.
- *Vaccine Education Center (VEC) at Children’s Hospital of Philadelphia*. Headed by Dr. Paul Offit, a national expert on vaccine safety and practice, the VEC provides regular and timely web talks on vaccine issues and continuing education for healthcare providers: chop.edu/centers-programs/vaccine-education-center.
- *Vaccinate Your Family (VYF)*. The language used throughout the VYF website is intentionally structured so that any reader can understand the most complex issues related to vaccines. The site is visually engaging with easy-to-find sections specific to babies and young children, adults, pregnant people, older adults, and others: vaccinateyourfamily.org.

—M. K.-P.



Empowering Each Other

When nurses empower each other to be vaccine champions, we can make an unbelievable impact to prevent disease in our communities. Several years ago, I worked for the Suffolk County Department of Health Services in New York, in a health system that included eight primary care centers and a skilled nursing facility. Part of my focus was improving the influenza vaccination rate, which at that time was 20 percent across all facilities. Knowing that success could

only happen if we approached the problem together, I reached out to all of the facilities' nursing supervisors to talk about why the rates were so low. The supervisors believed healthcare workers needed greater buy-in as team members in the effort to protect themselves and their patients from influenza. So we got to work, building the trust and having the conversations necessary to make a difference.

Each supervisor provided opportunities for healthcare workers to receive influenza vaccinations at their facilities during work hours. They also discussed the vaccine with each nurse and staff member, emphasizing the responsibility each had as healthcare workers to protect patients from influenza and answering questions about the effectiveness and potential side effects of the vaccine. One by one, the nurses and other staff began to get vaccinated. They would trade off and cover each other's patients or duties for the time it took to get vaccinated. Once a vaccinated employee returned to duty, another took their place in line for vaccination. It became a contest to see which facility could get the most healthcare workers vaccinated in the shortest period.

In one year, the vaccination rate across all facilities rose to 60 percent—but the project didn't end there. The nurses continued to work together over the ensuing years to bring staff immunization rates up over 90 percent. This was a clear case of nurse empowerment,²³ and the Suffolk County project became a model for the CDC and the national paradigm for staff immunization programs.²⁴ This is what can happen when nurses own vaccination. And the more we do it, the easier it becomes.

We nurses can do this work. We can start by getting vaccinated ourselves, and then we can use our incredible influence to empower each other to follow the evidence and serve as examples for our communities. We can muster the nerve it takes to start these crucial conversations. My experiences watching my mother and grandmother suffer from now-preventable illness and death are what give me the nerve every day to start

these conversations—and I have no doubt you have similar stories to lean on. We owe it to ourselves. We owe it to each other. +

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Fighting for Our Patients and Our Profession

Two Experienced Nurses on the Staffing Crisis

As the COVID-19 pandemic stretches into its third year, providing patient care and services has become increasingly challenging for nurses and healthcare workers. Vaccine hesitancy and lack of access continue to drive surges of illness that overwhelm the healthcare system and care providers. The addition of these extraordinary stresses, on top of long-term problems due to profiteering and the resulting inadequate staffing, has created a crisis of epic proportions.

Moral injury is now far too common, and healthcare professionals are questioning how much more they can endure. As Patricia Pittman explained in the Spring 2021 issue of *AFT Health Care* in “Moral Injury: From Understanding to Action” (available at aft.org/hc/spring2021/pittman), moral injury is a systemic problem. It demands collaborative, systemic solutions—including reallocation of resources in the healthcare industry to focus on patient care, healthcare for all, and providers’ working conditions.

Here, we learn from two longtime nurses—Barb Pomasl, a recently retired ICU nurse who is on the bargaining team for the Wisconsin Federation of Nurses and Health Professionals (AFT Local 5000), and Bill Garrity, the president of University Health Professionals (AFT Local 3837) and an emergency department nurse in Connecticut—about how the worsening strain in their workplaces has impacted their view of the future of the profession.

The articles that follow, by Rebecca Kolins Givan (page 16) and by Peter Lazes and Marie G. Rudden (page 22), explore the kinds of collective action you as frontline unionized workers can take now to fight for your patients, for your profession, and for a healthier and safer world for everyone.

—EDITORS



EDITORS: The enormous challenges we see bedside nurses and other healthcare workers facing now existed pre-pandemic and have only been exacerbated in the last two years. Can you talk about these challenges from your lived experiences?

BARB POMASL: I’ve been in nursing for 37 years, and most of that time was spent in the intensive care unit (ICU) of Aspirus Langlade Hospital, a 25-bed critical access hospital in northern Wisconsin. We are the only hospital in all of Langlade County, and the employees are part of the community. Not a day or even a shift goes by without seeing a patient who is somehow related to or knows a staff member. So we have a vested interest in the hospital. But the hospital does not invest in us.

“We are simply asking to be paid fairly and treated as professionals, but we are treated as if neither we nor the work we do every day matters.”
—Barb

We have been fighting for the same issues—safer working conditions (which are also patient care conditions) and adequate wages—for years. Yet, hospital management continues to be more concerned with lining their pockets than with what our patients and the people who care for them need. They were already cutting back our staffing before the pandemic so that they could improve their “productivity”; to me that translates into cutting staff to make more money. Of course, a hospital must be fiscally responsible to survive, but patients suffer when we cannot care for them safely or when we struggle to give them the standard of care we were trained to provide; this is not acceptable.

We have given our all to our patients for years, and Aspirus has repeatedly demanded more while cutting our supports from under us. We started bargaining for our upcoming contract in October 2021, which has been difficult and demoralizing. By February (when this issue was going to press), management had only offered us a 2 percent increase—meanwhile, between 2019 and 2020 alone, when frontline workers were risking our lives and health for our patients, executives earned between 12 and 27 percent increases.¹ We are simply asking to be paid fairly and respected as professionals, but we are treated as if neither we nor the work that we do every day matters. This is emotionally, mentally, spiritually, and physically exhausting, and there is only so much we can take. I am only 59 years old, but I retired at the end of 2021. I had to do it for the sake of my mental health. I still fight for nurses as part of the bargaining team, but I feel guilty every day for leaving my patients and my coworkers behind in that environment.

BILL GARRITY: I have been a nurse for 32 years, and 25 of those have been with the state of Connecticut. When I started, I was doing bone marrow transplant and oncology nursing, and then I spent about five years in the emergency department (ED) before I was elected president of University Health Professionals (UHP). I am in my sixth year as president, and I am also the AFT Connecticut divisional vice president for public employees working with the State Employees Bargaining Agent Coalition.

Every one of us has felt the toll of our working conditions through this pandemic, whether it be the loss of a family member, problems with the consolidation of healthcare facilities and systems, or just dealing with immoral people who keep asking us to do more with less. Many of our members just cannot handle it anymore. I have actually had suicide prevention talks with my own members.

I am afraid to think of where healthcare is headed because of privatization. Hartford HealthCare, which is the big guy here in Connecticut, has been eliminating services from smaller hospitals to send the money-making procedures to Hartford Hospital (“the mothership,” as we call it here). And patients are paying the price. I lost my father-in-law in Janu-



NATHAN HOWARD / GETTY IMAGES

ary because of this. He had a heart attack in the middle of the night, and the local EMS took him to New Britain General, a satellite of Hartford Hospital. He would have been better served at Hartford Hospital, which has the most extensive cardiac services, but it could not take him because of the omicron surge. While he waited for days in the ED at New Britain for a transfer to another hospital, he developed a fever—and he died waiting for a procedure that could have saved his life.

We see this kind of thing more and more in health-care as big conglomerates take over and essential services are moved from smaller community facilities to regional giants. I don't see an end in sight. Instead, I hear management talking about capping nursing salaries because of the expense, while agencies for travel nurses are extorting money from hospitals that could be used to pay nurses appropriately.

We are also in contract negotiations (as of February, when this issue was finalized for press). Management originally offered a 1 percent increase for a three-year contract. Of course, there was no hazard or pandemic pay, despite the fact that we endure mandatory overtime and an on-call system. They just keep demanding more and more from us without valuing our work or the toll that it is taking professionally and personally.

BARB: This is not rocket science. Pay nurses what we deserve and increase staffing so we can take care of our patients and do our jobs properly. Most hospitals have the money. During our bargaining, Aspirus's lawyers told us, “It is not an inability to pay you; it is an *unwillingness* to pay you.” How does that make us feel? It is no surprise that many of us cannot continue working in that environment.

EDITORS: Can you share a few details about the challenges nurses have been facing?



PPE when going from one patient to another, where were they to step in and say, “This is completely inappropriate”? This is not the good infection control that we were taught.

There were so many other changes from one day to the next with poor or no planning. Management would open an overflow COVID floor without people to staff it, then pull staff from other units to work the floor but give them no equipment. We quickly got tired of hearing them say “Just do your best.” We were the ones at the bedside when things went wrong due to the hospital’s failure to plan or to give us the resources we needed.

More recently, a challenge arose over COVID testing for staff. In one of our hospitals, some staff who got COVID had PCR test results that were still positive after five days. Management’s answer was to try different tests until the result is negative so we can bring staff back to work earlier. These decisions make no sense.

BARB: Nursing is a huge job to begin with, but when the pandemic started, suddenly we were expected to do everything. We absorbed all of the other disciplines because no one else was allowed into COVID patients’ rooms. Therapies, dietary, maintenance, housekeeping—we were doing it all. I never ended my shift on time because I knew that my patients needed hands-on care and I was doing as much as I could for them. You cannot change the standard of care during a pandemic. If you are not doing the right things, people are going to die.

BILL: And caring for patients has become more challenging because acuity levels are more significant and staffing ratios are even worse. During the worst surges, our ICU ratios tripled—not just in our health system, but around the state. So an ICU nurse who should have had one patient too often had three. And while the hospital tried not to have nurses caring for COVID-positive and COVID-negative patients simultaneously, that was impossible in many units.

BARB: On top of this, we were dealing with uncertainty about our own safety. Early in the pandemic, hospital protocols for personal protective equipment (PPE) were changing every single day and sometimes within the same day. Sometimes the changes would be posted on Friday afternoon at four o’clock after management left, so there was no one to answer our questions.

BILL: In the hospitals where my members work, many managers and administrators were not there to begin with; they were working from home while we were risking our lives. And where were the Joint Commission and the Occupational Safety and Health Administration when we needed them to answer questions and provide guidance? When we were being told to save all of our N95s in paper bags or to wear the same

EDITORS: You both have been in nursing for a long time. How were working conditions different for bedside nurses 30 years ago, before the rise of corporatization and profiteering in healthcare?

BILL: We move patients in and out of care much more quickly now than 30 years ago. I started out on a 34-bed orthopedic unit, on night shift with a 12-patient assignment. That sounds like too many, but on any given night, some of my patients were waiting for surgery the next morning, and others were staying with us for up to a week after their surgery, so while the patient load was high, the work was very manageable. Now procedures like total hip or knee replacements are almost same-day surgeries, so patients are in and immediately out. In fact, because the recovery time is so much shorter, sometimes the hospital is forcing these patients out before they have all the anesthesia out of their systems.

Everything is about acuity and moving patients faster and faster. In the ED, we are measured by “door-to-balloon” times to save patients, and in some of our best-case scenarios we are under 20 minutes. This means that a patient is on a table for a procedure to clear their heart or a vessel in their brain within 20 minutes of coming through the emergency room door. That’s the kind of result the hospital is looking for, and the pressure it puts on healthcare workers is brutal because the demand has not been met with adequate staffing levels. This type of pressure is why we have nurses who are committing suicide or thinking about suicide.

BARB: I first started on the medical-surgical unit night shift, and we could have up to 18 patients. But like Bill’s, some needed very little; they were pre-op or prepping for a colonoscopy. Patients also stayed longer, so we had time to get to know their unique needs.

“Many of our members just cannot handle it anymore. I have actually had suicide prevention talks with my own members.”
—Bill



NIC COURTY / BLOOMBERG VIA GETTY IMAGES

**"I wish more people knew the burden nurses are carrying. We love caring for our patients, but it is dangerous work."
—Bill**

Over the years, patients have gotten sicker and sicker, but they are in the hospital for much less time. We are expected to get them better and get them discharged quickly. It is much more work—and dramatically harder—to care for patients this way. It requires expertise, particularly the ability to read patients and know what they need much faster.

BILL: This is where hospitals are often dishonest about staffing needs. They will say, for example, that an oncology nurse can care for up to 6 patients. Well, at any given minute, that nurse may have 5 patients, but during a 12-hour shift they will actually care for 14 different people: 1 existing patient who stays, 4 who are discharged, 3 who are admitted, and then 6 who need care while a coworker takes a lunch break. But the hospital will claim that staffing is adequate because not all of that nurse's 8 patients were there at the same time, and the additional 6 were only while briefly covering for a coworker. Management needs to think more carefully about what such claims mean for patient care.

In obstetrics, some administrators want to consider mother-baby couplets as a single patient. Giving a nurse nine patients in this case means they are actually caring for nine mothers and nine babies. It is an impossible expectation.

BARB: Having safe and reasonable patient-nurse ratios is so important, but so is acuity, which I think is a much more accurate way to assign patients, especially in the ICU or ED. Lowering the ratio means little if the hospital does not take care of the employees it has to ensure they are satisfied and stay to provide the excellent care they always have.

The hospital's refusal to see this underscores that while we have improved patient care significantly in the last 30 years, what has not really changed much is the treatment of nurses. When I started out, nurses were seen as subservient. If a physician was around, we were expected to get up and let them have our chairs. And we have been subjected to verbal abuse from patients and families for years.

BILL: Nurses may be the most trusted profession, but we are certainly not respected. More and more frequently, we are personally attacked. We are hit, bit, spit on, and urinated on by patients, and family members take out their stress on us.

It is unacceptable to treat us this way. Yet, because we are professionals, it's tough to get nurses to walk away. We stay past our shifts, stay through the abuse, without support from our employers, until we just burn out. A nurse reached out to me some time ago to tell me that she had clocked out after 18.5 hours. According to our state law, you cannot work more than 16 hours. When I asked why she stayed, she said, "I couldn't leave. My work wasn't done." And that is exactly what the healthcare system expects from us. This job uses nurses up until there is nothing left.

BARB: I think the public needs to be more aware not only of what a nurse does but also that nursing is a profession, and we have a lot of education. We do so much more than pass out medication. We are the last line of patient advocacy. If something is going wrong with a patient, it's the nurse who knows about it, not the physician who saw the patient briefly. We read labs and know what can be expected to change in the patient's condition based on the results. We oversee all aspects of their care. If a physician orders an incorrect dose, the nurse is one of the people most likely to catch it and correct it.

I also wish more people knew how much assessment and monitoring a nurse is continually doing for each patient—so increasing our patient load has serious consequences. Adding just one patient to the workload increases the risk of patient mortality by 7 percent²—but it's common for hospitals to increase the load by two or three patients, especially for night-shift nurses.

BILL: I wish more people knew the burden nurses are carrying. We love caring for our patients, but it is dangerous work. In addition to the unsafe patient loads, you never know what situation you are about to walk into with any given patient. Not long ago, a younger nurse

who I was training asked me to help her deal with an intoxicated, combative patient who was climbing out of bed in the ED. I approached him, put my knees right up against his, and tried to get him to calm down and lie back. Then the nurse realized he had a gun, and he started to reach for it. I jumped on the bed to hold him down, and another nurse called our in-house police. Thankfully, they arrived immediately and took control of the weapon and the situation.

Sharing this incident stresses me out even now. Nobody should have to experience that. But some hospitals do not even have security—yet another key issue in the systemic short staffing we are suffering.

EDITORS: You have both seen nurses leave the bedside in recent months as a result of these challenges—some of whom have been in the profession for decades, just as you have. What is lost in nursing and in patient care when longtime nurses leave?

BILL: What is lost is our institutional knowledge. Longtime nurses know the history of our hospitals and our units. When new managers come in and try to make changes without understanding the reasons certain practices have been established, it is important to have someone who was there the first time that change was suggested to keep mistakes from being repeated.

We also have considerable union knowledge that helps us look out for each other. Younger nurses can be easily manipulated by management if they do not know their contract, but that is more difficult with experienced nurses. Right now, between myself, my first vice president, and my chief steward, we have over 70 years of union knowledge with which to help our members. My first vice president is retiring this year, and I am dreading the loss of that invaluable knowledge.

And then we also have very significant patient care knowledge. The large corporate hospitals love to use the “See one, do one, teach one”³ adage for precepting new nurses, but when seasoned nurses leave, the task of precepting can fall to someone who has only been in the job for months. Without our experience, new nurses may know the theories of patient care, or they may know policies and procedures, but they do not know the ways care is actually delivered at the bedside.

BARB: So much patient care knowledge is lost. With 37 years of experience, I am able to tell when a patient is declining much earlier than a nurse who has only been practicing for a year or two. We had to temporarily close our ICU in October 2021 because we could not staff it. We moved ICU patients into the ED, but ED nurses are not trained to be ICU nurses. Management said, “Just go down and show them. See one, do one, teach one.” But it does not work that way. Now that I have retired, all of the ICU nurses have fewer than five years of experience. I recently spoke with a new nurse who graduated last June and is already burning out,

questioning why she is in this field, because there is no one left with the experience to help her when patient care grows challenging. Newer nurses cannot teach what they don’t know.

Ideally, those of us with decades of experience would not leave but would transition into teaching roles, providing the training at the bedside that is lacking in nurse preparation today. But that would mean a reallocation of resources that, so far, hospitals have been unwilling to do. When I retired, I offered to stay on at Aspirus Langlade to do orientation and train some of the newer ICU nurses who were coming in. Management was not interested; they were too focused on the money an “extra” nurse would cost them.

EDITORS: What changes do you need to see in healthcare before you’ll recommend nursing to others as a great profession?

BILL: I don’t know that I could tell someone that this is a great job anymore. Too much would have to change. We would have to see an end to privatization and profiteering and a meaningful investment in patient care and providers’ working conditions, including fair wages and national staffing legislation that includes accountability. For now, I have to have uncomfortable conversations with my members. As a union leader, I have to tell them that nurses are here for the patients and the benefits, but we are not here for the pay. I have to tell them that if they want more money, they can take a travel contract—but they will be burned out in a few years. The system has been designed this way and must be completely redesigned.

BARB: The entire healthcare system needs major reform. My heart breaks for our young nurses. My granddaughter is 28, and she did not listen when I warned her not to go into nursing. She works at the same hospital I did, in our medical-surgical unit, and I can hardly bear to think of everything she will have to live with in this profession over the next 30 years.

Of course, that is only if she stays and the environment doesn’t change. I do not see how she will be able to stay long because the money is not in the right place. Profit, not patient care, is the center of healthcare. We need a radical shift in priorities to remember that we are here for the patients, not to line executives’ and investors’ pockets. Until this shift happens, patients and frontline staff will continue to suffer the consequences. +

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“We need a radical shift in priorities ... we are here for the patients, not to line executives’ and investors’ pockets.”
—Barb

Organizing on the Frontlines



Improving Patients' Care and Workers' Conditions

By **Rebecca Kolins Givan**

Rebecca Kolins Givan is an associate professor of labor studies and employment relations in the School of Management and Labor Relations at Rutgers, the State University of New Jersey, and president of the Rutgers AAUP-AFT. She is the author of *The Challenge to Change: Reforming Health Care on the Front Line in the United States and the United Kingdom*.

Shanon Pereira had taken every precaution to keep herself and her family safe from COVID-19—but as a nurse at Backus Hospital, where the supply of personal protective equipment (PPE) was so inadequate that she had to reuse an N95 mask that she stored in a paper bag, it felt like it was only a matter of time. “Reusing PPE until it’s broken or visibly soiled is the reason that my family and my coworkers became ill,” she said. “We deserve safety, protection, and respect.”

Instead, Pereira got blame. Backus Hospital insisted that the repeated COVID-19 outbreaks among staff were due to lapses in proper use of PPE. It was only the latest in a series of cascading issues that compromised staff safety and patient care in the years since Backus was bought by Hartford HealthCare and hospital priorities shifted from patients to profits (or surpluses, as profits are euphemistically known in the non-profit sector). This outside focus on the bottom line meant that wages were dramatically lower than at neighboring hospitals—14 to 16 percent on average—which made it difficult to hire or retain nurses. The resulting chronic staffing shortages left nurses overworked, exhausted,

and struggling to care for their patients. Even with these problems and the additional strain of the pandemic, the employer had been dragging its feet at the bargaining table for months, leaving nurses working without a contract.

In October 2020, the Backus Federation of Nurses (AFT Local 5149) went on strike for 48 hours. Just over a week later, they had a new contract with significant pay increases and better workplace protections, which they expect will help with staff retention and patient safety. “We choose to strike only when it becomes a life-or-death situation for our patients,” Pereira said. “I would rather be at the bedside ... caring for my patients, ... but we cannot allow unfair labor practices to continue. We will not back down when it comes to protecting safe patient care.”¹¹

Healthcare workers like Shanon Pereira have always been our leading experts on the strengths and weaknesses of our healthcare system. For decades, they have sounded the alarm about their struggle to provide patients with the care they need because of the inappropriate distribution of

resources and the perverse incentives built into the entire system.²

The COVID-19 pandemic has demonstrated that our healthcare system is not fit for protecting public health. We have seen clearly that the system was not built for pandemics, but a larger and more essential point has also emerged: the system was not built to provide needed healthcare to all of us or to improve the health of our society as a whole. Rather, our fragmented, profit-driven healthcare system allocates care on the basis of the patient's ability to pay (or the system's ability to profit) and depends on healthcare workers who consistently endure high levels of stress from striving to provide adequate care in the face of dire need.*

Nurses working through the pandemic have experienced unimaginable hardships. They have faced high patient mortality rates and have endured mental and physical exhaustion as they race to respond to all patient needs. They have risked their own health and the health of their family members, and they have worked in hospitals and nursing homes that initially had insufficient supplies of PPE. The mortality of healthcare workers due to the pandemic has been high,³ with death rates amplifying other societal inequities; for example, the large number of deaths of Filipino nurses demonstrates the cumulative impact of structural disadvantages for immigrant workers of color in a system that perpetuates health inequities.[†]

For nurses and other health professionals who had been drawing attention to insufficient staffing levels for years, the pandemic proved yet again that they were right in focusing on the link between staffing levels and patient care—but being right provides cold comfort. The experience of the pandemic has confirmed that the needs of patients are firmly aligned with the needs of healthcare workers: what's good for one is good for the other.

For years, the immense challenges to nurses and the crises in morale and job tenure have been categorized by observers as burnout. This description, however, elides the longstanding systemic problems in nursing and in healthcare organizations. Among other issues, the shifts in hospital management policies toward lower staffing levels, higher patient loads, and stagnant wages make it nearly impossible for nurses to provide adequate patient care; ultimately, these shifts may drive as many as 40 percent of nurses away from the profession.⁴ And yet, we have known for 20 years that sufficient staffing alleviates this “burnout”

while also improving clinical outcomes.⁵ Sufficient staffing levels may even have a more significant positive impact on job satisfaction and tenure than pay.⁶

More recent analyses have recast the problem of burnout, which occurs on an individual level, as *moral injury*, the complex psychological and emotional harm that results from working in a system that makes it so difficult to provide the needed level of care to patients.⁷ In unsupportive environments, the strain of the moral injury becomes a self-reinforcing, vicious circle. Nurses feel unable to fully care for their patients, in part due to low staffing levels, and their confidence in their employers and their affinity for their own workplaces diminish. To meet minimum staffing requirements, hospitals are spending more and more on travel nurses (as travel nurse agencies make a profit for every hour their nurses work) and have less money remaining to pay their committed nurses.⁸ As stable, permanent nurses are replaced with travel nurses, the strain on the remaining permanent nurses becomes more severe; they are tasked with training the newcomers to their workplaces, all while knowing that these newcomers are taking home much higher wages. As the work environment deteriorates further and the wage disparity becomes more extreme, the temptation to take a more lucrative contract or a travel nursing job—or to leave the profession entirely for something less stressful—only increases. In this vicious circle, some immediate patient care challenges may be met, but the long-term, systemic problems that cause harm to nursing staff and affect their ability to provide care remain.

It's no surprise to nurses that hiring and deploying more staff improves patient care and in turn prevents moral injury—or that healthcare workers' firsthand knowledge of systemic problems affecting the day-to-day work of patient care makes them uniquely qualified to devise solutions. But what may surprise many healthcare workers is that they have the power to fight back. How? By organizing. As Patricia Pittman put it in the Spring 2021 issue of *AFT Health Care*, “Nurses, along with other healthcare providers, need to elevate the discussion of moral injury to a system-level conversation about solutions. Until the major sources of moral injury are addressed across many different practice settings, a large segment of the nurse workforce will continue seeking to reduce their work hours and even leaving the profession as soon as they can.”⁹ While leaving the profession is understandable in the face of these challenges, growing the union movement in healthcare offers a better path forward—one that allows patients and workers to have the care and conditions they deserve. In the terms of classic industrial relations research, workers can choose *voice* rather than *exit* if they stay and organize to improve their workplaces. Collective action has the power to address the sources of moral injury both individually and at the system level.

A growing body of research shows that unionizing is good for both healthcare workers and patients.

*For a comprehensive plan to reform our healthcare system and provide universal access to quality care, see “COVID-19: From Public Health Crisis to Healthcare Evolution” in the Fall 2020 issue of *AFT Health Care*: aft.org/hc/fall2020/kitzhaber.

†For more on the challenges Filipino nurses face in the US healthcare system, read “Investing In Our Future: Learning from Our History to Build a Healthier, More Equitable Society” in the Fall 2021 issue of *AFT Health Care*: aft.org/hc/fall2021/bailey_moon.

The Union Advantage for Patients

Healthcare unions have always served a dual purpose, advocating for the ability to provide the care that patients need while also providing crucial protections for employees. Even so-called bread-and-butter issues like pay and benefits are directly linked to patient care: when nurses and other healthcare workers cannot afford to remain in their jobs, or when low pay leads to recruitment challenges and insufficient staffing, patient care suffers.¹⁰ In contrast, a workplace that provides a supportive environment also enables these workers to provide the care their patients deserve. Unions ensure a safe voice on the job so that workers can speak up when they notice a problem without fear of retaliation. Unionized workers tend to stay in their jobs longer, and lower turnover means more experienced nurses are at the bedside every day caring for patients.¹¹ So, it should come as no surprise that a growing body of research demonstrates that the presence of a union improves the quality of patient care.



Just as it's possible to rigorously evaluate the impact of medication and other clinical interventions on patient health outcomes, it is possible to look at the link between organizational factors and patient outcomes.¹² We know, for example, that better work-life balance for workers can lead to better outcomes for patients.¹³ And we also know a great deal about the empirical effects of unionized workers on clinical care, as directly compared with patient care outcomes in nonunion workplaces.

A foundational study examined the link between the presence of a union for nurses and a patient's likelihood of surviving a heart attack. The authors found that the presence of a union increases wages for nurses, which had a positive impact on patient care.¹⁴ And, after rigorously examining other possible explanations and confounding variables, they concluded

that registered nurse unionization reduced heart attack mortality by 5.5 percent.¹⁵

A more recent study looked at multiple clinical outcomes and compared similar hospitals—those with successful and unsuccessful union organizing drives—to analyze the specific ways nurses can have an impact on patients. It found an improvement in the quality of care following unionization. Accounting for the fact that poor patient outcomes may lead nurses to organize a union in the first place, the researchers concluded that “hospitals with successful union elections in California during the 1990s and early 2000s had been experiencing declines in patient health outcomes relative to the average hospital prior to the election. But following the election, hospitals with union victories performed better relative to those in which the union lost.”¹⁶

In examining the difference between COVID-19 mortality rates in nursing homes in New York state, another study showed that residents of unionized nursing homes were less likely to die during the pandemic. Facilities with unionized staff saw mortality rates that were 1.29 percentage points lower, which amounted to “a 30 percent relative decrease in the COVID-19 mortality rate compared with facilities without these unions.”¹⁷

Taken together, these studies should assuage any concerns that unionized workers prioritize their own needs and interests at the expense of the needs of their patients. It's clear from this growing body of research that unionizing is good for both healthcare workers and patients.

But even in the face of this clear evidence, many employers pump a huge amount of money into stopping their employees from unionizing and, when there is a union, attempt to negotiate contracts that do not prioritize resources for quality patient care. Strong worker voice threatens management's ability to impose unilateral policy changes that protect the bottom line at the expense of both patients and staff. To fight this profiteering, healthcare workers must band together to achieve systemic changes that prioritize patients.

Organizing for System-Level Change

By protecting individual professionals through the enforcement of contractual rights, unions allow nurses and other healthcare workers to exercise professional judgment and provide patients with the care they need. But individual protections cannot bring about systemic change. Through strategic use of their collective power, unionized healthcare workers can bring about broader changes in their workplaces and can also work to transform or at least improve the larger healthcare system. While it is never easy, collective action is the only path to bringing about these changes in the face of powerful, well-funded opposition. And it is the only true solution: frontline workers—not administrators, lobbyists, or policymakers—have the

The Union Advantage During the Pandemic

The systemic issues that affect patient care and staff safety have taken on new dimensions and even greater urgency during the COVID-19 pandemic. Two recent examples—at St. Charles Medical Center in Bend, Oregon, and at Jersey Shore University Medical Center in Neptune, New Jersey—show how local healthcare unions have harnessed the power of collective action to protect themselves and their patients.

Winning a Fair Contract

The technical professionals at St. Charles Medical Center in Bend voted to join the Oregon Federation of Nurses and Health Professionals (OFNHP), AFT Local 5017, in September 2019, seeking more equitable compensation, an end to scheduling abuses, and safer working conditions.¹ But after dozens of bargaining sessions over 15 months—and nearly a year into the deadly COVID-19 pandemic that amplified the demands and stresses of their jobs—they still didn't have a contract.

St. Charles's refusal to negotiate in good faith wasn't out of character. As the largest employer in Central Oregon, the St. Charles Health System has outsized power and a long history of taking advantage of staff. Labor disputes have cost St. Charles more than \$10 million since 2013, and it has earned a reputation for union busting that it lived up to in this case: while St. Charles gave Bend techs 1 to 2 percent raises during the unionization campaign in an attempt to defeat it, in the months following the vote, it gave 10 percent raises to nonunionized techs at other locations to punish the Bend techs and discourage further organizing.² Trying to avoid settling a first contract is a typical anti-union tactic, and St. Charles was following the standard anti-union playbook.

In February 2021, Bend techs notified St. Charles of their intent to strike; when even that didn't bring management back to the bargaining table, the techs walked out on March 4, 2021, with the support of

their coworkers,* the community, and fellow unions.³ After nine days, OFNHP and St. Charles agreed to end the strike, and by the end of March OFNHP had secured a three-year contract that included raises of up to 25 percent, pay equity clauses, a grievance procedure, protections against the abuse of mandatory overtime, and more. When workers walked back into their workplace, they had won more than just a contract for OFNHP members. "We gained representation, unity, and a voice in our workplace," said ultrasound tech Dee Dee Schumacher.⁴ Radiation therapist Beatrice Redding-Walczyk agreed, noting that the workers finally have "a little bit of forced respect."⁵

Standing Up for Safety

The nurses at Jersey Shore University Medical Center, members of Local 5058 of Health Professionals and Allied Employees (HPAE, an AFT affiliate), endured unimaginable stresses and trauma during the first surge of COVID-19 in the spring of 2020. New Jersey was one of the states hit hardest by the pandemic. These nurses cared for thousands of COVID-19 patients in a hospital unequipped to deal with the sheer numbers of the sick, isolated from their families to avoid risking infection, and held dying patients' hands when loved ones could not—in many cases without adequate PPE. When staff raised safety concerns with the hospital, the hospital retaliated. In April of 2020, HPAAE Local 5058's former president Adam Witt was fired after he stepped up to defend a fellow nurse who was being disciplined by the hospital, prompting HPAAE to file both a grievance and a complaint with the National Labor Relations Board.⁶ (Witt was reinstated in a December 2021 arbitration decision.)⁷ HPAAE members filed numerous complaints to the Occupational Safety and Health Administration about unsafe practices

*For an inspiring video of the medical techs being cheered on by their coworkers, visit go.aft.org/u1x.



and insufficient PPE as the unsafe working conditions continued.⁸

As the spring wore on, Jersey Shore nurses faced the further indignity of being hailed as heroes by their employer in public while being stonewalled at the bargaining table as they tried to negotiate a new contract. HPAAE nurses had hoped that the hospital would respect their hard-won wisdom about how to protect staff and care for patients during the pandemic, but the employer remained unmoved at the table.

In late May 2020, with the end of the contract approaching, nurses voted overwhelmingly to authorize a strike.⁹ On June 22, with bargaining at a stalemate, nurses held an informational picket in front of the hospital, joined by their families, members of the community, HPAAE President Debbie White, and AFT President Randi Weingarten.¹⁰ The attendance at this picket was very high: Local 5058 turned out record numbers to walk the picket line that day, even in the midst of a pandemic.

By the first week of July, the local had a new contract that gave nurses a voice during pandemic surges, an average wage increase of 17.5 percent, and additional financial incentives to help with staff recruitment and retention.¹¹ By demonstrating that their strike threat was real and engaging in an informational picket, they showed hospital management that they were willing to strike if that was needed to achieve a contract that prioritized patient care. "We definitely have more work to do," said Local 5058 President Kendra McCann, "but we showed the employer, at that time, that we were able to mobilize when necessary to effect change."¹²

—R. K. G.

Endnotes on page 40

Local healthcare unions have used collective action to protect themselves and their patients during the pandemic.

experience, insights, and expertise to understand where and how these systems must change in order to better serve their patients.¹⁸

Unionized workers have three main types of collective action in the fight for systemic change: bargaining (and sometimes striking) to achieve strong contracts; enforcing the contract by using the grievance procedure; and advocating and mobilizing to achieve legislative changes that may improve all workplaces, not only unionized workplaces.

groundwork, with workers exercising power at the bargaining table before contemplating a strike. Healthcare workers can test strike readiness by embarking on a series of escalating actions through which fellow union members demonstrate their willingness to take a public stand in service of their goals. These actions might include signing public petitions, posting their views on social media, reaching out to community members and elected officials, participating in rallies, and/or attending public or open bargaining sessions. All of these actions enhance the union's bargaining position—and can amplify its advocacy initiatives. They also send strong signals to administrators and legislators: If healthcare workers remain unified as their actions escalate, then they are well organized and prepared for a long fight at the bargaining table, on the streets in a strike, or in the legislature. But if workers do not feel able to participate in smaller-scale collective action, they are unlikely to stay out of work for an uncertain period or to engage in sustained advocacy.

The three paths to improvement—bargaining, enforcing the contract, and advocating and mobilizing—can work as complements. No one path solves all the problems in any healthcare workplace, let alone all workplaces. But the collective strength of unionized workers provides a crucial resource for using all three paths to achieve sustainable, systemic improvements to patient care.



Frontline workers have the experience and expertise to understand how systems must change to better serve their patients.

Each action has strengths and weaknesses. When used together, each of the three can complement and reinforce each other, offering alternative routes to realizing improvements. For example, a strong contract is powerful—in practice it can provide a policy that is more enforceable than a state or federal law because using a contractual grievance procedure doesn't depend on a public agency that may be under-resourced or penalties that may be too weak to act as a deterrent. But bargaining is also limited in its impact; it means achieving improvements one employer at a time, and healthcare workers and patients in non-unionized hospitals do not receive the benefit of these improvements. By advocating for legislation, nurses can use their expertise, their collective strength, and the power of broader alliances and relationships to bring about improvements that reach every healthcare workplace and every patient.

In general, it is most effective when unionized healthcare workers engage in multiple kinds of collective action, as they are mutually reinforcing and require the same kind of organizing. For example, successful bargaining requires smart, long-term organizing in order to build sufficient power to win the contracts patients and workers need. In many cases, this means a willingness to strike—but a strike does not come out of nowhere. Workers must be well prepared to walk off the job on behalf of their patients and their coworkers. Successful strikes often require years of organizing and

Organizing for Safe Needles: A Case Study

Healthcare workers frequently feel frustrated and demoralized, and they may feel that the obstacles to providing the care their patients deserve are truly insurmountable. But collective action can create the confidence to build power and create positive change. The fight for safe needles is a perfect example.¹⁹

When Peggy Ferro, a nurse's aide in San Francisco, contracted HIV through a needlestick injury, the nurses she worked with knew that if her employer had been willing to pay for safer retractable needles rather than cheaper conventional needles, she would not have contracted this bloodborne disease. Employers were not spending money on these safer devices because they did not have to do so. Ferro testified before Congress about her situation in 1992. She died of HIV in 1998 at just 49 years old.

Ferro's story—and far too many others' stories of HIV and hepatitis—spurred Lorraine Thiebaud, a nurse and member of the Service Employees International Union (SEIU), to devote a decade to fighting for safer needles. To succeed, she engaged in all three types of collective action: contract enforcement, bargaining, and advocacy.

Thiebaud began her campaign for safer needles by using the grievance procedure in her contract, along with a workplace campaign consisting of a petition, public posters, and public demonstrations. Working with the other unions in her hospital, she and her col-

leagues eventually won the right to retractable needles in their San Francisco hospital. After achieving this important change, Thiebaud and others pushed to ensure that the same protections were covered in other union contracts throughout area hospitals and clinics.

While Thiebaud's strategies were successful in her workplace and in others with strong unions, they did not reach the large number of California workers in hospitals that were not unionized, so Thiebaud and others took the campaign to the state legislature. With added attention thanks to investigative journalism by the *San Francisco Chronicle* and support from healthcare giant Kaiser Permanente, a law mandating safety needles was passed in 1998. (Thankfully, Ferro, who was also engaged in this campaign, lived to see it signed into law.)

California's legislative climate tends to be more favorable to workers than that of many other states, so the next step was to achieve federal legislation that would provide the same protections to healthcare workers nationwide. Thiebaud testified before the US House of Representatives that "SEIU and other health care unions, such as the American Federation of State, County and Municipal Employees, and the American Federation of Teachers, believe that the only truly effective way to prevent needlestick injuries nationwide is to pass a law requiring employers to evaluate and use safer devices."²⁰ Finally, in 2000, the Needlestick Safety and Prevention Act amended OSHA's Bloodborne Pathogens Standard and provided the same protections to all healthcare workers.

The fight for this important safety standard demonstrates the many levels and strategies of union work. Organized nurses were able to use their grievance procedures and their contract bargaining to mandate safer needles in unionized workplaces. But this success did nothing for healthcare workers who had no collective bargaining agreements. By pushing for stronger legislation, the unionized workers were able to ensure that all healthcare workers, no matter where they were employed, also had access to safer needles. Some unionized healthcare employers even supported this legislation. After all, if they were going to pay for more expensive retractable needles, they didn't want their competitors to keep their profits up by cutting safety corners.*

While the plight of nurses and other healthcare workers in the pandemic has been extreme and in many places devastating, their predicament is not new—it is an amplification of already difficult circumstances. The good news is that we know a great deal about how we can combat challenges like insufficient staffing and



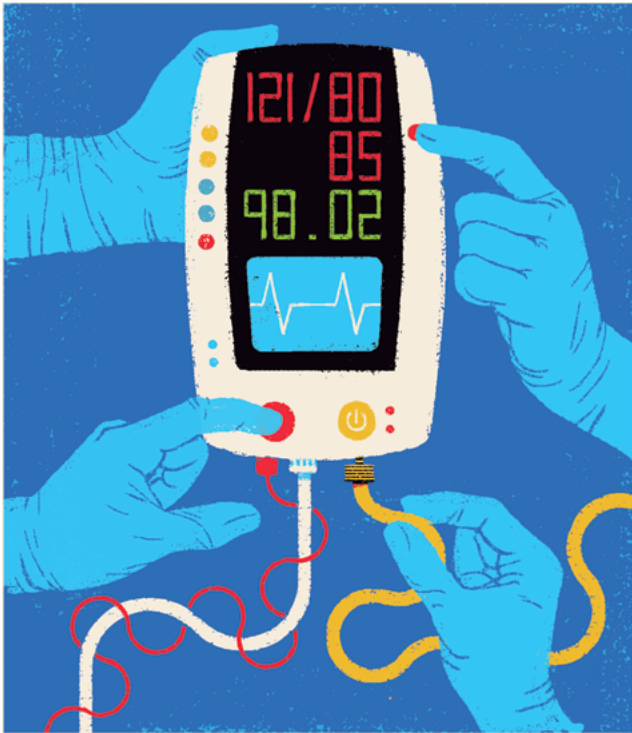
unsafe equipment that create these difficult and sometimes untenable working conditions. Organizing collectively by bargaining, sometimes striking, enforcing contracts, and advocating together for improved regulations and laws can yield concrete changes that allow nurses and other healthcare workers to provide the care their patients need. +

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Continued on page 40

*This is the same logic we see when employers such as Amazon that already pay \$15 an hour or more to all their employees advocate for raising the legal minimum wage to this level; employers would rather compete on a level playing field.



Improving Working Conditions in Turbulent Times

Expanding Unions' Toolkits

By **Peter Lazes** and **Marie G. Rudden**

Peter Lazes, PhD, founded the Healthcare Transformation Project in Cornell University's School of Industrial and Labor Relations and is now a visiting professor at the School of Labor and Employment Relations at Penn State, where he is a co-coordinator of the Healthcare Labor-Management Partnership Initiative. Marie G. Rudden, MD, is a psychiatrist and clinical assistant professor of psychiatry at Weill Cornell Medical College. Lazes and Rudden authored *From the Ground Up: How Frontline Staff Can Save America's Healthcare*.

In 2005, two staff nurses at Maimonides Medical Center in Brooklyn, New York, were on the verge of being fired. Six unexpected fatalities had occurred in the cardiology department over the previous 16 months. An initial investigation by hospital administration and risk management staff concluded that these two nurses were responsible for the deaths through lateness in responding to cardiac telemetry monitor alarms, and they were suspended without pay until the investigation was completed. Fortunately, they were not facing these accusations alone. Their unions (the Service Employees International Union's Committee of Interns and Residents and the New York State Nurses Association) and hospital leadership had established labor-management committees in many of the hospital's departments as part of their labor-management partnership. Members of the committee within cardiology, encouraged by union leaders, decided it was their responsibility to investigate the cause of the unexpected fatalities. After three months of research and analysis, the committee identified several issues that contributed to the fatalities, but these did *not* include inappropriate care by staff nurses. The two nurses who had been accused of causing the fatalities were reinstated with full back pay. In addition, the committee agreed to implement a series of interrelated solutions, including updated and standardized protocols for the care of all cardiac

patients (which were agreed to by all physicians and nurses), investment in better cardiac monitoring equipment that could be easily adjusted, and training for staff on the new procedures and equipment. During the following two years, they tracked the result of these changes, finding no unexpected adverse events on their cardiac units.¹

This positive, proactive outcome likely would not have been possible had this situation been handled solely by a traditional grievance process. The partnership process enabled frontline staff to investigate the situation, devote work time to researching the problem, and access clinical data about the care of the patients who died. Union leaders played a crucial role in representing their members and in improving patient care; they had a strong voice and a structure for intervening with the well-established labor-management partnership. The cardiology labor-management committee's problem-solving process was successful—for the providers and the patients—because it offered a comprehensive analysis from the standpoints of *all* stakeholders to get at the root causes of the problem.

What Is a Labor-Management Partnership?

Labor-management partnerships are different in every workplace, but fundamentally they establish structures

and processes to address a wide range of issues, allowing unions greater influence in decision making. Unions have used labor-management partnerships since the 1970s to increase their power to improve working conditions for their members. When these partnerships are effective, unions have much greater access to patient and budget information, workarounds are eliminated, and members have more meaningful jobs (e.g., they have greater decision-making power about their working conditions, have input into how technology is used in their departments, and gain considerable respect for improving patient care). Importantly, unions still have all of their traditional sources of power when there is a partnership process.

We have been researching, helping create, and supporting labor-management partnerships for more than 40 years. Although we understand that the idea of partnering with management may be inconceivable—especially now, since so many hospital administrators have shown little regard for staff members' safety during the pandemic—we have seen the power of partnerships to improve staff satisfaction and patient outcomes.² Even if a partnership does not seem feasible for your local now, knowing about partnerships' structures and processes may be beneficial in the future. When circumstances change or opportunities arise, being equipped to seize these opportunities can be useful.

In some cases, unions have used traditional tactics like negotiations, protests, walkouts, or strikes to initiate partnerships or to more forcefully press for changes in existing partnerships. For example, in July 2018, the Vermont Federation of Nurses and Health Professionals, AFT Local 5221, which had established a labor-management partnership more than a decade earlier, conducted a two-day strike over staffing levels and retention issues at the University of Vermont Medical Center.³ One result of the strike was the establishment of the Unit Staffing Collaboratives Project, a robust process for ensuring reasonable, safe staffing levels for all hospital units and outpatient clinics.⁴ This initiative involved intensive research and analysis to determine adequate staffing for nurses and support staff, unit by unit, with each one proposing a new staffing grid that had to be approved by both the chief nursing officer and the union president, Deb Snell. According to Snell, the project has resulted in the addition of 77 new positions, primarily in nursing roles, across all but two units in the hospital.⁵ (See "Boxing and Dancing at the Same Time: Finding Balance in a Labor-Management Partnership" on page 24 for more.) While ongoing challenges in hiring and retaining nurses remain, greatly exacerbated by the COVID-19 pandemic, the new staffing levels are in the process of being implemented, based on the recommendations of frontline nurses.

Essential Elements

When labor-management partnerships are successful, they have a specific structure for their work that

is agreed upon at its outset. Workgroups are created to make use of the collective knowledge and skills of frontline staff, who know the most about the working conditions in their units and departments, and staff members are given time to participate in workgroups. Lastly, union and management leaders support and provide a vision for this joint work.

Labor-management partnerships specifically provide frontline staff time to identify, research, and implement changes in targeted areas of the hospital to improve working conditions and patient care. This gives workers greater control over how they do their work, including the material and equipment they use and, in some cases, their actual clinical practice. Unlike traditional management-driven improvement processes, where management determines the issues to work on and the changes to enact, in a labor-management partnership the areas for improvement and the actions to take are determined by mutual agreements between frontline staff and management. When all stakeholders are truly engaged and the staff is not dictated to, these partnerships can be highly effective.⁶

Creating a labor-management partnership process requires establishing a social contract to set ground rules about who can participate and how decisions are made. This agreement clarifies the arrangement for establishing work teams and should state that no employee will lose their job as a result of worker involvement activities. Once a proposed change is accepted by labor and management leaders, frontline staff are provided time for implementation. A partnership process also establishes a budget so that staff time is allocated to participate in problem-solving activities during work hours and some members can be paid to serve as internal consultants to support the partnership process. In many hospitals, where wall-to-wall frontline staff are represented by unions, all frontline staff are encouraged to participate in partnership activities. In other hospitals, when only some staff are represented by a union, the partnerships process is focused on these unionized staff—although nonunion staff might be members of a specific workgroup.

In our experience, labor-management partnership processes are an important tool for unions because they create opportunities for frontline staff to improve their working conditions and to safeguard their own well-being and that of their patients. It is best for a new partnership to begin with areas for change that are fairly easy to improve and where there is a readiness of management and frontline staff to work together. This is particularly important if your organization hasn't had much experience with labor and management working together. Over time, as worker involvement activities achieve positive outcomes, the process can be expanded to address more complex problems.

As a result of these cogenerated activities, frontline staff and their union often obtain access to budgets, patient satisfaction scores received by the hospital, and

Unions still have all their traditional sources of power when there is a partnership process.

Boxing and Dancing at the Same Time

Finding Balance in a Labor-Management Partnership



At the University of Vermont Medical Center, we're struggling with the same critical issue that hospitals and healthcare unions across the country are: we don't have enough staff.

Three years ago, in July 2018, our nurses went on strike for two days over persistent inadequate staffing and our hospital's unwillingness to implement changes that would result in better recruitment and retention of nurses. We have been partnering with management through our staffing committee since our first contract in 2003, but we weren't making enough headway on this critically important issue. By 2018, we knew we needed to take a stronger position. For the sake of patient and staff safety, we had to strike. Out of the resulting contract came the Unit Staffing Collaboratives Project, a system-wide initiative to address staffing issues. Each unit's collaborative included four or six nurses and two administrators who met regularly to develop proposals for new staffing grids that better reflected unit needs.

The first step in the project was to evaluate our current situation. We and the hospital jointly hired a consulting team that specializes in staffing issues. They looked at the whole organization: at each department, at the patient population, at all of our staffing grids, and more. They also benchmarked us against like-size academic medical centers to provide a clear picture of where our staffing levels should be. Collaborative members took the information back to their units, where they spent time looking closely at their staffing—not only nurses but also the licensed nursing assistants, the unit secretaries, and everyone who contributed to patient care. They then used the consultants' report and their own internal analyses to propose new staffing grids for their units. Both the chief nursing officer (CNO) and I had to sign off on their proposals.

This process was significantly delayed because of COVID-19, but ultimately we achieved a total of 77 new positions, spread across all but two units in the hospital. The majority of those jobs are nurses,

and the rest are licensed nursing assistants or medical assistants. Unfortunately, we haven't been able to fill many of these openings yet because of the larger nursing shortage and COVID-19. But most areas were able to add staff and a circulating nurse to help out on the floor. We know that will make a big difference in the short term to relieve the stress our care providers are feeling and to ensure patients get excellent care. In the long term, our Unit Staffing Collaboratives will continue meeting throughout and beyond implementation of these staff additions so that we can monitor our progress and reassess as new needs emerge.

What Good Relationships Can—and Can't—Do

Staffing is always our top issue, but our labor-management partnership tackles a range of issues. One recent situation involved a hospital vice president who was discussing COVID-related furloughs and instructed managers to talk to staff quickly, before union stewards could get involved. We filed an unfair labor practice, and we got the hospital to agree to regular joint training sessions with union leadership and all hospital managers who oversee bargaining unit members. These sessions will give us the opportunity to identify the most common types of grievances and educate managers on the contents of our contract (including members' right to have a steward present in meetings with management). We will begin with two sessions in 2022, and if we find the meetings productive, we will continue to hold them every year, with mandatory attendance by managers and supervisors. Both sides have long agreed that it's best to try to settle things without needing to file grievances. But this is the first time the hospital has agreed to a training process like this, and it would not have been possible without our labor-management committee.

Many positive results have come out of the labor-manage-

By **Deb Snell**

Deb Snell, RN, has served as president of AFT Vermont and the Vermont Federation of Nurses and Health Professionals since 2019 and has been a critical care nurse at the University of Vermont Medical Center for 21 years.

ment committee—but there is a lot of friction, too. In many circumstances, the hospital has not been honest with us, and issues we have brought to them have not been addressed. The CNO and I have worked together very closely, especially throughout the Unit Staffing Collaboratives Project. We keep a set appointment to meet every two weeks. We also meet with the president of the hospital every month. But sometimes the president tells people what they want to hear at that moment and then changes his mind when he is in front of another group. We have had to confront our CNO on some points as well. In December 2021, at the beginning of the omicron surge, I asked if the rumor that the National Guard and the Federal Emergency Management Agency were sending staff to our hospital was true. She said no—then a week and a half later they were at the hospital.

We are dancing and boxing at the same time. We want to try to have a good working relationship with hospital administrators and be able to discuss the issues that affect our ability to provide care, but it can be hard to trust them.

The biggest source of lack of trust is that even after the strike and all the work of the Unit Staffing Collaboratives, our staffing situation remains dire. Filling all 77 new positions will only be the first step; administrators have yet to truly reckon with our staff retention problem. They hired a company to survey all the staff across the hospital, and they were shocked when most workers said they didn't feel appreciated. Upper management did what I call the Great Apology Tour, where they shared the data from the survey about how employees felt and promised to take the problems seriously. But even so, very little has changed.

Despite their acknowledgement of flaws in the organization, it is difficult for us to trust that the hospital will act decisively to repair those flaws because management continues to rely on the union to tell them how to improve the situation. Still, having

a voice is a benefit of the partnership, even though we know that winning implementation of our ideas almost always requires tough tactics.

For example, we are currently (February 2022, as this issue goes to press) in another long phase of more boxing than dancing. In July 2021, the hospital asked us to offer a proposal that would help with staff retention, so we brought in a group of members to explain to management how unsustainable the situation is. Not only are wages low and the demands of the work extraordinary, but our members also struggle with obtaining housing in a very tight market, finding childcare, and paying their student loans. We asked the hospital to take the initial step of raising base wages 10 percent across the board for all of our members and for nonmembers, too—including our housekeeping staff, our maintenance staff—all the employees who work so hard every day. Management refused. In December, the hospital came to us again asking to bargain for two days about base wages, but at the bargaining sessions they offered nothing for nonmembers. Thinking they could sow division in the staff, they offered a wage increase for nurses only and a bonus for our technical professionals, with several conditions attached. In our bargaining survey, 98 percent of members voted to use our power at the bargaining table to win wage increases for our nonunion colleagues and make it easier for them to organize. Refusing the hospital's offer was a relatively easy choice for us.

Finally, in February the hospital offered an immediate 10 percent raise. In addition, this October and next we will receive a 3 percent raise and 2 percent step increase, all with no strings attached. At long last, they are taking our financial struggles seriously. But other aspects of the contract remain to be resolved this spring, and we agreed that this would only be a two-year contract.

While we are pleased with the new wages, these negotiations have been frustrating because

the hospital has learned little from our two-day strike in 2018 or from the last several years. The strike was not just about wages; it was about strategies to recruit and retain staff—but the hospital still has not made critical investments that show they care about staffing. When there are so many other job opportunities out there, we need incentives to bring nurses to our hospital and keep them here. That's what these conversations have been about all along, and that's what they will continue to be about in our ongoing bargaining.

Adding to Our Toolbox

The most important thing to remember with a labor-management partnership is that it does not replace the other tools we have to work with as a union—it gives us more tools to try. And the partnership can change over time. If one plan does not work, we can try a different way. With a labor-management partnership, we have more flexibility to work on solutions between bargaining contracts—and members have more opportunities to be involved in coming up with those solutions.

The members guide me in all of these decisions. I listen to them, get them involved in the process, and communicate regularly, especially during bargaining. After every session, we're handing out leaflets, sending emails, posting to Facebook—doing whatever we can to make sure members see that we're doing our best, and that they have opportunities to offer feedback. We tell them what we're fighting for, based on what they told us they wanted. We also share the hospital's counteroffer to ensure members are involved in sorting through our options. Members may choose to accept the hospital's offer, or they may choose to continue negotiating. If all else fails, they may choose to strike. The power of the labor-management partnership is in that in-between space. Striking is always the last resort, and if we do exercise that option, we know that we tried all our other options first. The partnership makes that possible. +

With a labor-management partnership, we have more flexibility to work on solutions between bargaining contracts.



documentation of clinical outcomes. Having access to this critical information enables union members to understand the parameters within which they are working and to receive feedback on their performance. Without a worker involvement process, much of this information is usually not available to either frontline staff or their union leaders. For example, some unions only get access to basic budget and staffing information and have limited opportunities to engage in problem solving about work and patient care problems during contract negotiations. In our experience, increased access to information on an ongoing basis is one of the ways in which partnerships are valuable to unions and frontline staff. A partnership process is also useful to management because it can enhance management's understanding of the union contract and how the union functions, which is much different than management. These understandings often improve labor relations and strengthen the ability of management to work with a union and its leadership.

The important outcomes achieved by recent health-care labor-management partnerships have included reducing staff injuries by purchasing equipment to turn and transport patients safely, reducing emergency department visits for diabetic patients, reducing the turnaround time of test results between an emergency department and the lab, coordinating care for patients by creating patient-centered medical homes, improving hospital cleanliness, reducing the number of patients needing to return to ICUs, and increasing staffing ratios for registered nurses and their support staff.⁷

Establishing a labor-management partnership takes time: managers, staff, and their union need to determine an appropriate structure for supporting the new worker involvement activities. Although learning about existing partnerships is useful, each organization is unique in terms of its patient population, so the structures and processes for a particular partnership must be customized. Most critical to the success of the partnership is that union and management leaders are committed to and show support for these activities.

Why Are Labor-Management Partnerships Needed?

Long before the pandemic, nurses and other health-care workers faced seriously deficient working conditions. Scholars such as Suzanne Gordon, a healthcare researcher and nursing professor, and Theresa Brown, a registered nurse and bestselling author, documented the dangers for patients and healthcare workers of staffing that focuses “more on costs than care.”⁸ Not long after COVID-19 arrived in the United States, what had already been long-term problems—especially with staffing and with the availability of equipment—became catastrophes. Connie M. Ulrich, a professor of medical and surgical nursing and bioethics, described how bad things became with COVID-19: “Many [nurses] have moral scars from ethical issues

and trauma they experienced while trying to provide the best care to sick and dying COVID patients—lack of personal protective equipment and other supplies, inadequate staffing and poor leadership, bedside attendance at multiple deaths daily, and shifting messages on how to protect themselves and their patients.”⁹

AFT nurses have had similar experiences during the pandemic and have struggled to find ways to deal with the impacts of these issues. This has left many AFT healthcare leaders and members frustrated and angry. Many nurses feel abandoned and betrayed by their employers and now share a massive distrust of hospital management. Inadequate staffing, the lack of training for hastily arranged new assignments, the lack of PPE, and administrators' physical absence on COVID-19 treatment units have been cited as deeply disturbing.¹⁰

Looking to the future, Linda H. Aiken, a professor of nursing and sociology, wrote, “We celebrate nurses now. We call them heroes. But if we value their sacrifices and want them to be there when we need them, we must prevent a return to the poor pre-pandemic working conditions that led to high nurse burnout and turnover rates even before COVID.”¹¹ Aiken advocates for creating local and national initiatives to achieve better staff-to-patient ratios as a way to improve working conditions of nurses. Better staffing levels will indeed help to reduce some of the exhaustion frontline staff experience and will ensure better care for their patients. But increasing the number of nurses on a unit will not be sufficient to improve the compromised working conditions that nurses face, such as a lack of safety equipment or a lack of training on new equipment or on procedures for treating different patient populations as a result of being assigned to new departments. Nurses know that they can't deliver good care to their patients when the time available to them is severely compromised. These situations have contributed to a sense of moral injury among many nurses.* Far too many nurses do not feel that their working conditions have allowed them to offer the ethical care they have been trained to provide.¹² Bedside attendance at multiple deaths daily during the COVID-19 pandemic adds to their pain and trauma. Too few healthcare organizations have developed effective processes to help nurses process these stresses or provided them opportunities to improve these working conditions. In some hospital systems, however, labor-management partnerships have helped improve working conditions both before and during the pandemic.

During the pandemic, we have been in contact with many union leaders and members who are engaged in labor-management partnerships. Based on these conversations,¹³ we have learned that many hospitals

*To learn more, see “Moral Injury: From Understanding to Action” in the Spring 2021 issue of *AFT Health Care*: aft.org/hc/spring2021/pittman.

with structures for involving frontline staff used these structures to help cope with significant issues caused by the overwhelming number of extremely sick patients. For example, in labor-management partnerships at Jackson Memorial Hospital (in Miami), Los Angeles County Health Services, and UMass Memorial Health, management, union leaders, and frontline staff worked together to create access to adequate protective equipment and to keep staff informed of updated protocols for caring for COVID-19 patients and safety procedures (many of which were changing daily). Some hospitals with labor-management partnerships increased compensation for nurses working during the pandemic and offered therapeutic support for them when needed. Healthcare workers still faced tragic circumstances, but these efforts, assisted by partnership structures and processes, have led to better working conditions during COVID-19. Further, many workers in these settings did not feel as betrayed by their managers as workers in hospitals without partnerships.¹⁴

Labor-Management Partnerships Are Not New

Giving workers a voice in decision making to improve their working conditions and the effectiveness of their organizations while also contributing to union building dates back to the end of World War II. After the war, union and political leaders in Scandinavia decided to develop specific structures through national legislation to ensure that frontline staff had opportunities to identify and solve working condition and production problems. They felt that these structures would strengthen their economy and create meaningful work for frontline staff. They also saw the value of worker participation, since those who had this experience tended to become active in civic life.¹⁵ Worker participation was viewed as a vital approach to retaining an active democracy.¹⁶ Worker participation continues to be an important focus of Scandinavian unions.

In the United States, union leaders of the Amalgamated Clothing and Textile Workers Union (ACTWU) and the United Auto Workers (UAW) started to think about potential ways to adapt worker participation strategies to American companies and the work culture of American workers after learning from the Scandinavian initiatives and understanding that an active role of unions was needed to increase worker participation activities.¹⁷ Their expanded vision for their unions was that in addition to securing wages and benefits, unions had a responsibility to find ways to work with management to improve the success and productivity of their organizations and to create opportunities for workers to have more meaningful work.¹⁸

Three significant partnerships created during the 1970s and 1980s were found in the General Motors (GM) North Tarrytown assembly plant with the UAW, the Xerox Corporation with the ACTWU, and the Saturn-GM assembly plant with the UAW.¹⁹ At the

Tarrytown plant in New York state, worker involvement activities adapted the concept of quality control circles from Japan to create unit-based problem-solving teams. Initial work teams reduced damage to windshields and water leaks in cars' front windows during the manufacturing process. The success of these initial teams resulted in workers being asked to tackle other problems with the quality of the newly assembled cars. In just four years, the worker participation process resulted in the Tarrytown site being rated the highest quality plant in GM's car assembly division. Before this, it had been in the bottom tier of manufacturing quality ratings. The partnership also led to a radical reduction in grievances and arbitrations in the plant.

At the Xerox Corporation in Webster, New York, the worker participation process established problem-solving workgroups in all of their manufacturing plants to improve the quality of manufacturing Xerox machines. By late 1981, however, Xerox faced serious competition from Japanese copier companies. Xerox management's response was to develop plans to move the manufacturing of subcomponent parts (the wire harness) of their machines to Mexico—which would save \$3.2 million, in part by laying off 180 US-based employees. After learning of this potential layoff, the leadership of ACTWU, the union representing workers at Xerox, persuaded Xerox management to use a study action team process to identify other ways to reduce costs instead. A group of frontline manufacturing staff, a manager, and an engineer spent six months identifying ways to save the \$3.2 million in operating costs. As a result of their solutions, \$3.7 million was saved, as were all 180 jobs. In fact, these joint activities resulted in the creation of 150 jobs, on top of those saved, due to the development of a new, high-quality production process that included redesigning the flow of work, training employees to do multiple processes, and purchasing and using new equipment.

At the Saturn Corporation in Spring Hill, Tennessee, a partnership process was established to structure how the union and management would work together in this new car division of General Motors. Manufacturing staff, union leaders, and management made all decisions jointly from the inception, including designing the cars, choosing production equipment and suppliers, and licensing dealerships. This partnership resulted in the manufacturing of high-quality, affordable cars that successfully competed with the Honda Civic for many years.

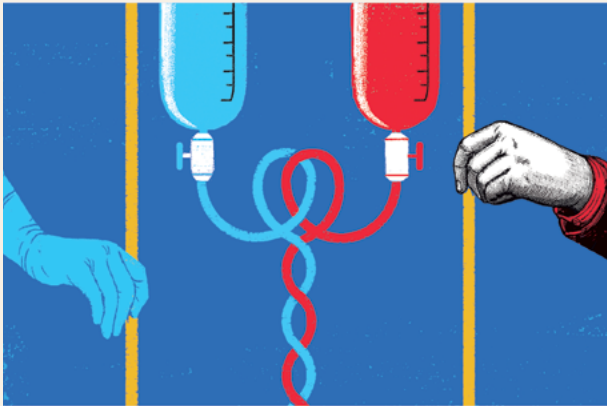
The success of these worker involvement activities caught the interest of union leaders in both private and public healthcare organizations during the late 1990s. In 1997, one of the first healthcare labor-management partnerships was established at Kaiser Permanente, which has facilities in several states. At the same time, a partnership was also developed at Maimonides Medical Center in Brooklyn.

After a long history of strikes, labor leaders and managers at Kaiser Permanente decided to establish their

With an LMP, frontline staff can improve their working conditions and protect their patients.

Partnership in Flux

The Importance of Strong Relationships



One of the more challenging things about a labor-management partnership is navigating and maintaining the relationships that are at its core. These relationships impact the way that both sides approach negotiations. Building strong partnership relationships takes time, communication, and trust; when those break down, the partnership falters. That is what happened during our most recent round of bargaining at Kaiser Permanente—and it is what nearly drove us to strike in November 2021.

The labor-management partnership at Kaiser dates back to 1997. Although any partnership has ups and downs, our work with Kaiser had been going well, and the organization's commitment to unions and worker voice was strong. Then, after the former chief executive officer died unexpectedly in 2019, there were changes in key leadership roles. Most importantly, just as we were entering bargaining in 2020, Kaiser hired a new chief human resources officer who did not have a background in healthcare or with labor-management partnerships.

Because of these changes, we had little time to build relationships, and the partnership lacked the openness and dialogue of previous years.

When the pandemic hit, we were shocked at how management was allocating resources. While we were advocating for critical additional staffing and PPE, Kaiser was spending millions of dollars on a bogus research study about employee compensation. The study concluded that all our job classifications were

overpaid. We easily debunked that assertion through simple online research, but it fit management's (also bogus) narrative that Kaiser was in dire financial straits.

At the bargaining table, Kaiser's new leaders proposed an egregious two-tiered wage scale that would have created two classes of employees in our unions. It seemed designed to turn members against each other. Of course, we were not going to agree to any two-tier system, so negotiations were both incredibly painful and fruitless. For months, we continued to bring up the staffing crisis and the need to educate new frontline providers to replace staff who were taking positions in other hospitals, retiring, or abandoning healthcare altogether—in part because of the pandemic and in part because of Kaiser's working conditions. Management claimed that they could not afford to continue increasing payroll. We countered that since they could not hire or retain enough people now, they would never successfully recruit others for less money. But they refused to understand. It was as if we were speaking two different languages.

By the fall of 2021, our only option left was to strike—and we were prepared. The Alliance of Health Care Unions, which includes 21 locals of 10 different national unions, represents over 50,000 Kaiser employees in eight regions. Our members were unified, largely because they saw Kaiser's position as putting patients at risk. The locals' votes authorizing the strike were overwhelming. For example, 96 percent of the AFT members (Kaiser employees in Oregon represented by Local 5017) voted to strike. Not surprisingly, soon after this demonstration of our solidarity, management gave up on the two-tier wage system and began bargaining in good faith. We only narrowly averted what would have been the largest private sector strike in the history of the country. In the end, we did not get everything we wanted, but

we did win strong contracts—with wage increases, good healthcare and retirement benefits, funds for career development, commitments to reduce the use of traveling nurses, and more information for making staffing decisions. Our solidarity was the key.

Partnerships evolve over time; so far, our current evolution has not been for the better. After these contentious, protracted negotiations, many of our members are still angry—and rightfully so. But the former executive director of the alliance regularly asks a question that I think is important: "If you hate each other, do you still have a partnership?" For me, the answer is yes.

The partnership has allowed us to bargain for improvements in working conditions that I do not believe we would have won otherwise. We would not have gotten card check neutrality or the no-cancellation clause that gives our members income security. We would not have created our unit-based teams, which give members a say in the work they do and meaningful opportunities to enhance patient care. We would not have our amazing educational trust, which funds career development and is the most popular opportunity we offer our members outside of pay and benefits.

Looking to the future, we're proud of the work that's getting underway to promote equity, inclusion, and diversity. This will be a collaborative labor-management effort to provide social justice training and learning opportunities for all staff. We have a chance to create a culture shift toward greater equity in everything we do, and that's exciting.

Working inside the confines of a partnership is not for everyone, but I'm cautiously hopeful about where we can go from here. I'm eager to see what can happen if we can build the positive, trusting relationships with management that we need to solve problems together every day for our patients. It won't be easy. But we'll see what the future holds. +

By Katie Ekstrom

Katie Ekstrom is the Northwest director of the Alliance of Health Care Unions (which represents over 50,000 Kaiser Permanente employees) and former vice president of the Oregon Federation of Nurses and Health Professionals, AFT Local 5017. Previously, she worked for Kaiser Permanente for nearly 10 years as a frontline care provider.

partnership process to improve patient care, worker satisfaction, and labor relations.²⁰ Most of the focus of this partnership has been on creating unit-based teams in both inpatient and outpatient departments to improve staff working conditions, staff and patient safety, and labor relations. For the most part, this partnership has been productive, thanks largely to the strength of the unions and to the commitment from the former CEOs.²¹ More recently, as discussed in “Partnership in Flux: The Importance of Strong Relationships” on page 28, labor and management have faced significant disagreements over management’s proposal for a two-tier wage system, insufficient staffing, and long-term problems with recruitment and retention, among other issues. The Alliance of Health Care Unions at Kaiser Permanente (representing 21 unions, including the Oregon Federation of Nurses and Health Professionals [OFNHP], AFT Local 5017) was prepared to go on strike in November 2021; that strike was narrowly averted in large part because management finally agreed to remove its demand for a two-tiered wage system.²² According to Jodi Barschow, president of OFNHP and a registered nurse, “The pressure our members, labor leaders, and community supporters put on Kaiser and the threat of a strike worked and moved Kaiser leadership to do the right thing and abandon the two-tier system.” She further explained that “Members of OFNHP were ready to go on strike over the persistent staffing issues. A two-tier system would have been disastrous and would have compromised Kaiser’s ability to attract, recruit, and retain labor—worsening the staffing crisis.”²³ Other major wins in the new contract include staffing committees to address vacancies and travelers; safe staffing and workload requirements; across-the-board wage increases; a renewed commitment to patient safety; an organization-wide focus on equity, diversity, and inclusion; and a variety of educational, health, and retirement benefits.²⁴

Although the partnership has been strained in recent years, there is value in the partnership’s long history and the hard-earned problem-solving abilities of its frontline unit-based teams.²⁵ Explaining her commitment to the partnership, Barschow said, “Members want to have a voice in their workplace and in their care delivery because that’s how to achieve the best outcomes for the patients. When it is working well, the partnership helps build relationships and gives workers the stronger voice they deserve.”²⁶ Still, this is a good example of the fact that having a labor-management partnership doesn’t take away the rights of either labor or management. Being able to cooperate as much as possible and confront each other when necessary are skills that labor and management leaders need to master to establish and sustain a labor-management partnership process.

At Maimonides Medical Center, a partnership grew out of an already strong and positive relationship between senior union and management leaders.

This partnership was seen as an important process to deepen activities of the hospital for improving access and quality of care. After making a trip to the Saturn assembly plant to learn from its staff what was needed to create and sustain a labor-management partnership, union and management leaders at Maimonides established ground rules for their partnership process. The initial focus of worker participation activities was on unit-based teams to solve patient care issues identified by the staff on each unit. Based on the success of these teams, the process shifted to departmental initiatives that extended beyond individual units. It was a departmental team, for example, that addressed the significant problem of unexpected patient deaths on several cardiac units mentioned at the beginning of this article. That team was able to exonerate two nurses from being responsible for these deaths and to establish new processes to avoid such deaths in the future. As a result of the Maimonides partnership, significant changes were achieved: patient falls decreased significantly, a faster turnaround of lab and radiology reports was enacted, bedsores were reduced, and more meaningful jobs were created by the frontline staff themselves.

Thus, based on their different cultures, needs, and resources, these healthcare partnerships created unique structures and processes for engaging frontline workers in problem-solving and restructuring initiatives.

Today’s Partnerships Have Varied Approaches

We have found that three approaches to change are typically used within labor-management partnerships: unit-based teams, departmental labor-management committees, and study action teams. Because we have already provided examples of unit- and department-based initiatives, we will briefly review their key features and then devote more attention to study action teams.

Unit-Based Teams

In our experience, unit-based teams are the most common method of worker involvement in healthcare organizations. This structure provides frontline staff a direct role in identifying and solving working-conditions and patient-care problems. Unit-based teams usually meet every other week. Once they solve a particular problem, the group selects another problem to work on.

Departmental Labor-Management Committees

Departmental labor-management committees usually meet monthly and serve as an oversight group to identify crucial patient care and staff satisfaction issues. Once a committee identifies a specific area of work, a small workgroup, composed of members from all units and all shifts in the department, begins to meet on a regular basis until a solution is determined. During this process, the members of the designated workgroup consult with staff on the relevant units of their depart-

Many hospitals with LMPs have used them to help frontline staff cope with issues caused by COVID-19.

Successful LMPs have reduced staff injuries and patient returns to the ICU and improved staffing ratios.

ment to obtain a comprehensive understanding of the circumstances of a particular problem or process and seek their advice about a potential solution. Once a solution is approved by the departmental labor-management committee, the workgroup is responsible for implementing the solution.

Study Action Teams

In addition to unit- and departmental-based teams, study action teams are a third approach used in some healthcare partnerships. This method is particularly helpful when extensive research and experimentation are needed to restructure a current service or to create an entirely new one. A study action team usually consists of six to nine frontline staff, union representatives, and managers. The group's research is assisted by the hospital's quality improvement, risk management, and financial departments.

Labor and management leaders on the hospital's partnership council jointly identify areas for change that need intensive research and analysis. A team is then created by union and management leaders, with suggestions from frontline staff, recruiting volunteers for this work. Study action team members work full time, usually for three to four months, on the project. This approach enables staff and managers to have sufficient time to analyze a given system and to design effective approaches to solving what is not working adequately. If a new design involves changes in jobs and/or compensation, the bargaining committee of the union and management leaders need to approve the suggested changes. Outcomes of study action teams in healthcare organizations have included improving the cleanliness of a hospital by involving all departments and frontline staff, not just its housekeeping employees, resulting in higher patient satisfaction scores for cleanliness; reducing costs, usually by more than 30 percent, and creating new revenues; creating a centralized call center for setting up appointments effectively; transforming outpatient departments into coordinated patient-centered medical homes; and creating home dialysis services.²⁷

Regardless of the worker involvement approach that is established, employees throughout an organization with a structured labor-management partnership process are encouraged to identify problems to work on. This becomes an ingrained aspect of the hospital's culture.

The Need to Expand Collective Action

Nurses and other healthcare workers have suffered for years with poor working conditions and disrespect for their skills.²⁸ It is important, therefore, to find effective ways to cope with and change these circumstances, now more than ever. Conditions have only gotten worse during the COVID-19 pandemic.²⁹ Daily, the situation is driving increasing numbers of healthcare professionals to leave their essential and valuable work.³⁰

Looking to the future, when we start to emerge from the desperate firefighting aspects of the pandemic, there will be an important opportunity for healthcare union leaders to push for worker involvement activities for their members. As the public is now more aware of how broken our healthcare system is, unions can make use of this awareness to build public support for initiating worker involvement activities. Relying solely on collective bargaining language within contracts and on established grievance processes will force nurses and other healthcare professionals to continue to create workarounds to simply do their jobs well.

As we emerge from the pandemic, it might be important to consider some nontraditional ways to provide members a direct voice in decision making to improve working conditions. Returning to the stressful pre-pandemic working conditions that led to high nurse burnout and turnover rates before COVID-19 should not happen. Maybe it's time to consider adding new approaches to our toolkit! +

Endnotes

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Continued on page 40



Environmental Justice

How Pollution Is Ruining Our Planet and Our Health—and What We Can Do About It

I am a daughter of the South, with Mississippi roots, but my personal and professional trajectories were shaped by a five-year stint in Louisiana’s Cancer Alley corridor. Cancer Alley is an 85-mile stretch along the Mississippi River between Baton Rouge and New Orleans that has more than 135 petrochemical companies and other pollution-generating facilities. I remember those years in Baton Rouge vividly. The pollution index was always high, and the air and the water smelled like rotten eggs, even in my middle-class neighborhood. Eventually, I started suffering from a condition called hypopigmentation—light-colored splotches on my skin. I visited several doctors who performed a battery of tests, but they never came up with a cause. Still, I didn’t have hypopigmentation before I lived in Cancer Alley, and it went away when I moved.

Cancer Alley became more than just a name and a medical mystery for me when my mother was diagnosed with breast cancer after living in the area. While we could not make a direct connection between my mother’s diagnosis and the facilities nearby, the possibility compelled me to begin studying these issues.

Fortunately, my mother is still with me—and so is my passion for creating a clean, healthy environment. In this article, I’ll share an overview of the intertwined problems of pollution and climate change and their disproportionate impacts on the health of marginal-

ized communities. Then, I’ll attempt to inspire you to join in the fight for environmental justice by describing my community-based work in west Atlanta and sharing ideas for how we all can get involved.

Place Matters

A growing body of evidence points to the zip code as the single best predictor of one’s future health, wealth, and well-being.¹ All places were not created equal: data from across the United States have revealed huge differences in life expectancy in neighborhoods within the same geographic locales, particularly in urban settings. A 2018 study produced estimates of life expectancy at birth for the majority of the census tracts in the United States from 2010 to 2015.² In cities like Atlanta, Chicago, New Orleans, and New York—cities with significantly higher than average racial and ethnic segregation—life expectancy varied along geographic and racial lines, offering a powerful demonstration of both the influence of place on health and its association with residential segregation by race.³

What’s behind these findings? Studies in disciplines as diverse as environmental health, geography, sociology, and urban planning offer evidence that residents of chronically under-resourced communities and communities of color suffer disproportionately from a host of negative and often overlapping environmental factors that harm health.⁴ These factors include

By **Na’Taki Osborne Jelks**

Na’Taki Osborne Jelks is a nationally recognized environmental justice leader and innovator in engaging urban communities and youth of color in environmental stewardship through hands-on watershed and land restoration initiatives, environmental education, and training. She is an assistant professor of environmental and health sciences at Spelman College and cofounder of the West Atlanta Watershed Alliance.

Zip code is the single best predictor of one's future health, wealth, and well-being.

- poor air quality from nearby diesel bus depots, highways, or industrial sites;
- substandard housing that exposes residents to mold, lead, and/or asbestos;
- an abundance of convenience stores with unhealthy, shelf-stable snacks but a dearth of grocery stores with healthy, fresh, affordable foods;
- an overrepresentation of fast-food establishments with high salt, high sugar, and calorie-dense dollar menu items;
- inadequate access to sanitation or to clean, affordable drinking water; and
- increasing exposure to climate change impacts, such as extreme heat in low-income communities where there are few trees and many residents cannot afford air conditioning, and/or frequent flooding in neighborhoods where sewer systems (and other mitigation infrastructure) have not been updated in decades.

Such communities also often lack access to health-promoting resources and amenities, such as quality open spaces, green spaces and playgrounds, sidewalks, well-paying jobs, healthcare, and representation at decision-making tables.

In Atlanta, where I've lived for more than 20 years, such disparities are stark and abundant. But to see them, you have to be willing to look across communities. A study of the five core counties that make up the Atlanta metro area found the highest life expectancy—nearly 88 years—in Vinings and the lowest—fewer than 64 years—in Bankhead.⁵ Vinings is in suburban Cobb County, on the northwest edge of Atlanta. It's predominantly white and wealthy, with easy access to well-maintained parks, green space and recreational sites along the Chattahoochee River, quality foods, and high-paying jobs. Bankhead is in the city of Atlanta in a pollution hot spot. Named for the former highway (now renamed Donald Lee Hollowell Parkway) that runs through it, Bankhead is crisscrossed by railroad tracks, home to city solid waste and combined sewer overflow facilities (the hazards of which are discussed below), and bounded by a Superfund site to the east. Although its demographics are starting to change as gentrification reaches the area, it has long been predominantly Black and very low income. Bankhead is less than 10 miles from Vinings, but it is a marginalized community cut off from key resources for health and well-being.

These phenomena, in the Atlanta region and in other locales, did not happen by chance, and attempts to “fix” these injustices and societal ills have been insufficient because they don't address the larger structural issues. Cries from the streets and ivory towers alike are beginning to coalesce around a consistent refrain: the system is not broken—it was built this way.

The Enduring Effects of Redlining

Among the many factors that have made zip code such a strong determinant of health, redlining stands

out as the most far reaching, detrimental, and long lasting. Redlining refers to lenders' practice of denying borrowers access to mortgages based on neighborhood demographics. In the wake of the Great Depression, as a part of President Franklin Delano Roosevelt's New Deal, the US government created the Home Owners' Loan Corporation (HOLC) as an emergency agency tasked with limiting foreclosures and stabilizing the housing market. The HOLC did this, in part, through loaning billions of dollars to American homeowners and transforming and standardizing the way property was appraised. Most notably, the HOLC established a system to assess neighborhood creditworthiness. Neighborhoods were systematically ranked based on housing-related factors such as age and quality of housing stock, occupancy, and prices, along with community-related factors such as access to transportation and proximity to amenities like parks or to undesirable land uses such as polluting industries. But these rankings were also based on nonhousing-related demographic factors, such as neighborhood racial and ethnic composition, immigration status, and socioeconomic status, as well as the employment status of residents and the percentage of renters in the community.⁶

When the HOLC put this new appraisal system in place, it used real estate agents throughout the country to determine property values. At the time, agents were professionally responsible for upholding segregation. In 1924, the National Association of Real Estate Boards adopted a code of ethics that stated, “A realtor should never be instrumental in introducing into a neighborhood ... members of any race or nationality ... whose presence will clearly be detrimental to property values in that neighborhood.”⁷ In essence, the HOLC's system for assessing neighborhood creditworthiness and home values was largely influenced by the documentation of specific social factors such as race, ethnicity, and economic class. Neighborhoods were graded from A to D, with the lowest ranking areas in each city identified as “hazardous.” These undesirable areas were colored in red on the maps, and they were largely correlated with the areas with the highest percentages of Black residents. They were also correlated with pollution, as many municipalities intentionally put industrial zones—for landfills, incinerators, chemical plants, and other facilities that make air and water toxic—near Black residential zones.⁸

One year after the HOLC was established, Congress and President Roosevelt created the Federal Housing Administration (FHA) to help renters become homeowners. But it operated much like the HOLC, strongly favoring white neighborhoods, creating policies to maintain segregation, and making it very difficult for Black people to get mortgages (regardless of their income). Then, after World War II, the Veterans Administration (VA) compounded

the problem; when it began backing mortgages, it adopted the FHA's racist policies.⁹

Ultimately, the HOLC, the FHA, and the VA helped build the white middle class by making it easier for white people (including those with lower-paying jobs) to refinance or buy homes—but they prevented Black people from doing the same (including professionals who could have easily afforded the types of mortgages routinely offered to white people). Because redlining made homeownership for Black Americans nearly impossible, it also created highly segregated, under-resourced communities, with Black families crowded into rental units and landlords largely unable to secure credit to make repairs to their buildings. The relatively few Black people who were fortunate enough to purchase homes had their investments severely devalued. As a result, both those forced to rent and those able to buy had their wealth-building capacity stifled for generations.¹⁰

Although the HOLC was rendered defunct by 1954, and the Fair Housing Act was passed in 1968 (largely reforming FHA and VA policies), the effects of redlining persist.* Seventy-four percent of the neighborhoods that the HOLC graded as “hazardous” are low-to-moderate income communities today, and 64 percent of these areas are predominantly populated by people of color.¹² Compared with white people, on average, Black people still have lower rates of homeownership¹³ and are more likely to rent in unhealthy buildings¹⁴ (with mold, lead, and/or asbestos) and live near pollution-generating businesses, with less access to quality foods and jobs.¹⁵ As a result, they have far less wealth and suffer from far more stress, asthma, diabetes, and other health problems.¹⁶

Although the history of government-backed segregation, disinvestment in Black communities, and minimal support for low-income people of all races is far more extensive than can be addressed here, even this brief introduction to redlining makes clear the relationship between where we live and how we live. The need for structural solutions to dismantle this legacy becomes even more evident when we consider the climate crisis.

The Growing Effects of Climate Change

Climate change affects all of us, but not equally. Once again, zip code is a powerful predictor of health impacts, which are far more severe in communities that have been made vulnerable by redlining

and other discriminatory planning and investment practices. In effect, climate change acts as a great multiplier. Its impacts layer on top of other inequities, interacting with and exacerbating the effects of the social determinants of health. A 2021 Environmental Protection Agency (EPA) study revealed that Black and African Americans are projected to face higher climate change-related impacts for each of the areas analyzed in the report, including changes to air quality, extreme temperature (and related work disruption), and coastal and inland flooding.¹⁷

We can get a better picture of what this means by focusing on two of the major climate-related challenges: extreme heat and urban flooding.

Extreme Heat

The leading cause of weather-related deaths in the United States is exposure to extreme heat.¹⁸ In 2021, record-breaking summer temperatures across the country amplified nationwide concern about this phenomenon and its potential to cause harm.¹⁹ Extreme heat even prompted the establishment of a new federal initiative to reduce heat-related illness, protect public health, and bolster the economy, part of the Biden administration's broader commitment to addressing workplace safety, climate resilience, and environmental justice by focusing on children, seniors, workers, and other vulnerable groups.²⁰

Urban heat islands are one cause of extreme heat. Heat islands occur when natural land cover is replaced with dense development, which often brings with it massive amounts of asphalt, concrete, buildings, and other surfaces that absorb and trap heat.²¹ Research published in 2020 demonstrated that in 94 percent of US cities studied, there was a positive association between the intensity of urban heat islands and the location of historically redlined neighborhoods—the lower the HOLC rating of a given neighborhood, the hotter it was.²² The legacy of racist policies and planning has created widespread inequities across urban landscapes, with a lack of investment in natural land cover and trees, green and open spaces, or built environment infrastructure like parks, all of which help mitigate the effects of urban heat islands.²³

Exposure to urban heat islands can impair the health of children, older adults, people with respiratory illnesses or other underlying health conditions, unhoused people, and those who work outdoors or engage in outside recreation for long periods of time. With increasing temperatures comes increased risk of heat-related illnesses, such as heat cramps, heat stress, heat stroke, heat exhaustion, and death. People with underlying chronic health conditions, people with disabilities or mobility constraints, and people taking certain medications can also be vulnerable to extreme heat exposure. In addition to direct health effects, higher temperatures can worsen air pollution through the formation of photochemi-



The legacy of redlining is that Black people have far less wealth than white people and far more health problems.

*It's important to note that our government is still harming some of our most vulnerable people. Here's one example: of the more than five million families across the United States who live in federal public housing, the majority are Black, Latinx, children, people with disabilities, and members of other groups who are most susceptible to exposure to environmental hazards. And yet, even though the federal government released data in 2017 showing that more than 70 percent of this country's Superfund sites are located within one mile of federal public housing,¹¹ little has been done to protect residents.

A New Partnership at a Critical Time

Climate change harms our water and food supplies, air quality, and mental health. It increases the occurrence of vector-borne diseases and extreme weather events. And its effects are worst for people of color and people with low incomes, who already disproportionately face other challenges—such as barriers to obtaining equitable healthcare. The need for us to join together to fight for a world that is safer and healthier for everyone has never been clearer.

As nurses and health professionals, you are trusted and influential communicators and can have a critical role in working for climate solutions in your workplaces, in your communities, and in state and federal policy. To help you do that, the AFT's Nurses and Health Professionals division has joined the Nursing Collaborative on Climate Change and Health, a campaign that empowers nurses and health professionals to educate others about the health impacts of climate change and advocate for solutions. The Nursing Collaborative (go.aft.org/bxm) is coordinated by the Alliance of Nurses for Healthy Environments (ANHE) with Climate for Health.

Here are a handful of the many opportunities the Nursing Collaborative offers to help you start right where you are:

Training, education, and professional development materials for individuals and groups, including

- a guide for getting started (go.aft.org/xdd);
- an introduction to climate change as a health crisis (go.aft.org/21e); and
- workshops (envirn.org/calendar), webinars (go.aft.org/r0j), and a podcast (go.aft.org/o1a).

Additional resources are available through ANHE partner Climate for Health, including

- a toolkit (go.aft.org/zk1); and
- customized talking points (go.aft.org/pyq).

—EDITORS



cal smog, a pollutant associated with asthma and other respiratory illnesses.²⁴ And for those fortunate enough to have air conditioning, urban heat islands also increase energy costs, making it more difficult for those who are most vulnerable to the effects of extreme heat to protect themselves.

We can counter the effects of urban heat islands in part by helping to unmake them—by increasing the proportion of urban green space and tree canopy cover in affected neighborhoods. In Atlanta, a place with a strong legacy of redlining,²⁵ I am co-leading efforts to map urban heat islands across neighborhoods by engaging student and community scientists and equipping them with low-cost, high-tech mobile temperature sensors. While we are only one year into our data collection efforts, we have been intentional about bringing a diverse set of stakeholders to the table, including city officials, a key audience for setting environmental justice priorities and proposing practical policies and remedies. We have been able to provide officials and local communities with valuable data about urban heat island impacts and begin discussing the role of urban green space, city planning, and energy burdens, especially as they relate to people with low incomes and communities of color living in historically redlined neighborhoods—with all of this coming directly from local students and other people who live and work in those communities and are most affected.²⁶

Urban Flooding

As climate change brings more heavy rain events, many communities' stormwater and wastewater systems are being overwhelmed. Aging water and sewer infrastructure, as well as inadequate stormwater management, subject some communities to contaminated drinking water and flows of raw, untreated sewage mixed with stormwater runoff contaminants like pathogens, metals, sediment, and chemical pollutants.²⁷ Approximately 860 communities—about 40 million residents—are especially vulnerable because their communities have combined sewer systems, which are remnants of 19th-century sewage and sanitation technology.²⁸ Here's how the EPA describes the problem:

A combined sewer system (CSS) collects rainwater runoff, domestic sewage, and industrial wastewater into one pipe. Under normal conditions, it transports all of the wastewater it collects to a sewage treatment plant for treatment, then discharges to a water body. The volume of wastewater can sometimes exceed the capacity of the CSS or treatment plant (e.g., during heavy rainfall events or snowmelt). When this occurs, untreated stormwater and wastewater, discharges directly to nearby streams, rivers, and other water bodies.

Combined sewer overflows (CSOs) contain untreated or partially treated human and industrial waste, toxic materials, and debris as well as

stormwater. They are a priority water pollution concern for the nearly 860 municipalities across the US that have CSSs.²⁹

While most communities affected by combined sewer systems are located in the Northeast and Great Lakes regions of the country (in states such as Pennsylvania, New York, Maine, Michigan, Illinois, Indiana, and Ohio), they are also found in the Appalachian and Southeastern regions (in states such as West Virginia and Georgia). Most areas served by these systems have populations of fewer than 10,000 people, but large and midsized cities, including Philadelphia, New York, and Atlanta, also face combined sewer overflow challenges.³⁰

The EPA views combined sewer overflows as “a major water pollution concern for cities” because of their potent combination of untreated waste, harmful contaminants, and debris.³¹ Raw sewage carries a variety of human bacteria and viruses. Depending on the amount and concentration of the sewage and the route of people’s exposure to it, the accompanying bacteria and viruses can cause illnesses including hepatitis and gastroenteritis, cholera, skin rashes, and infections like giardiasis. In cities like Atlanta that are affected by combined sewer systems, this means that potential hazards are all around us. Creeks and streams that run through front and back yards, alongside apartment buildings, in public parks, and on school grounds where children and adults fish, swim, and play are not fit for such activities because of the potential for exposure to disease-causing pathogens.³²

In neighborhoods like those in west Atlanta that were redlined and remain predominantly low income and Black, the risk of exposure is significant. In these older parts of the city, the legacies of turn of the 20th century wastewater infrastructure and older, often substandard housing stock are akin to preexisting conditions for the community. Families have been displaced by historic floods laced with sewage, losing both their homes and their property. Some people fish in overflow-contaminated streams to supplement their diets. Some children play in the creeks because they have few other options. To solve challenges like these, the United States will have to rebuild its wastewater and stormwater infrastructures and act to slow climate change. Doing one without the other will not be enough.

Communities of color and under-resourced communities are the proverbial canaries in the coal mine when it comes to climate change. The impact of our climate crisis is currently more severe for these communities, but eventually it will be severe for all of us. The time to act is now—and as a health professional, there’s so much you can do in your commu-

nity to restore our collective health and well-being. To inspire you to think creatively about ways to get involved, I’ll share some of the work I’m doing.

Fighting for Environmental Justice in West Atlanta

As important as it is to acknowledge how unevenly the perils of place are distributed, it is even more urgent that we elevate and leverage *the promise of place* in the pursuit of health equity. I have devoted my career to doing both. In addition to being an assistant professor at Spelman College, I lead the West Atlanta Watershed Alliance (WAWA), a community-based environmental justice organization that works to grow a cleaner, greener, healthier, more sustainable west Atlanta. WAWA represents communities of color in west Atlanta’s Proctor, Utoy, and Sandy Creek watersheds—the communities most inundated with environmental challenges but often least represented at environmental decision-making tables. Living in these watersheds, with their long legacy of inequity, gives us expert knowledge of how place can be dangerous—and our community knowledge is essential to finding the solutions that will make our neighborhoods healthy and safe for everyone.

Collaborating on Community-Centered Solutions

WAWA was established in the aftermath of two successful community struggles to advance environmental justice in southwest Atlanta’s Utoy Creek watershed. The community came together to fight the construction of (1) a combined sewer overflow facility in a community park and (2) an eight-mile sewage tunnel that would burden Black neighborhoods with carrying and treating waste from predominantly white and affluent communities on Atlanta’s north side and from two neighboring municipalities, DeKalb and Gwinnett counties.³³ In both situations, southwest Atlanta residents conducted their own research, educated and mobilized themselves, built important coalitions with environmental activists from other communities, and developed their own “citizens’ plans” to address the technical wastewater challenges that the city of Atlanta had proposed to remedy by effectively adding to the community’s pollution burden. Community elders who led these campaigns by establishing an ad hoc group, the Environmental Trust, laid the foundation for the formation of WAWA.

As an organization, we fight projects and policies deemed to have a negative effect on the environment, health, and well-being of west Atlanta communities, but we do more than that. Together, we also elevate a positive vision for what west Atlanta can be and is becoming: a community that protects our watersheds and recognizes and appreciates our important connections to these vital resources; a population of informed and engaged residents who fully par-

Climate change acts as a great multiplier, making existing inequities worse.

Residents' local knowledge is essential to solving the environmental problems that threaten our neighborhoods.

ticipate in decision making on issues that impact environmental quality, our health, and community well-being; and a place with strong and equitable environmental protections.

WAWA believes that a healthy environment is a key ingredient of a healthy community, and the guiding principle of our work is that the process, in which we work together and learn from one another, is just as important as the results. That process must center the needs of the community and leverage the community's unique local knowledge and expertise in the development and implementation of solutions. We don't believe that our actions empower the rest of the community—we help to set conditions that enable residents to empower themselves and elevate their voices as we work together to advocate for our neighborhoods and press for environmental, community, and systems change. We get results for and with west Atlanta communities through

- grassroots organizing;
- creating and delivering place-based, culturally relevant, and responsive environmental education to “K through Gray” community audiences;
- engaging in community science and other participatory research approaches; and
- facilitating community-led environmental protection strategies and hands-on land and watershed stewardship.

As a key approach to our community research, WAWA engages west Atlanta residents in environmentally overburdened neighborhoods to bring their local community knowledge and lived experiences to bear on the problems; we also work together to monitor local environmental conditions so we can generate actionable data for community change. This helps us to develop effective interventions that revitalize toxic, degraded spaces and transform them into healthy places. In addition, we collaborate with community members to engage in advocacy and cultivate relationships with government agencies, schools and universities, local businesses, and community organizations. Building these public-private-community partnerships enables us to influence how public and private dollars are spent on projects that impact environmental quality, health, and quality of life in our watersheds.

Revitalizing the Proctor Creek Watershed

The power and promise of community-engaged research and action approaches is evident in WAWA's work to restore Atlanta's Proctor Creek watershed. Proctor Creek is an urban tributary to the Chattahoochee River, the drinking water source for over 70 percent of metro Atlanta and the most heavily used water resource in Georgia; Proctor Creek is also the only major watershed located wholly in the city of Atlanta.

The creek originates in downtown Atlanta and travels for nine miles northwest to the Chattahoochee River, meandering through historic Black neighborhoods on Atlanta's Westside. The Proctor Creek watershed—the land that drains to this imperiled yet resilient body of water—represents rich history, culture, and strength. The creek travels through more than 38 neighborhoods, the same soil where Rev. Dr. Martin Luther King Jr. lived with his wife and children and where other civil rights leaders, internationally known entertainers, and Black scholars such as Dr. W. E. B. Du Bois and Dr. Benjamin Elijah Mays lived and worked. It is also home to the Atlanta University Center Consortium, the largest consortium of historically Black colleges in the United States. Historically, Proctor Creek has been a source of pride for northwest Atlanta communities, a place where children played and where people fished, swam, and were baptized. Today, however, Proctor Creek is highly impacted by pollution and other stressors and is not safe for fishing or any other use.³⁴ What once was a community amenity has become a toxic nuisance and eyesore.

The Proctor Creek watershed has a population of more than 127,000.³⁵ Many of the watershed's residents, who are primarily Black, face multiple environmental challenges that pose health risks, including illegal dumping, impaired water quality, aging sewer infrastructure, potentially contaminated and abandoned industrial sites (known as brown-fields), and pervasive flooding.³⁶ The Bankhead community, which I noted in the introduction for its low life expectancy, is in this watershed and is the location of one of metropolitan Atlanta's top five environmental justice hotspots.³⁷

WAWA works with residents in Proctor Creek communities to improve the health of our water and land while also addressing other critical community priorities. Among these problems are aged wastewater infrastructure, lax code enforcement, environmental degradation, long-term divestment of public resources in Proctor Creek neighborhoods, blighted and substandard housing, and little regard for our natural resources, along with inadequate stormwater management and sewage, trash, and debris in our surface waters.

For several years, WAWA was part of the Urban Waters Federal Partnership for Atlanta's Proctor Creek watershed. This partnership seeks to reconnect urban communities, particularly those that are overburdened or economically distressed, with their waterways to help community members become stewards for clean urban waters. From 2013 to 2020, the urban waters designation brought new attention and resources from a diverse array of federal agencies to focus on restoration of the watershed. New and previously unlikely partnerships emerged as federal agencies and national nonprofit organizations col-

laborated with watershed residents and community-based organizations, leveraging the financial and staff resources of these organizations and agencies to prioritize community-led initiatives that address the watershed's varied environmental, economic, health, and social challenges.

Embracing Our Community Power

WAWA collaborated with Environmental Community Action and the Community Improvement Association to launch the Proctor Creek Stewardship Council. The council is a grassroots organization whose mission is to restore, revitalize, and protect the ecological health of the Proctor Creek watershed basin and the quality of life of *all* its people. It helps residents of the watershed harness collective power to advance community-centered and community-chosen solutions to the challenges we face.

As a resident, community leader, and researcher, I've been at tables with multiple stakeholders where the community's vision for a playable, fishable, swimmable Proctor Creek has been a source of consensus, but the process by which we make the Proctor Creek watershed cleaner, greener, healthier, and more sustainable has not. I've seen and heard the voices of community residents dismissed when we've complained about pollution in our creek, illegal dumping on our land, and flooding in our neighborhoods. We've been told numerous times by city officials that many of these occurrences were nonexistent or that we were exaggerating. For example, when Proctor Creek watershed residents first began reporting thousands of tires in the watershed, officials did not trust us and did not believe there was a major dumping problem. By carefully documenting the tires with photographs and exact locations, our community scientists pressed officials to take note. An early achievement of the council's Compliance and Enforcement Committee was the city of Atlanta investing tens of thousands of dollars in cleaning up the creek, including the removal of at least 20,000 illegally dumped tires in the watershed.³⁸ This win was hard fought, but still, it showed that we could accomplish our goals.

For years, WAWA has worked with Proctor Creek watershed residents—sometimes as the lone voice crying out in the wilderness. Government agencies have not always been responsive to community concerns. Nongovernmental organizations (NGOs) have come and gone. Some NGOs brought a program here or there to the community when there was available funding, but they followed the trail of financial resources to other efforts and activities when the Proctor Creek well of funding ran dry. As a result, community-based groups have been left to themselves to figure out most of the solutions. But one thing we've learned in the process is that we have the knowledge and power to make meaningful change within our community, together.

The Stewardship Council is one of several community-based organizations in Atlanta whose members have engaged in participatory research initiatives using community science³⁹ and community-driven citizen-science approaches. These projects have fostered community participation in water quality monitoring,⁴⁰ identifying community assets and environmental health concerns utilizing photovoice (a specific participatory research methodology),⁴¹ and documenting neighborhood conditions and the spatial distribution of "hidden" environmental hazards through participatory mapping.⁴² Little by little, drop by drop, local community knowledge is being amplified by the practice of community science.

Community science brings together community residents, academics, nonprofits, and others, tapping into the wisdom of some of our most knowledgeable community experts, who collectively represent hundreds of years of lived experience in the watershed. We've joined together to leverage this community knowledge of environmental hazards to elevate community concerns in a way that cannot be ignored. The old saying "the squeaky wheel gets the grease" has not been the experience of Proctor Creek watershed residents with respect to demand for equity in services to address code enforcement, watershed management, and infrastructure problems. But now we are changing that paradigm. Our efforts have not only helped to democratize scientific research but also have led to stronger community-based watershed protection and restoration outcomes. For example, ongoing water quality data collected by WAWA personnel, Proctor Creek residents, and Stewardship Council members were instrumental in helping the city of Atlanta to discover leaking sewer pipes that were delivering untreated waste to Proctor Creek. After the city confirmed the validity of the community-generated data with its own data, it was compelled to invest nearly \$100,000 in fixing the problem.⁴³

We have found that the photovoice research methodology has been especially effective in our community science work.⁴⁴ Photovoice has three goals: (1) to help people use photographs to document strengths in and concerns about their communities, (2) to raise awareness and encourage critical dialogue about personal and community challenges through discussions of those photographs, and (3) to influence decision makers.⁴⁵ It involves giving cameras to people whose perspectives may not always be valued by those in positions of power—such as workers, people with low incomes or little formal education, people with disabilities, unhoused people, immigrants, and children—recognizing that they have unique knowledge and access to their communities that outsiders do not. Photovoice helps community researchers empower themselves to define the challenges they face and help shape the proposed solutions.

Community-generated water quality data convinced the city to fix leaking sewer pipes.



Community science helps us harness our collective power to make meaningful change where we live.

The photovoice process in the Proctor Creek watershed has been useful in amplifying community concerns about little to no enforcement of illegal dumping ordinances, the need for new community green spaces in park deserts, gentrification and community displacement in the wake of new developments, and authentic community engagement in infrastructure improvement projects. We can't claim that the photovoice project is the sole reason that illegal dumping areas have received more attention from the city, new parks and green spaces have come online, and some city officials have taken unprecedented steps to co-design, with community leaders, community engagement processes for new watershed restoration projects. However, since the community has been engaged in collecting and presenting its own data to city officials, we have seen numerous positive changes. We have more open and direct lines of communication between Proctor Creek residents and community-based organizations such as WAWA and the Proctor Creek Stewardship Council, the city has become more responsive to community concerns, and city agencies are more willing to collaborate with the community on the design and implementation of initiatives that impact environmental quality, health, and quality of life in the Proctor Creek watershed.

What's more, in the context of documenting Proctor Creek environmental challenges, maps produced by watershed (community) researchers and their associated databases lend credibility to community concerns. In a community-university collaboration, watershed researchers worked with local college students to co-design a mobile app that aids community members in collecting GPS-enabled data. The app helps to precisely identify the locations of illegal dumping sites on land and in Proctor Creek itself, flooding or water pooling in the Proctor Creek watershed, and failing stormwater infrastructure. Through co-creating and using this app, residents have leveraged their knowledge of environmental stressors in the watershed to elevate community concerns in a way that cannot be ignored by the city, as some residents feel has happened in the past.

Demonstrating the existence of these "hidden hazards" helps to fill in gaps, providing data about environmental conditions in the Proctor Creek watershed that don't show up in public data repositories and therefore have not previously been used in environmental decision making. In generating our own maps, we bear witness to our toxic realities. Where we once used our literal voices, now the data tell our stories. Our truths are no longer hidden, and we are getting some traction: sites have been cleaned up, and enforcement actions have been taken against polluters. In addition, resident engagement in these projects and in other watershed-based training, capacity-building, and community-science efforts

has begun to improve the city's responsiveness to problems that are identified by community members.

Through this research and other on-the-ground efforts, the Proctor Creek Stewardship Council has established itself as a critical forum for resident engagement on topics related to the environment and quality of life within the Proctor Creek watershed. At its monthly meetings, the council convenes residents along with government, nonprofit, and other Proctor Creek stakeholders to ensure that residents' voices are heard as restoration and revitalization efforts for the watershed are planned. While it is a work in progress, the dialogue on meaningful citizen engagement in the restoration and revitalization of the Proctor Creek watershed has dramatically changed, with greater respect for community leadership and community-identified needs. The roles that the Proctor Creek Stewardship Council, Proctor Creek watershed residents, and organizations such as WAWA have played in advancing environmental health protections through participatory approaches to research are also works in progress. But we can see the tangible results of our efforts. They have helped to improve municipal services, address community health concerns, advance environmental justice, and positively impact the implementation of urban policies and practices that influence health, livability, and quality of life. This knowledge of our collective power pushes us to continue the fight.

Join the Fight

No one person can tackle all of these interrelated pollution, climate, and health problems, but we can each choose something to work on where we live. As health professionals, you are among the most trusted people in your communities. You can use that power to make your neighborhoods safer and healthier for everyone and to ensure that all of your neighbors have the opportunity to be heard. You can

- learn more about the history of redlining and the related environmental and health issues in your region;*
- join, volunteer with, or provide financial support to a grassroots or community-based organization that addresses environmental justice issues in your local community or another community nearby;
- join or start an organization to plant and maintain trees, particularly in city neighborhoods with minimal tree cover that are suffering from extreme heat;
- become an advocate for replacing diesel buses with electric buses—especially school buses that pollute the air and make children more likely to develop asthma or cancer;
- get engaged with local policymaking to add your

*For a searchable, nationwide map of redlining, see "Mapping Inequality" at go.aft.org/y84.



voice and expertise to important decisions that have the potential to impact intersecting environmental, climate change, and health issues in your community;

- advocate statewide or regionally to advance policies that promote emissions reduction to improve air quality and public health;
- lend your expertise to local community-based efforts to advance environmental justice and health equity;
- learn about specific climate-related threats to your patient population and join with others in your practice to develop education strategies that will help patients better adapt to a changing climate and eliminate impacts where feasible;
- join or start an organization of health professionals to engage in systematic, interdisciplinary, and applied research or to create and advance a policy and action agenda to address health-related climate change impacts in vulnerable communities (see, for example, Georgia Clinicians for Climate Action: states.ms2ch.org/ga/gcca); and
- work with others in your health system by joining or starting a task force to reduce the system's carbon footprint, minimize waste, and green your operations.

The wrongs of segregation, chronic disinvestment in low-income neighborhoods, and inaction on climate issues will not be righted overnight. The challenges we face are equally persistent and stubborn, and we need to be equally persistent and determined in confronting them. It will take a village of community residents and other stakeholders—all of us, working together—to secure healthy and sustainable futures for us all. +

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No one person can tackle all these problems, but we can each choose something to work on in our communities.

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Continued from page 19

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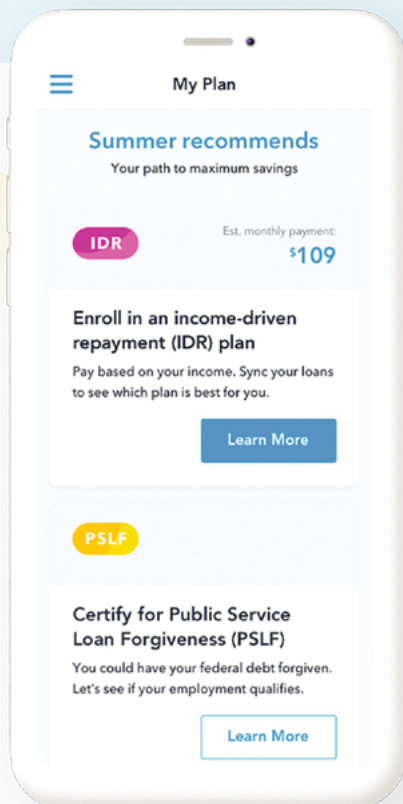
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