The Health Care Labor Shortage

Report of the Health Care Labor Shortage Work Group

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There is critical shortage of available workers in many health care occupations in Washington State. This shortage is seriously jeopardizing the availability and quality of health care for the people of Washington, and is undermining the vitality of one of the largest industries in the state. The healthcare industry provided over $6.2 billion in wages in 2000.[1] This is almost twice as much as the agriculture, forestry, and fishing industries combined. Between 2002 and 2008 there will be over 6,000 job openings in healthcare each year.[2] The shortage is further deterring other businesses that want to locate and grow in communities that offer good health care.

During 2001, the Workforce Training and Education Coordinating Board facilitated a Work Group analyzing the shortage of workers in the health care industry. The Work Group focused on education and training issues related to the shortage. The Work Group did not attempt to address the full range of issues related to the shortage such as workplace issues, employers other than hospitals or the full range of providers. The Work Group included representatives of the following entities: the Department of Health; the Department of Social and Health Services; the Employment Security Department; the Higher Education Coordinating Board; the Office of Trade and Economic Development; Service Employees International Union 1199 Northwest; the State Board of Health; the State Board of Community and Technical Colleges; the Washington State Nurses Association; the Washington State Hospitals Association; the Washington State Nursing Care Quality Assurance Commission; the University of Washington Center for Health Workforce Studies; United Food and Commercial Workers United Staff Nurses Union; and input from regional employer groups and Workforce Development Councils.[3]

This report summarizes the findings of the Work Group, including objectives and strategies for addressing the many challenges we face. The report does not constitute official endorsement of the objectives and strategies by each organization represented on the Work Group. The strategies are intended as a menu of ideas for state and local policymakers to consider. We believe these ideas are worth exploring and discussing. Work group member organizations are already beginning to implement many of these strategies.

The Current Crisis

Recent studies show Washington's shortage of health care workers is at crisis level. Health occupations that face critical shortages include nurses, medical aides, dental hygienists, billers and coders, laboratory personnel, pharmacists, physicians and radiology technologists.[4]

State statistics of nursing shortages demonstrate the gravity of the problem. The state's acute care hospitals reported a shortage of 2,200 workers in 2001.[5] Recruiting new as well as experienced nurses poses a major challenge. Over 79 percent of hospitals reported difficulty in recruiting newly trained registered nurses during 2000 – 2001, and over 95 percent reported difficulty in hiring experienced registered nurses.[6]

When hospitals cannot fill shift vacancies, they resort to using staffing agencies, and sometimes increase workloads and staff overtime, decreasing the quality of care and increasing costs.[7] If hospitals do not have enough staff in their emergency facilities they must divert ambulances to other hospitals. During 2000 to 2001, 55 percent of Washington's hospitals went on "divert status." In urban areas, 54 percent of hospitals were on divert status for a more than 6 days.[8]

High rates of burnout further contribute to critical workforce shortage levels and jeopardize patient care. During 2000 to 2001, the average nursing staff turnover rate in Washington hospitals was 16.7 percent.[9]

With the aging of Washington's population the rate of retirements will increase dramatically exacerbating the shortage of health care workers and increasing the demand for health care for elderly patients. Ethnic and racial minorities will constitute an increasing proportion of the population but studies show there are significant health disparities between this segment and the general population. Recent studies demonstrate that increasing diversity in the healthcare worker population to reflect the diversity in areas served can reduce these health disparities.[10]

Objectives and Strategies

The Work Group identified a series of objectives and strategies to address the shortages. The objectives and strategies have not been prioritized.

Note:
"L" indicates strategies that require or could benefit from legislative action.

1. **Objective: Increase the number of students in training for health care occupations.**

   Strategies

   1.1 Fund student FTEs in high demand community and technical college, and four-year college and university health care programs. (L)
   1.2 Retrain dislocated workers for health care occupations. (L)
   1.3 Increase customized training opportunities for new and incumbent workers for specific jobs in health care. (L)
   1.4 Use WorkFirst resources to enable low-income individuals to enter health care occupations.
   1.5 Increase recruitment efforts to encourage students to enroll in health care programs.
   1.6 Create special financial assistance (scholarships, loans, and loan forgiveness) for students who enroll in health care programs. (L)
   1.7 Assist colleges and universities in acquiring or gaining access to equipment for health care programs. (L)

Discussion:

Three factors demonstrate the need to increase the capacity of healthcare educational programs at colleges and universities. First, institutions are unable to meet current demand. Second, forecasted growth in the industry will require increased capacity beyond current demand. And third, there will be additional recruits seeking education and training in healthcare from the ranks of dislocated workers, workers in low-income occupations, target populations, and a growing number of students graduating from high school.

In 2001, 19 programs of 41 selected allied health programs at community and technical had waiting lists. The State Board of Community and Technical Colleges is conducting a survey of colleges to determine barriers they face in offering health care programs.[11] Further strain is placed on the education and training system because nursing and many other health care programs are among the most expensive programs to deliver due primarily to the cost of equipment required to be licensed.

2. **Objective: Increase opportunities for clinical training.**

Strategies

2.1 Create partnerships between colleges and workforce development councils to enable students to attend colleges outside their geographic area that have unused capacity.
2.2 Strengthen partnerships between employers and education institutions to increase the availability of resources for and access to clinical training.
2.3 Provide reimbursement or tax credits to employers that provide resources for clinical training. (L)

Discussion:

Health care personnel require clinical experience to become qualified. However, once students are trained in the classroom, there is an overall lack of clinical experience opportunities. While some regions are filled with students in clinical training, other areas maintain unused clinical training capacity. Workforce Development Councils could collaborate with education institutions and employers to connect students with clinical training opportunities currently available in the state. Partner entities could devise incentives to encourage students to temporarily move to other regions for training, and then return to their home communities.

3. **Objective: Remove barriers to training for current health care personnel.**

Strategies

3.1 Create "Career Maps" of training and employment opportunities in health care occupations that identify multiple points of entry and advancement—including vertical and horizontal opportunities—from high school through professional schools.
3.2 Increase articulation so that prior education, training, and experience are recognized and accepted by education institutions and employers. (L)
3.3 Re-examine rules regarding recognition of military training.

3.4 Identify and implement flexible scheduling in class offerings and shift-work assignments in order to meet employee needs.
3.5 Create more opportunities for distance learning.
3.6 Provide support services—such as financial aid, childcare, language skills classes, life skills classes, and transportation—to enable health care personnel to attend additional education and training.

Discussion:

More training of current health care personnel could help to increase retention and reduce shortages, but incumbent workers are often deterred from beginning or continuing study due to existing barriers. Barriers include transportation, lack of English language proficiency, times of class offerings, program fees, loss of wages, and family responsibilities such as childcare. Some employment contexts can pose barriers. For example, students may have difficulty attending classes because of rotating shifts or because they work in isolated rural areas.

Partnerships that facilitate communication between local Workforce Development Councils (WDC) and employer groups can assist in removing barriers to education and training. For example, a skills panel organized by the Tacoma-Pierce County WDC has successfully enabled more low-paid, and immigrant staff to enter training and climb a career ladder within the health care by linking students with English language classes and adjusting shift schedules to allow students to attend classes regularly.

The healthcare industry would benefit from increased articulation between institutions and programs, and increased emphasis on competency-based learning. Increased flexibility in training opportunities at various points in a career enables more individuals to gain qualifications to enter healthcare occupations, or traverse to other high demand healthcare occupations. Increased points of entry and credit for competencies already achieved promote timely achievement of qualifications and alleviation of critical shortages.

4. **Objective: Recruit diverse populations into the health care profession (including diversity in gender, race, ethnicity, age, and disability).**

Strategies

4.1 Increase outreach efforts aimed at target populations including partnerships with community organizations.
4.2 Provide incentives such as scholarships and loan forgiveness. (L)
4.3 Continue and expand efforts to enhance the retention of minority students at colleges and universities.
4.4 Encourage men to consider health career options that have traditionally been female-dominated, such as nursing and dental hygiene.

Discussion:

Recruiting diverse populations into healthcare occupations could alleviate shortages, and at the same time improve the quality of care for minorities by enhancing cultural and multilingual competency. Similar to national statistics, a recent state study shows that significant health disparities exist in Washington between the general population and ethnic and racial minorities. The infant mortality rate for American Indian and African Americans is more than double the rate for Caucasians.

African Americans are more than three times as likely as Caucasian to die from HIV/AIDS and diabetes. The rate of tuberculosis for Asians is more than 15 times greater than it is for Caucasians, and compared to Caucasians, American Indian and Alaska Natives are 2.5 times more likely to die from diabetes and as almost twice as likely to die from cervical cancer or asthma.[12]

Racial and ethnic minorities represent the most rapidly growing segment of Washington's growing population highlighting the need to improve the health status of this segment of the population. Recent studies demonstrate the health status of racial and ethnic minorities improves when served by a healthcare workforce that is proportionately diverse to the area's population.[13] These studies show that increasing health care workforce diversity can improve the quality of care and health outcomes among often high-risk patients, as well as help increase the number of health care professionals.

Since people of color and people with disabilities constitute a disproportionately large piece of the underutilized, underpaid workforce, and will form an increasing proportion of the population, the future of the healthcare industry is dependent on their participation in healthcare occupations and their educational outcomes. Efforts to improve educational outcomes of minorities should be supported, such as the State Board for Community and Technical College's strategies for increasing college completion rates for minorities, or the Office of Superintendent of Public Instruction's recent emphasis on improving methods of assessing English language proficiency.

5. **Objective: Increase the availability and retention of qualified health care faculty.**

Strategies

5.1 Establish local partnerships between employers and education institutions to help provide instructors.
5.2 Re-examine rules for qualifications of health care instructors.
5.3 Increase resources for funding health care faculty recruitment and retention. (L)

Discussion:

Education and training institutions have difficulty attracting high quality faculty to teach in health care programs. One of the major problems for community colleges is that health care instructors must have a Masters qualification, and Masters qualified health care personnel can earn more outside teaching. With limited state funding for faculty salaries, community colleges need assistance in finding ways of attracting and retaining faculty.

6. **Objective: Increase awareness among young people of opportunities in health care, and of the math and science requirements.**

Strategies

6.1 Enhance efforts in high schools to provide counseling, work-based learning, and mentors in health care occupations.
6.2 Increase counseling of high school students regarding the math and science requirements of health care occupations.
6.3 Devise marketing efforts to make health care occupations more desirable to young people.

Discussion:

Recent emphasis on "career pathways" in the K-12 system, including health care, has built a foundation for increased efforts to make students aware of opportunities available in healthcare occupations. High school students require rigorous guidance and multiple opportunities to become involved and understand a career. Counseling, work-based learning, and mentor programs can provide meaningful exposure to healthcare occupations and students should have the opportunity to participate in such career activities.

Increased high school efforts to make students aware of healthcare opportunities should include awareness of the math and science requirements. When young people commence two or four-year courses of study with a plan to pursue healthcare they are often not aware of the math and science requirements. Students take valuable time to complete prerequisites that could have been taken during high school and delay their path to graduation.

7. **Objective: Enable local communities to address health care shortages.**

Strategies

7.1 Form industry skill panels of employers, labor, education and training providers, and local Workforce Development Councils to analyze local needs and to develop and implement strategies in local areas of the state.
7.2 Secure funding to implement locally identified strategies to address the health care labor shortage. (L)
7.2 Facilitate communication between local industry panels through meetings, conferences and visits to share lessons learned.
7.3 Secure funding, such as grants, for statewide data collection on the shortage of workers in health care.

Discussion:

The Workforce Training and Education Coordinating Board has worked with many of the state's 12 Workforce Development councils to establish industry skill panels, composed of employers, labor, education and training providers. The skills panels have produced

measurable successes in various regional industries including healthcare since 2000. The panels provide local communities with information about the location and severity of healthcare shortages and help devise solutions. For example, in its first year the Northwest Alliance for Health Care Skills, conducted research to identify five priority healthcare occupations and worked with local hospitals to provide training facilities at Bellingham Technical College in conjunction with Skagit Valley College in radiology technology.

Local efforts can benefit from increased communication of best practices. Local leaders who have established successful practices can visit other regions to share lessons learned. The association of the directors of Workforce Development Councils, WDEW, and state entities such as the Workforce Training and Education Coordinating Board can facilitate communication at conferences and meetings. In addition state and local entities can collaborate to seize any state or federal grant opportunities.

The Center for Health Workforce Studies (the Center), located at the University of Washington, is one of five federally funded centers that focuses on the health workforce. The Center is available to consult or partner in studies, though Washington is just one of ten states the Center is directed to study.[14]

8. **Objective: Provide innovative leadership for solving health care labor shortages.**

Strategies

8.1 Create a state health care workforce commission to devise a state strategic plan for ensuring the adequate supply of health personnel. (L)

Discussion:

The critical health care workers shortage suggests that a commission should be established to monitor and formulate policies to alleviate the shortage and reassure Washington citizens and businesses of high quality care, and to help plan and evaluate workforce strategies that prevent major shortages and surpluses in the future. Our workgroup focused solely on workforce development issues in health care and primarily for occupations at the sub-baccalaureate level. A commission could address issues that go beyond the narrow scope of this report. For example, issues concerning health care policies and practices that feed the shortage of workers, and the need for ongoing basic data. The commission could comprise representatives from employers (hospitals, long-term care facilities, clinics and others), professional health care organizations, labor organizations, business, education, and the legislative and executive branches of state government.

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[1] Employment Security Department data: 2000 Covered Employment and Payrolls in WA State by County and industry. This figure does not include wages for people who are self-employed.

[2] U.S. Department of Health and Human Services, Bureau of Health Professions, Health Resources and Services Administration, National Center for Health Workforce Information and Analysis, *HRSA State Health Workforce Profiles: Washington,* Rockville, Maryland, December, 2000.
Available online at: http://www.bhpr.hrsa.gov/healthworkforce/profilesl

[3] Washington has twelve Workforce Development Councils that were established according to requirements of the Workforce Investment Act (1998) to oversee regional workforce development programs. These Workforce Development Councils are composed of a majority of leaders from the business community, and representatives from education and labor.

[4] Washington State Hospitals Association, Association of Washington State Hospital Districts. *Who Will Care For You?: Washington Hospitals Face a Personnel Crisis,* Pages 7-8 and the University of Washington Center for Health Workforce Studies: Results of dental survey (forthcoming) reveal a vacancy rate of 25 percent.

[5] University of Washington Center for Health Workforce Studies in conjunction with University of Washington School of Nursing and Washington State Hospitals Association, *2001 Washington State Hospital Workforce Survey: Nursing and Allied Health Staffing*, (unpublished). Survey of 83 acute-care hospitals in Washington State. These figures account for part-time and full-time workers that equal 1,400 FTEs. These figures do not take into account the employed nurses who work in specialty and federal hospitals and the approximately 40 percent of nurses who work in non-hospital settings. King and Pierce counties have the highest vacancy rates of over 10 percent and Spokane has the lowest vacancy rate of about 2 percent.

[6] University of Washington Center for Health Workforce Studies, Sue Skillman, seminar presenting preliminary findings of survey, October 3, 2001. Sixty-five percent of hospitals reported it was "very difficult" to find experienced registered nurses.

[7] Ibid. 4. Pages 9-12.

[8] Ibid. 4. Pages 23-37.

[9] Ibid. 6.

[10] See studies cited in State Board of Health report, Joe Finkbonner, R. Ph., M.H.A., the Honorable Margaret Pageler, J.D., Vickie Ybarra, R.N., M.P.H., *Final Report State Board of Health Priority: Health Disparities,* Committee on Health Disparities, May 2001.

[11] State Board for Community and Technical Colleges "Selected Allied Health Programs," December 21, 2001.

[12] Ibid. 10. Page 2.

[13] Ibid. 10.

[14] University of Washington Center for Health Workforce Studies: Personal communication with Sue Skillman, Deputy Director.