Health Workforce Council

2021 Annual Report

December 2021

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Washington Workforce Training & Education Coordinating Board

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Health Workforce Council Membership

The Health Workforce Council (Council) is composed of leaders from a range of healthcare stakeholders, including: education and training institutions; healthcare organizations; community health services; labor and professional associations; and employer representatives. The Council has flexibility to add members from additional sectors or organizations as needed. The Council is chaired by Dr. Suzanne Allen, Vice Dean of Academic, Rural and Regional Affairs at the University of Washington School of Medicine. The Vice-Chair is Dr. Kevin McCarthy, President of Renton Technical College. The Council is staffed by the Workforce Training and Education Coordinating Board (Workforce Board).

2020 Health Workforce Council Members

Council Member	Organization
Suzanne Allen, Chair	Vice Dean for Academic, Regional & Rural Affairs, University of Washington School of Medicine
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Health Workforce Council History & Role

Twenty years ago, the state's Workforce Board gathered a group of healthcare stakeholders to address growing concerns about personnel shortages in Washington's healthcare industry. In those years, healthcare facilities across the state faced critical staff shortages with industry reaching out to temporary employment agencies to fill regular staffing needs. In some cases, patients were turned away from emergency rooms or delayed scheduled procedures. At the same time as demand was growing, many of Washington's healthcare training programs turned away qualified students because of lack of capacity, faculty, and clinical sites to train them.

Soon after, in 2002, then-Governor Gary Locke directed the Workforce Board to create the Healthcare Personnel Shortage Task Force (Task Force). The Task Force developed a statewide strategic plan to address severe personnel shortages in the healthcare industry, and in January 2003, the Task Force released an action plan to tackle the growing gap between the number of trained healthcare professionals and the needs of Washington residents. The report, *Healthcare Personnel Shortages: Crisis or Opportunity*, was presented to the Governor and Legislature.

Later, in 2003, the Legislature passed Engrossed Substitute House Bill 1852, directing the Workforce Board to continue gathering stakeholders to address healthcare workforce shortages. The intention of the plan was to provide a framework that helped ensure a sufficient supply of trained personnel, with an emphasis on increasing diversity to better reflect the demographics of Washington's residents, along with efforts to ensure that healthcare services were available everywhere, including rural and underserved places in the state. The bill also required an annual report to the Governor and Legislature on this work, including updated recommendations to address healthcare occupations facing the most acute shortages. In 2014, Task Force members voted to change their name to the Health Workforce Council to better reflect a new focus on the overall health of a person instead of just considering healthcare delivery.

Health Workforce Council Provided Staff Funding

In 2019, the Workforce Board received funding from the Legislature to staff the Council, along with increased administrative support. The Workforce Board also received ongoing funding to support the Health Workforce Sentinel Network (see p. 8). This allowed the Council to take a greater role in connecting the educational community to on-the-ground workforce needs, and explore more fully a wide range of health workforce issues—from loan repayment options for those who work in shortage areas to ongoing retention challenges due to stress and burnout

In 2021, as the second year of the COVID-19 pandemic progressed, the health workforce system continued to feel tremendous strain. Healthcare workers, many of them serving

as frontline workers treating the pandemic's ballooning patient population, experienced record levels of burnout with some leaving the healthcare field entirely, even as the development and distribution of vaccines helped to mitigate the spread of the virus. The pandemic continued to bring its own unique challenges and opportunities for the Council, with requests from healthcare employers and policymakers for input and guidance on key workforce challenges, including long-term care, nursing, and dental workforce. The Council also turned attention toward the state's growing behavioral health needs, with Council members participating in the development of recommendations from the Behavioral Health Workforce Advisory Committee (BHWAC). The Council also adopted a long-term care workforce proposal as a key policy initiative.

Council's Roles Remain Critical

The Council's main roles continue to be providing updates to policymakers on the number of qualified healthcare personnel (by occupation) graduating from the state's education and training programs, providing insight on the real-time workforce needs of area healthcare providers, and tracking the progress of newly implemented programs. By bringing together a wide range of stakeholders to develop and advocate for sustainable solutions, the Council is able to identify key policy and funding priorities for the Governor, Legislature, and other policymakers and stakeholders.

Health Workforce Council Year-in-Review

Council members held three formal meetings following the end of the 2021 Legislative session, to hear legislative updates, discuss topics of interest, and identify key priorities for the year. In accordance with pandemic safety measures, Council members gathered virtually, with meetings broadcast for the public on TVW.

In June, Council members received legislative updates from different realms of the health workforce field: behavioral health, long-term care, allied health, and physical health. Council members also received an update from the Health Workforce Sentinel Network leadership and staff. Council members discussed topics of interest and engaged in conversation to identify the Council's key priorities for the year. Those priorities were determined to be:

- Long-term care.
- Allied health professions, particularly dental health and nursing.
- Behavioral health.

The Council's continued emphasis on behavioral health included engaging with the BHWAC, along with stakeholder/professional network engagement to promote participation in the Health Workforce Sentinel Network, which provides regular, on-the-ground information about the state's evolving workforce needs.

The August Council meeting offered members an opportunity to hear detailed presentations on priorities identified in June. The Washington State Dental Association (WSDA) highlighted their recently launched workforce task force with Delta Dental. The Washington Dental Hygienists' Association shared challenges facing students from enrollment to graduation in dental/allied health programs. In addition to behavioral health and Sentinel Network updates, Council members received a presentation on the long-term care workforce proposal, developed by Council and Nursing Care Quality Assurance Commission staff, which was formally endorsed as a priority initiative of the Council (see p. 27). *Spotlight reports on each of these topics can be found in subsequent sections of this report.*

Finally, the Council's October meeting provided an opportunity to review an outline for the 2021 Council report, receive a Sentinel Network update, and hear draft recommendations from the BHWAC, as well as an update on WA-STEM's research partnership with the Committee. Council members engaged in a discussion of their respective legislative priorities in advance of the upcoming 2022 Legislative Session, including opportunities for cross-industry collaboration and support. Council members and staff will advocate for priorities, including the long-term care workforce proposal, in the 2022 Legislative Session.

Council Project Update: Washington's Health Workforce Sentinel Network

Washington's Health Workforce Sentinel Network links the state's healthcare industry with partners in education and training, policymakers, and other workforce planners to identify and respond to emerging demand changes in the health workforce. The unique qualitative information captured by the Sentinel Network provides the "why" behind changes in occupations, roles, and skills needed to deliver quality care. Created as part of the state's Healthier Washington initiative in 2016, with ongoing funding provided by the 2019 Washington State Legislature, the Sentinel Network is a collaboration of the Workforce Board (and the Health Workforce Council) and the University of Washington Center for Health Workforce Studies (UW CHWS).

Every six months, employers ("Sentinels") from across the state and from a wide range of healthcare sectors share their top workforce challenges. This information is used to identify signals of changes in the healthcare workforce and suggested solutions. The data are compiled and made available on the Sentinel Network website and disseminated through meetings and reports so that employer needs are communicated to policymakers.

Focus on Employer Needs from a Selection of Healthcare Settings

The Sentinel Network allows members of the Health Workforce Council and other stakeholders to learn about employers' health workforce needs in specific settings and in different geographic regions of the state. During 2021, healthcare employers shared their experiences and suggested solutions to workforce challenges in April and again in October. This semi-annual check-in with employers allows educators, regulators, policymakers, and other key partners to adjust to the rapidly changing healthcare environment and to tailor workforce solutions to the needs of unique sectors and areas of the state.

Summarized below are some of the top issues raised by employers from long-term care (LTC), behavioral health, and oral health settings. Unless otherwise noted the findings are from the Fall 2021 information-gathering period. See the Sentinel Network dashboards at wa.sentinelnetwork.org for findings from additional settings and time periods.

Employer Perspectives: Long-Term Care Facilities

In Fall 2021, employers in LTC settings, including skilled nursing facilities, nursing homes, and assisted living facilities, reported that they were not able to hire enough RNs, nursing assistants, and licensed practical nurses (LPNs). Many organizations struggled to fill their staffing schedules when workers called in sick or had to quarantine due to possible COVID-19 exposure, and were limited in their ability to move staff among

facilities to cover absences because of efforts to limit COVID-19 exposure to staff and residents. In the past, staffing agencies could provide workers to fill these gaps, but employers reported that agencies were charging high rates and were also short-staffed. Many facilities had to limit admissions of new residents because they didn't have enough workers to accommodate a full census. Some Sentinels from LTC facilities mentioned that the vaccine mandate contributed to the loss of workers.

Independent Living Facility
"Retirement aged staff have chosen to exit the workforce and there are not enough nurses graduating from programs to fill the growing demand… Further complicating the issue is the genuine arms race that now exists for the declining talent pool… There just aren't enough licensed nurses or CNAs to fill all the open positions everywhere!"

In addition to being short-staffed, Sentinels reported that workers in LTC settings were asked to take on additional responsibilities. Examples of work intensification and changes to staff roles because of the pandemic included: limited help from family members and friends of residents due to attendance limitations; increased monitoring requirements, especially related to telehealth visits; increased signs and symptoms of depression among residents; and clinical staff having to fill food service and housekeeping roles.

Skilled Nursing Facilities
"We recently added two units which increased our bed capacity, but can't open fully because we can't fill current open positions for existing units."

"COVID has affected nursing home residents greatly… Mental health services are lacking, due to not enough available or provider is unable to come into the facility."

Staffing shortages at long-term care facilities have impacted area hospitals, with many unable to discharge patients who no longer require hospital care but have no place else to go. A November Seattle Times article cited two hospital systems that are housing patients in need of longer-term care, stressing acute-care resources and boarding more of these patients in their emergency rooms.[1]

Since its inception, the Sentinel Network has tracked the occupations reported to be experiencing exceptionally long vacancies. The tables below show the occupations that employers from nursing home/skilled nursing facilities (Figure 1) and assisted living facilities (Figure 2) have indicated were the hardest to hire.

[1] Seattle Times, Nov. 29, 2021.

Figure 1. Nursing Homes/Skilled Nursing Facilities
Occupations with exceptionally long vacancies: 2017-2021

Rank	Fall 2017*	Summer 2018	Spring 2019	Fall 2019	Spring 2020	Fall 2020	Spring 2021	Fall 2021	
1	Nursing assistant	Nursing assistant	Registered nurse	Nursing assistant	Nursing assistant	Nursing assistant	Registered nurse	Registered nurse	↑ Most cited
2	Registered nurse	Registered nurse	Nursing assistant	Registered nurse	Registered nurse	Registered nurse	Nursing assistant	Licensed practical nurse Nursing assistant	
3	Licensed practical nurse	Licensed practical nurse	Licensed practical nurse	Licensed practical nurse	Licensed practical nurse Dentist	Licensed practical nurse	Licensed practical nurse	Occupational therapist Physical therapist	
4	Multiple occupations cited at same frequency	Dentist Physician/ Surgeon	Occupational therapy assistant Physical therapist Social worker Psychologist	Speech-language therapist	Multiple occupations cited at same frequency	Occupational therapy assistant Physical therapist Physical therapy assistant	Occupational therapist Physical therapist Social worker Speech-language therapist	Speech-language therapist	
5		Multiple occupations cited at same frequency	Multiple occupations cited at same frequency	Multiple occupations cited at same frequency		Multiple occupations cited at same frequency	n/a	Multiple occupations cited at same frequency	

**Findings prior to Fall 2017 can be viewed on the Sentinel Network dashboard: wa.sentinelnetwork.org*

Figure 2. Assisted Living Facilities
Occupations with exceptionally long vacancies: 2019-2021

Rank	Spring 2019*	Fall 2019	Spring 2020	Fall 2020	Spring 2021	Fall 2021	
1	Nursing assistant	Nursing assistant	Home health aide or home care aide	Nursing assistant	Nursing assistant	Nursing assistant	
2	Licensed practical nurse	Licensed practical nurse	Licensed practical nurse Registered nurse Nursing assistant	Licensed practical nurse	Licensed practical nurse	Registered nurse	
3	Home health aide or home care aide Registered nurse	Home health aide or home care aide Registered nurse	Multiple occupations cited at the same frequency	Registered nurse	Registered nurse Personal care aide	Home health aide or home care aide	← Most cited
4	Personal care aide Chemical dependency professional Social worker	Personal care aide Cook		Home health aide or home care aide	Cook Home health aide or home care aide	Licensed practical nurse	
5	Multiple occupations cited at the same frequency	Multiple occupations cited at the same frequency		Personal care aide Food service Housekeeping	n/a	Personal care aide	

**Before Spring 2019, assisted living facility responses were combined with other long-term care facility responses*

Employer Perspectives: Behavioral and Mental Health Facilities

Employers from behavioral-mental health facilities reported a sharp increase in patient acuity and an overall increase in demand for mental health services in the past year. Closure of other local services has led to increased demand for services that have remained open.

Behavioral-Mental Health Clinics

"Candidates are struggling to complete all of the state peer certification training necessary. They can complete the online portion, but have to wait long periods to complete the in person portion."

"In the past, staff often considered this to be 'mission' work and came into the field knowing pay would be low. We are in a different time with very different generations who (rightfully) expect to be paid appropriately."

Behavioral health Sentinels reported difficulty hiring as well as increased turnover in 2021, primarily due to better wages in other settings (including private behavioral health employers); the intense effort required to care for challenging, high-acuity patients; documentation requirements; and some concerns about vaccine mandates. Some respondents also remarked that turnover created a greater burden on remaining staff, which in turn encouraged more turnover. Some employers hired providers from other states or newly credentialed workers but reported difficulties with the licensing and credentialing procedures.

Figure 3. Behavioral Health Facilities*
Occupations with exceptionally long vacancies: 2017-2021

Rank	Fall 2017	Summer 2018	Spring 2019	Fall 2019	Spring 2020	Fall 2020	Spring 2021	Fall 2021	
1	Chemical dependency professional	Mental health counselor	Mental health counselor	Mental health counselor	Mental health counselor	Mental health counselor	Mental health counselor	Mental health counselor	← Most cited
2	Mental health counselor	Chemical dependency professional Peer counselor	Chemical dependency professional	Chemical dependency professional	Chemical dependency professional	Chemical dependency professional (SUDP)***	Substance use disorder professional***	Substance use disorder professional***	
3	Social worker Nurse practitioner	Nurse practitioner	Social worker	Peer counselor	Social worker	Social worker (Mental Health/SUDP)	Psychiatrist Social worker	Social worker (Mental Health/SUDP)	
4	Peer counselor	Social worker Psychiatrist	Marriage & family therapist	Marriage & family therapist	Peer counselor	Registered nurse	Peer counselor	Peer counselor	
5	Registered nurse	Marriage & family therapist	Peer counselor Psychiatrist	Social worker	Multiple occupations cited at same frequency	Marriage & family therapist Peer counselor Psychiatrist	Registered nurse	Social worker (Child, Family and School)	

**Behavioral/mental health, substance use disorder clinics and residential treatment facilities*
****Occupation title changed to Substance Use Disorder Professional (SUDP) in 2019*

Employer Perspectives: Dental Offices and Dental Clinics

During 2021, patients continued to return to dental care, and dental offices have struggled to meet the increase in demand. Respondents to the Sentinel Network cited the following as examples of workforce issues they have faced in the past year:

- Too few dental assistant, dental hygiene, and administrative applicants.
- Employers report that higher wages than in the past are frequently requested by applicants.
- Staff leaving the profession due to COVID-19 related concerns, including gaps in childcare coverage and/or at-home schooling requirements.
- Some employers feeling that they must reduce their hiring standards due to the perceived lack of qualified applicants.
- In Fall 2021, some respondents from dentist offices/dental clinics cited vaccine mandates as hampering hiring and retention efforts.

Dental Offices & Dental Clinics

"Many patients took a break from going to the dentist over the past two years due to COVID. We now have huge wait times for appointments because we don't have enough assistants to see the backlog of patients."

"Due to high demand and low supply, wage demands are rising at an unsustainable rate, considering insurance reimbursement rates have been frozen for over a decade."

"We have been forced to consider applicants that we wouldn't have considered in the past given that there is such limited workforce availability."

"Not enough dentists to be able to provide students enough clinical hours."

Since 2016, the Sentinel Network has tracked the occupations that dental offices and dental clinics reported as experiencing exceptionally long vacancies. As the table below shows, dental assistants and dental hygienists have been the occupations that have been most difficult to hire, followed by dentists and office personnel. This trend predated the COVID-19 pandemic, but many dental employers report that hiring has become even more difficult since the pandemic began.

Figure 4. Dentist Offices/Dental Clinics
Occupations with exceptionally long vacancies: 2018-2021

Rank	Summer 2018	Spring 2019	Fall 2019	Spring 2020	Fall 2020	Spring 2021	Fall 2021	
1	Dental assistant	Dental hygienist	Dental assistant	Dental hygienist	Dental assistant Dental hygienist	Dental assistant Dental hygienist	Dental assistant	← Most cited
2	Dental hygienist	Dental assistant	Dental hygienist	Dental assistant	No additional occupations reported	Dentist	Dental hygienist	
3	Dentist	Dentist	Dentist	Dentist Office personnel		Office personnel Medicaid navigator	Dentist	
4	Multiple occupations cited at same frequency	Office personnel	Multiple occupations cited at same frequency	Multiple occupations cited at same frequency		No additional occupations reported	Administrative personnel	

**Responses prior to Summer 2018 not shown due to low response counts*

Uses of the Sentinel Network

In the past year, information about the Sentinel Network and its findings was used to guide many health workforce planning activities in Washington, including assessing the state's behavioral health workforce, informing nurse workforce planning, and describing COVID-19's impact on the health workforce.

> *"Colleges are adjusting programming to respond to industry needs. The Sentinel Network is a valued resource that supports the efforts of higher education to produce the essential health workforce."*
>
> – Dan Ferguson, Yakima Valley College

Below are some of the highlights from 2021:

1. Included in Testimony to the Washington State Legislature

Healthcare employer needs and other findings from the Sentinel Network were reported to the Legislature through subcommittee meetings and in partnership with the Health Workforce Council. This continues to be an effective way for employers from around the state to communicate their needs and guide policy decisions.

2. Informed Reports Used by Planners to Formulate Health Workforce Policies

Findings from the Sentinel Network were used to supplement key informant interviews for recent assessments of Washington's behavioral health workforce prepared for Governor Inslee and the Legislature. These assessments have guided the formulation of a comprehensive set of recommendations to improve access to behavioral health care in the state.

3. Amplified Employer Voices Through Outreach Initiatives to Key Stakeholders

The Sentinel Network and its workforce demand findings were presented to support workforce topics presented at state meetings and planning sessions. Presentations to groups such as the Deans and Directors of Washington State Community Colleges and the Health Workforce Council highlighted the messages shared by employers and gave stakeholders the opportunity to understand and interpret the findings.

> *"The Sentinel Network delivers current and valuable workforce data that informs our various scholarship models, ensuring that our state has the talent it needs to respond to the transforming health care environment."*
>
> - Washington State Opportunity Scholarship Administrator

4. Findings Were Publicly Available and Used as a Resource by Educators and Employers

Dashboards showing every comment collected during the information-gathering periods, as well as findings briefs summarizing key themes, have been publicly available and are regularly updated on the Sentinel Network website (wa.sentinelnetwork.org). Educators and employers used these findings to support grant applications, compare the needs of their organization to those of other similar organizations, and plan health workforce development initiatives, among many other uses.

> *"The ability to pair recruitment and retention challenges our employers are facing with verified data from the Sentinel Network adds credibility to our discussions around solutions with legislators."*
>
> – Lauri St. Ours, Washington Health Care Association

Overall, the Sentinel Network continues to demonstrate value in Washington by providing:

- Rapid turnaround of signals of health workforce demand changes.
- Identification of skills needed and local conditions that may make hiring difficult.
- Information about the "how and why" behind health workforce demand signals.
- Engagement of the full network of stakeholders needed to identify and help solve health workforce problems.

Council Project Update: Behavioral Health Workforce Advisory Committee

Adapted from the 2021 Behavioral Health Workforce Advisory Committee report

Background

Following the bidirectional integration of Washington's physical and behavioral health systems, the state continues to face a shortage of much-needed healthcare professionals, while demand for behavioral health workers continues to grow. The existing behavioral health workforce encompasses many highly competent, committed professionals working hard to deliver behavioral health services, but barriers to educational attainment needed to enter or advance in the field, along with professional recruitment challenges, and long-term retention issues, hamper the state's ability to meet the behavioral healthcare needs of its residents. The need for this care – defined in this report as mental health and substance use disorder (SUD) treatment – will only grow as the COVID-19 pandemic continues.

The Workforce Training and Education Coordinating Board (Workforce Board) has been leading efforts to address recruitment and retention of the behavioral health workforce since 2016. The 2021 Washington State Legislature formalized the stakeholder workgroup that had informed previous iterations of policy and practice recommendations as the Behavioral Health Workforce Advisory Committee (BHWAC). The BHWAC was charged with assessing the progress of recommendations from the Workforce Board's previous assessments and updating actionable policy recommendations. The 2021 state operating budget also funded a research collaboration between the Workforce Board and Washington STEM (WA STEM). This partnership will develop an analysis of the talent development pipeline for behavioral health workers, along with a projection for employer demand, which will inform recommendations for the BHWAC's full report in 2022.

As with previous iterations, the BHWAC is led by staff at the Workforce Board. Stakeholder membership, which includes health facility leaders, behavioral health providers, educators, organized labor, not-for-profit organizations, state and local government agencies, and many more, shaped the recommendations in this preliminary report. The items addressed in this report reflect those identified by stakeholders as "Highest Priority" for the 2022 Legislative Session.

The full report can be read here.

Key Findings

When asked about the specific topics covered in the BHWAC report, stakeholders were consistent in mentioning the following challenges:

Medicaid Reimbursement Rates

- Medicaid reimbursement rates, particularly those in community behavioral health, remain too low to provide the level of financial compensation needed to recruit and retain a well-qualified, well-supported workforce.
- Recent legislative funding increases to Medicaid reimbursement rates, while appreciated, are insufficient to translate to demonstrated increases in staff compensation. This report estimates an increase of at least 7 percent is needed.

Support for Community Behavioral Health

- Employers in community behavioral health struggle to recruit, but particularly to retain, well-qualified workers amidst the surging challenges brought on by the COVID-19 pandemic. Additional resources and incentives for community-based employers would help to the state gain ground in this struggle.
- As they grapple with the second year of the pandemic, workers in community behavioral health need increased financial support and incentives to address rapidly increasing rates of burnout and professional trauma, and to prevent further departures from the field.

Research Partnership with WA STEM

In tandem with the BHWAC's legislative charge, the 2021 Legislature charged the Workforce Board and WA STEM with collaborating on an employer demand projection and talent development pipeline analysis, focused on behavioral health workforce in the state. This includes "*an analysis of behavioral health workforce shortages and challenges, data to inform systems change, and relevant policy recommendations and actions*."[2]

WA STEM, with engagement from over 150 individuals, including active participation of the Workforce Board and BHWAC, identified a list of occupation groupings related to behavioral health. This list will be used in in the development of a behavioral health labor market projections tool that will support the 2022 BHWAC work.

A draft, but comprehensive, list of behavioral health occupations and job titles that accurately reflects the field and the contexts of the work can be found here: https://washingtonstem.app.box.com/v/BH-Job-Titles.

[2] ESSB 5902, 2021.

WA STEM released a draft Tableau dashboard in November 2021 that aims to accurately reflect the behavioral health occupation landscape and the projected job openings in that landscape, by both sub-occupation and region. This tool is a behavioral health industry-specific version of WA STEM's more general Labor Market Data Dashboard. The draft Behavioral Health Labor Market Data Dashboard can currently be found here: https://bit.ly/2Z8iNSu.

The Workforce Board's related efforts will concentrate on developing a ground-level picture of employer demand, by holding focus groups and conducting employer interviews regarding their workforce needs. A major focus of this work is discussing with employers whether the structure of the behavioral health workforce pipeline is meeting their needs for client care, and if Washington's system is providing the appropriate mastery levels of competencies and skills to address the complex needs of the patient population.

Demand for health workforce, including behavioral health, is also evaluated by the Health Workforce Sentinel Network,[3] an initiative of the Washington Health Workforce Council,[4] in collaboration with the University of Washington Center for Workforce Studies and the Workforce Board. The Sentinel Network (covered in depth on page 8 of this report) utilizes data and responses from a voluntary short survey of Washington's healthcare employers ("Sentinels"), which collects qualitative information regarding changes in health workforce demand across the state.

Project Approach

Stakeholder engagement for the 2021-23 biennium began in August 2021, when stakeholders gathered via virtual meeting for an in-depth review of previously issued recommendations. Workforce Board staff led the meeting and provided historical context for the development of each recommendation, reviewed language, and solicited stakeholder feedback regarding legislative and other policy action taken in the years since those recommendations were issued.

The August meeting was followed by distribution of a stakeholder prioritization survey, in which stakeholders were asked to rank each recommendation on a scale of zero to five (five being "Highest Priority," zero being "Not a Priority") and to further identify information regarding progress or action related to the recommendation. Workforce Board staff subsequently reviewed the prioritization results and grouped each recommendation within five categories:

1. Highest Priority
2. High Priority

[3] http://wa.sentinelnetwork.org/
[4] https://www.wtb.wa.gov/planning-programs/health-workforce-council/

3. Mid-Level Priority
4. Low Priority
5. Lowest Priority

Given the limited timeframe in which this preliminary report was developed, the BHWAC elected to move forward with those items identified as "Highest Priority" in the stakeholder survey: Medicaid reimbursement rate increase for community behavioral health and increased financial support/incentives for both workers and employers in community behavioral health. During the second year of the current charge, the BHWAC will review individual recommendations, with each meeting focused on a different priority tier.

A second stakeholder meeting was held in October 2021. Stakeholders had an opportunity to review the findings of the prioritization survey and to discuss recommendations identified as "Highest Priority." Certain recommendations were identified as "reissued," with minimal changes to the original language, while others were "updated" to provide additional guidance or recommend new policy action.

Draft preliminary recommendations were shared at the end of October with stakeholders, who were provided two weeks to provide feedback with Workforce Board staff. Stakeholder input was incorporated into the final preliminary recommendations, in subsequent sections of this report.

The recommendations below are directly reflective of stakeholder sentiment and were developed and finalized with extensive stakeholder feedback over the course of the BHWAC's timeline.

Recommendations

Topic I: Medicaid Reimbursement Rates

Recommendation: Adjust reimbursement rates to better support competitive recruitment and retention of a skilled behavioral health workforce. (*Originally issued as Recommendation 1, 2017.)*

Updated Policy Action: Implement a minimum 7 percent increase to Medicaid reimbursement for licensed and certified community behavioral health agencies contracted through managed care organizations, to be effective January 2022. Washington's Health Care Authority (HCA) shall continue mechanisms such as directed payment or other options allowable under federal Medicaid law to assure the funding is used by the managed care organizations (MCOs) and/or behavioral health administrative service organizations (BH-ASOs) for a 7 percent provider rate increase.

- The rate increase shall prioritize staff compensation in all behavioral health non-hospital inpatient, residential, and outpatient providers receiving payment for services contracted through the MCOs and/or BH-ASOs.
- HCA shall provide an annual report to the Governor and the appropriate committees of the Legislature detailing how the rate increase was used to improve employee recruitment and retention; and where data is available, information on recruitment and retention of underrepresented populations.

Topic II: Retention Incentives – Community Behavioral Health Employers

Recommendation: Increase the ability of behavioral health agencies to accept students/trainees by incentivizing and supporting clinical and registered apprenticeship training sites. *(Originally issued as Recommendation 3d, 2017.)*

Updated Policy Action: Develop and implement a readiness assessment to support behavioral health agencies providing behavioral health services to evaluate their capacity and ability to implement behavioral health training programs. This should include considerations regarding the agency's ability to recruit, support, and retain clinicians/students from underrepresented communities, with potential for sharing best practices among employers.

Reissued Policy Action: Promote increased collaboration between universities/colleges and clinics providing behavioral health services for clinical training of behavioral health professions.

Reissued Policy Action: Review opportunities to provide additional incentives, possibly loan repayment and stipends, for clinical training sites to send preceptors to become trained as supervisors and provide clinical training.

Recommendation: Develop and implement a funding mechanism that recognizes and supports community behavioral health agencies for performing a significant training function required for behavioral health workers to obtain their educational degree or completion of a registered apprenticeship and their clinical licensure. (*Originally issued as Recommendation 1.1, 2020.)*

Updated Policy Action: HCA was directed by proviso 74a from ESSB 5092 (2021) to develop a recommended teaching clinic enhancement rate for behavioral health agencies training and supervising students and those seeking their certification or license. After recommendations are issued as charged in proviso to HCA, the Washington Council for Behavioral Health (the Council) should further develop the rate via pilot site testing, as previously funded by private philanthropy. HCA must coordinate with the Council throughout the pilot site testing process and may seek supplemental funding from the Legislature if necessary.

Topic III: Retention Incentives – Community Behavioral Health Workers

Recommendation: Provide financial support and other incentives to those pursuing careers in behavioral health. *(Originally issued as Recommendation 5a, 2017.)*

Updated Policy Action: Funding should be appropriated for grants providing pandemic-specific retention bonuses to be allocated to community behavioral health workers. Funding should be allocated to licensed and certified behavioral health agencies to distribute to their workers.

Updated Policy Action: With funding previously allocated by the Legislature, local government, and private philanthropy, behavioral health apprenticeships developed for entry-level roles should be implemented throughout the state using a pilot site testing model.

Recommendation: Strengthen and fund loan repayment programs, including the established Washington Health Corps model, that incentivize direct behavioral health service provision. *(Originally issued as Recommendation 1.3, 2020.)*

Reissued Policy Action: Increase funds allocated to the Behavioral Health Program (BHP) to expand the number of behavioral health workers in Washington who receive loan support through the BHP. Additional funding sources should be explored, including private philanthropy and the private sector, and a dedicated funding source should be established.

Reissued Policy Action: The Washington Student Achievement Council (WSAC) should modify the existing BHP model to increase access for eligibility and participation in the program. This should include:

- Increasing the number of workers able to receive BHP loan repayment funds per profession type, per site, from two to at least three.
- Increasing the percentage of FTE allotted to administrative work to 30 percent to increase the ability of individuals providing clinical supervision to participate.

Additional Reissued Recommendations

Recommendation: Assess the impact of current supervision requirements on size, distribution, and availability of select occupations in the behavioral health workforce. Provide recommendations on ways to reduce or standardize the number of supervised hours required for licensure, while assuring clinical competency. *(Originally issued as Recommendation 2.2, 2020.)*

Updated Policy Action: Develop a workgroup to identify discrepancies in the number of supervised hours required for certain clinical licenses and to make recommendations regarding standardizing the number of supervision hours required for clinical licensure

across these occupations. The workgroup should include behavioral health professional associations (social workers, mental health counselors, and marriage & family therapists); relevant state agencies; employers; individuals with clinical supervision experience; and individuals pursuing clinical licensure.

Recommendation: Anticipate a possible increase in behavioral health workers in emergency services/first responder roles. *(Originally issued as Recommendation 5.2, 2020.)*

Reissued Policy Action: Expand the role for certified peer counselors in Washington to address any potential increase in demand for workers, as behavioral health workers are needed to support emergency services/first responder departments.

Recommendation: Reduce paperwork requirements for established professionals. *(Originally issued at Recommendation 4.2, 2020.)*

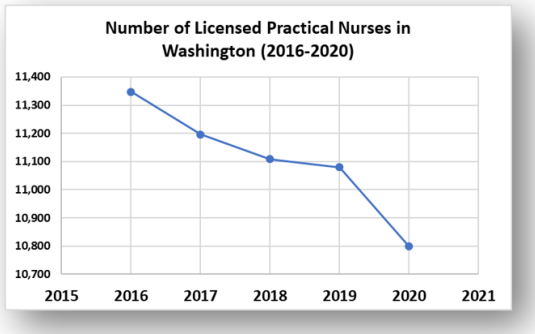
Reissued Policy Action: Update Department of Health's (DOH) recently adopted rule providing a behavioral health professional who has been licensed for five consecutive years in good standing (no discipline and no criminal history). This should state that a professional who has been licensed for two consecutive years in good standing is deemed to have met the required post-graduate supervised hours without providing formal documentation, regardless of the base number of supervised hours required in the other state at original licensure.

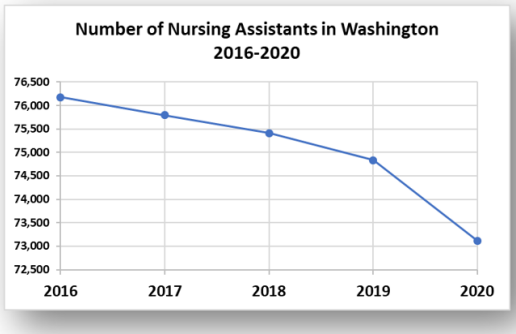
Council Spotlight: Long-Term Care Workforce

Long-term care (LTC) services are an essential resource for meeting the health, safety, personal care, and quality of life needs of our aging population and individuals with disabilities.

LTC Nursing Workforce Shortages

Essential LTC services cannot be provided without an adequate nursing workforce. Nursing assistants (NAs), licensed practical nurses (LPNs), and registered nurses (RNs) have ranked as the top three occupations with exceptionally long vacancies in LTC for the last five years (2016-2020).[5] NAs and LPNs, in particular, make up the majority of the LTC workforce. In fact, NAs make up 36 percent of the entire workforce in U.S. nursing homes.[6] NAs and LPNs are in scarce supply, and their numbers have been dropping while demand has been skyrocketing. Since 2016, the number of Washingtonians aged 65+ has increased by 24.3 percent[7] while the number of actively credentialed NAs and LPNs has declined by 4 percent and 4.8 percent,[8] respectively. RNs are in scare supply as well, given that only 9.6 percent of Washington RNs work in LTC[9]—likely due, at least in part, to the fact they can earn more in a hospital setting.[10] While a much greater percentage of Washington LPNs work in LTC (40.1 percent),[11] the total number of LPNs in our state is very small compared to RNs (10,461 v. 100,673, respectively, in 2020)[12]—and declining.





[5] UW CHWS & Workforce Board (Fall 2020). *Washington's Health Workforce Sentinel Network Examples of Findings from Nursing Homes and Skilled Nursing Facilities.*
[6] National Institute on Aging (2017). *LONG-TERM CARE: What is Long-Term Care?*
[7] Office of Financial management. *Age Data, Projections of State Population by Age, Sex, Race, and Hispanic Origin, 2010-2040.* Age data | Office of Financial Management (wa.gov)
[8] Nursing Care Quality Assurance Licensing Data (2020).
[9] UW CHWS & Workforce Board (Fall 2020). *Washington's Health Workforce…* PowerPoint Presentation (sentinelnetwork.org)
[10] Bureau of Labor Statistics, U.S. Department of Labor. *Occupational Outlook Handbook*, Registered Nurses.
[11] UW CHWS (May 2020). Washington State's 2019 Licensed Practical Nurse Workforce
[12] Nursing Care Quality Assurance Licensing Data (2020).

Complex Factors Compound LTC Nursing Workforce Shortages

COVID-19 Impact

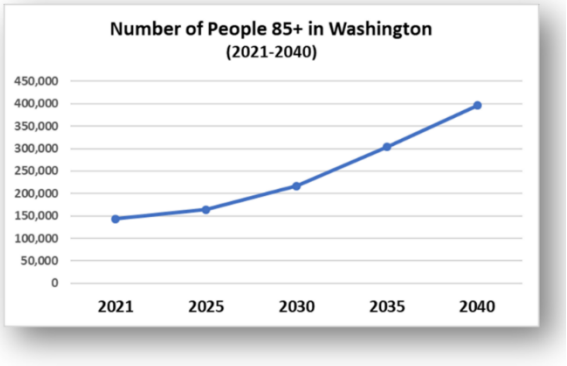
COVID-19 accelerated longstanding staffing shortages to a crisis level. In October 2020, the Department of Health estimated that approximately 8 percent of total COVID-19 cases and 55 percent of total COVID-19 deaths in Washington were associated with a LTC facility.[13] These statistics included employees as well as residents and visitors.

In the first eight months of 2020, the number of actively credentialed NAs dropped by approximately 5,000—or 6.7 percent of the overall nursing assistant workforce.[14] In response, the Department of Social and Health Services (DSHS) developed an emergency staffing program and began deploying Rapid Response teams of workers to many facilities in crisis.[15]

The Aging Population

In the next 10 years, according to the Office of Financial Management (OFM) data, the number of Washingtonians aged 65+ is expected to increase 33.9 percent. By 2040, older adults will make up 21.7 percent of our state's population, reflecting a 50 percent increase in people aged 65+ and a 176 percent increase in people aged 85+.[16] According to the Administration on Aging (AoA): Most adults aged 65+ have one or more chronic health conditions; 35 percent of adults aged 65+ reported some type of disability; and 44.3 percent of adults aged 75+ reported difficulties in physical functioning.

Year	85+
2021	143,323
2025	163,966
2030	216,851
2035	303,527
2040	395,808



The dramatic increase in the 85+ population is especially significant: The AoA has found people 85+: Are nine times more likely than adults aged 65-74 to live in a nursing home; and need help with personal care twice as often as people 75–84 and more than six times as often as people 65–74. [17]

[13] Department of Health (2020). COVID-19 Bulletin (dated October 15, 2020).
[14] Nursing Care Quality Assurance Licensing Data (2020).
[15] Nursing Care Quality Assurance Commission (June 2021). Long-term Care Workforce Development Final Report (wa.gov)
[16] Office of Financial Management. Age data | Office of Financial Management (wa.gov)
[17] Administration on Aging, Administration for Community Living (2018). *2017 Profile of Older Americans.*

Economic Barriers

Service to a high percentage of Medicaid recipients makes offering competitive wages in LTC a challenge. NAs in Washington can pay $1,000 or more in training, testing, and certification fees to earn a median wage of $17.29 per hour. They can earn as much or more working in data entry or as a receptionist or file clerk[18] without the same investment or the same level of responsibility for human life. Nurses can earn more working in hospital settings than in LTC.[19] In 2020, RNs working in hospitals vs. skilled nursing facilities earned $45.34 vs. $37.36 per hour on average.[20]

Lack of competitive wages hurts recruitment into LTC. National data for 2018 show that 36 percent of nursing homes needed to contract with short-term staffing agencies in order to fill vacancies—a practice that can disrupt care continuity for residents. Other options used include mandatory overtime and working short-staffed—both of which can lead to stress and burnout.[21]

These economic barriers create a compounding cycle of recruitment challenges that impact workload and lead to retention challenges that perpetuate costly practices (use of staffing agencies and sign-on bonuses, and a constant cycle of recruitment and orientation efforts).

Lack of Infrastructure to Support Educational and Career Advancement

There is a dire need for a well-crafted career ladder that incentivizes entry into caregiving roles and supports and rewards longevity and advancement into nursing. Currently, there is an educational and economic chasm separating caregiving roles from licensed nursing roles. Nationally, less than half of all NAs have completed any formal education beyond high school; 13 percent of them live below the poverty level; nearly half (44 percent) live in low-income households; and 36 percent rely on some form of public assistance.[22] Few can afford to advance their education; and many leave the field when they see no realistic avenue for advancement.

For those NAs who can make the economic leap to an LPN or RN role, they experience a jump of 70 percent and 153 percent in their median wages, respectively.[23] Legislatively-

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[18] U.S. Bureau of Labor Statistics, Occupational Employment and Wage Statistics, (May 2020). Washington - May 2020 OEWS State Occupational Employment and Wage Estimates (bls.gov)

[19] Bureau of Labor Statistics, U.S. Department of Labor. Registered Nurses : Occupational Outlook Handbook: : U.S. Bureau of Labor Statistics (bls.gov)

[20] U.S. Bureau of Labor Statistics, Occupational Employment and Wage Statistics, (May 2020). Washington - May 2020 OEWS State Occupational Employment and Wage Estimates (bls.gov)

[21] Paraprofessional Healthcare Institute (2019). US-Nursing-Assistants-2019-PHI (1).pdf

[22] Paraprofessional Healthcare Institute (2019). US-Nursing-Assistants-2019-PHI (1).pdf

[23] Employment Security Department (2020 for 2019 data). ESDWAGOV - Occupations (OEWS)

funded work (ESSB 5092) is underway to plan a registered apprenticeship pathway from home care aide to NA to LPN. Pilot funding and infrastructure for sustainability are key needs for supporting the success of this pathway.

Data Barriers

As noted by the LTC Workforce Development Steering Committee's June 2021 report to the Legislature, LTC workforce data are desperately needed to quantify and effectively address workforce shortages.

Current data capacity requires manual calculation of disparate data to cobble together a partial view of the LTC workforce pipeline and needs. For example, state-specific data on the racial and ethnic diversity of NAs is lacking; instead, we rely on national averages. Other workforce questions remain unanswered: How many are in the training and testing pipeline at any given time? How many certified NAs actively work? How long do they stay in the field? What changes would increase their longevity?

Investment in collecting, organizing, trending, and analyzing LTC workforce data is needed to quantify workforce needs, make data-driven policy and funding decisions, monitor the impact of interventions, and trend these data over time.

Conclusion

One conclusion is clear: Lasting change to address the complex, longstanding, now urgent needs in LTC call for interventions that are both multi-pronged and sustained.

Council Policy Proposal: Long-Term Care Workforce Investment

To address the urgent need for investment and support for Washington's long-term care (LTC) workforce—whose numbers are shrinking as the population ages and demand grows—the Council has endorsed a policy proposal for a long-term care workforce care quality initiative. Developed in partnership between the Nursing Care Quality Assurance Commission (Nursing Commission) and the Council, the proposal is a multi-year initiative focused on boosting caregiver skills and enhancing their ability to move up the healthcare career ladder to higher-skill, higher-pay healthcare roles, including LPN and RN. The initiative also focuses on ensuring the quality of patient care, as having a stable, well-prepared workforce that reflects the diversity of the patient population is proven to improve the quality of care provided.

This proposal draws on the work of previous and ongoing initiatives which have changed the culture of LTC, boosted the skills of caregivers, enhanced their ability to move up the healthcare career ladder, improved patient outcomes, and enhanced the diversity and retention of the LTC workforce. This includes an initiative deployed in Massachusetts starting in 2000 that created an extended care career ladder initiative in response to high turnover and vacancies in long-term care. Closer to home, Washington's SEIU 775 Benefits Group supported the creation of the nation's first social insurance program for long-term care. A payroll premium to help pay for long-term care in Washington starts in 2022 and will fill a dedicated trust that will help ensure caregivers are skilled, trained, certified, and paid fairly for their work.

Described below is a three-pronged proposal aimed at increasing recruitment and retention of LTC workers through skill-building and career ladder opportunities, while also boosting patient care in homes and facilities throughout Washington. The long-term care proposal was formally adopted as an action item by the Council at its August 2021 meeting. This package is also part of a broader proposal by the Nursing Commission to address challenges facing the LTC workforce, including curriculum development and testing improvements. In total, the scalable proposal recommends a $10 million investment in LTC workforce efforts over a three-to-four-year period, in addition to some funding that pays for ongoing health workforce research.

Long-Term Care Delivery Pilot Opportunities

$6.2M total, over four years

As referenced, the Massachusetts model and lessons learned from that initiative, which built capacity within long-term care by promoting skill development and improved quality of care through institutionalized career ladders and other worker supports, provides a potential framework to kick off a similar initiative in Washington. The Council recommends the following steps:

Stakeholder Convening, Research, & Recommendation Development

Bring together LTC stakeholders to create a coalition of champions to develop solutions to address the workforce challenges in this sector. There is no single solution, and no single entity that can change the situation. A coalition is needed for such a critical undertaking.

- Sample list: industry representation, business and labor, other business associations (like the Association of Washington Business and Washington Roundtable), Nurses Association, Hospital Association, Medical Association, advocates for patients and families, LTC Ombuds office, legal services, gerontology research institutions, business partners such as LeadingAge Washington, community & technical colleges, other relevant education and training providers, high school Career and Technical Education, healthcare foundations, Washington Health Care Association, Department of Health, Accountable Communities of Health, Aging and Long-Term Support Administration, Health Care Authority, OIC of Washington, third party payers.
- The voices of frontline workers are also needed to help understand and address retention and recruitment challenges.

Research Components

Massachusetts decided on a survey and focus groups for its initiative; Washington may want to utilize a worker advisory committee, as well as qualitative surveys of the landscape of stakeholders in LTC workforce. A sample effort in Washington might include:

- Conducting qualitative surveys (interviews, focus groups, etc.) with various populations involved in LTC work: frontline LTC workers, facility administrators, supervisors/managers, patient families, to identify what is working vs. what is not working.
- Analyzing responses to identify major themes. For example, in Massachusetts, wages weren't the primary frustration for workers; they felt they weren't viewed as caregivers by employer administration or family members. Workers wanted to be viewed as the voice of their patients, included in caregiving planning, and respected as caregivers.
    - Workers also sought opportunities for growth in the field, such as promotional opportunities, rather than just increased wages.
- Based on the information gathered in research and stakeholder efforts, deploy pilot programs to test different methods to inject change into the system.

Supports for LTC Workers

Providing funding for supports for LTC workers that might help them stay on the job and/or engage in training and education is vital to helping them advance to higher-skill, higher-pay jobs. Potential options include:

- Utilize the Workforce Development Councils (WDCs) and the state's WorkSource offices to provide career and education counseling and planning services specifically for LTC workers.
    - Funds should be made available for WDCs to have adequate staff available to meet with LTC workers periodically to provide ongoing support.
- Create a set-aside financial aid pool (such as from the Washington College Grant) that also includes funds for support services as needed, so workers can benefit fully from the educational experience.
- Provide funds to support enhanced childcare subsidies for LTC workers, who often work outside traditional business hours, which can make it difficult to find stable childcare arrangements. This becomes even more challenging when enrolling in education and training pathway programs, a necessary step to advancing through a career pathway.
    - In 2020, Washington extended childcare benefits for students receiving the Washington College Grant; this could be further expanded to include LTC workers.

Educational Institution Capacity Funding

Provide support and capacity funding for an array of educational modalities so that instructional programs can meet increasing demands for skilled workers in LTC. These modalities include: secondary career and technical education (CTE); community and technical colleges; apprenticeship; work-based learning (e.g., Career Launch); and customized incumbent worker education and training, such as Hospital Employee Education and Training (HEET) Grants.

Instructional capacity funding enables education and training programs to: develop new programs; add cohorts to existing programs; implement evidence-based methods for increasing the efficiency at which students move into and through programs to completion; and improve the effectiveness of evidence-based student retention and completion approaches. It also includes program redesign and efficiencies like building out bridges between related credentials, tools for assessing credit for prior learning or other competency-based innovations and developing employer-driven short courses that count toward degrees and certificates.

Long-Term Care Registered Apprenticeship

$3.5M total, over three years

In addition to survey responses and piloting, the Nursing Commission (in collaboration with the Workforce Board and the Department of Labor & Industries) has received funding for FY 2022 ($450,000) to develop a registered apprenticeship pathway from home care aide to nursing assistant certified to licensed practical nurse (HCA-NAC-LPN).

While funding is allocated for the *development* and groundwork, it is not included for the launch or implementation of the program. As part of the planning funding, the Nursing Commission must develop and prepare for the launch of at least three LPN registered apprenticeship programs to be implemented in the next phase of work. These must include sites in at least three geographically disparate areas of the state, experiencing high levels of LTC workforce shortages. Participation of the local Workforce Development Councils must be incorporated into the implementation phase, as well.

The state could continue this important work through the planning year by providing funds to support the launch of the three LTC registered apprenticeship sites in FY 2023.

Health Workforce Research FTE

$305K, ongoing

Funding a full-time data analyst is critical in gathering ground-level health workforce information, identifying issues, and tracking the progress of the overall LTC initiative. This (1.0 FTE) research position could be added to the Workforce Board's well-regarded research team, which regularly and independently evaluates the performance of the state's key workforce programs. This new position could:

- Conduct the initial research and program development.
- Develop recommendations for inclusion in annual reports.
- Provide necessary analysis of survey responses, and potentially provide evaluation of pilot program/site success.
- Work with, and report to, the Health Workforce Council and the Workforce Board to provide annual analysis and evaluation that brings best practices to scale across Washington.

Council Spotlight: Dental Workforce

Washington State Dental Association Report on Dental Workforce Task Force

In late 2020, the Washington State Dental Association (WSDA) and Delta Dental of Washington (DDWA) reached a successful settlement to a multi-year legal dispute. A part of this settlement was the adoption of a Memorandum of Understanding (MOU) between both organizations that, in part, developed a platform for collaboration on topics of significant importance to the delivery of dental care in Washington.

The first joint task force convened from this MOU is focused on dental workforce shortages. The task force is comprised of board members and senior staff leadership from both organizations. The group began their work by gathering data to help quantify the size of the workforce shortfall and has been meeting several times per month to identify solutions for tackling the state's severe workforce shortages.

Surveys developed by WSDA and the Washington Dental Hygienists' Association, administered by the Washington State Department of Health, and analyzed by DDWA put numbers to the problems dental offices across the state are experiencing every day. These surveys confirmed the severe shortage of both hygienists and dental assistants, with open positions averaging 4.2 months to fill statewide, and some markets taking up to six months.

Addressing Workforce Shortages

After reviewing the data and engaging in preliminary discussions with a broad stakeholder group, the task force developed four key objectives to address the workforce shortage.

1. Increase the number of hygienists and assistants in the field to meet current and future patient needs.
2. Increase diversity among these professions.
3. Improve accessibility and retention within these professions to help sustain the long-term oral health of the population.
4. Leverage multiple funding sources to affect these changes.

With these shared objectives in mind, the task force identified a variety of strategies. While strategies would require funding, all of them would be investments in the future of oral health care in Washington.

Some of these strategies include:

- Expand capacity at existing dental hygiene education and dental assistant training programs.

- Support establishment of new dental hygiene and assistant programs, particularly in areas like Snohomish County that do not have an existing program.
- Create public/private grant programs for dental hygiene and assisting schools to drive innovation (such as part time, evening, or virtual offerings) and to promote a more diverse pool of students in their programs.
- Develop on-the-job training resources for dental practices to use with new, untrained dental assistants.
- Standardize curriculum of dental assistant training programs offered to high school students through occupational skills centers across the state.
- Promote dental health professions to middle and high school students, with an emphasis on districts serving diverse student populations.

Many of these ideas are based upon successful programs that have increased the workforce in physical health and manufacturing in our state. Successfully implementing them could have a similar, measurable impact on the dental workforce and help close the gaps plaguing public clinics and private practices across the state.

WSDA & DDWA's Ongoing Work

WSDA and DDWA are committed to expanding dental hygiene and dental assistant training capacity at existing programs, supporting the establishment of new dental hygiene programs, and providing financial incentives to drive innovation and accessibility in dental hygiene and assisting training programs. WSDA and DDWA are also fully committed to increasing the diversity of all dental health professions and ensuring that we are better prepared to provide equitable care to the increasingly diverse patients of our state.

Dental Hygiene Education – Barriers to Recruitment, Retention, and Successful Graduation

The COVID-19 pandemic created several gaps in the healthcare workforce and dental hygienists are no exception. However, the ability to recruit, retain, and successfully graduate dental hygienists into the workforce has been a problem for the past several years. The recent pandemic merely brought the workforce issue to the forefront.

Recruitment

Recruitment to the dental hygiene profession poses a challenge for several reasons, including confusion regarding the role of dental hygienists within the broader dental workforce, the volume of educational requirements, and the Commission on Dental Accreditation's (CODA) requirements. In Washington, a dental hygienist must graduate from a CODA-accredited program to meet eligibility to apply for a dental hygiene license.

Education Requirements & Retention

CODA requires several college-level courses that are not included in the dental sciences and dental hygiene sciences curriculum.[24] These courses, which typically take at least 18 months to complete, include classes in biology, chemistry, math, English, communications, social sciences, psychology, and nutrition; these classes must be completed *prior to* a student's enrollment in one of the nine state dental hygiene programs in Washington. Dental hygiene programs are then required by CODA to be no less than two full academic years in length. Thus, a dental hygienist in Washington completes about four years of college-level education to be eligible for licensure as a dental hygienist.[25]

The length of time and rigor of a dental hygienist's education in Washington is valid and proportionate with the obligations and responsibilities a dental hygienist has in the prevention and treatment of oral diseases, specifically, periodontal (gum) diseases.[26] With the well-established link between periodontal disease and several systemic diseases, dental hygienists are one of the first healthcare providers to identify a need for further diagnosis and to assist in the maintenance of overall health.

In 2005, the state Legislature introduced a pilot program that allowed community and technical colleges to begin offering select Bachelor of Applied Science (BAS) degrees, providing students another pathway to four-year degrees in a variety of subject areas.

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[24] CODA. (August 2019). https://coda.ada.org/en/current- accreditation-standards
[25] CODA, Standard 2. (August 2019). https://coda.ada.org/en/current- accreditation-standards
[26] US Bureau of Labor and Statistics. (2018). https://www.bls.gov/soc/2018/major_groups.htm#31-0000

The BAS degree, now a standard offering at most of the state's community and technical colleges, includes one for dental hygiene.

The difference in cost of education between an associate degree and a BAS in dental hygiene is relatively small: approximately $3,000 in extra tuition. However, other costs do add up. Total fees required, including licensing exams, books, instruments, and supplies for this program are estimated at approximately $20,000, based off a sampling of community and technical college and baccalaureate hygiene education programs in the state.

Although the time commitment, rigor of education, and program costs could pose barriers to recruitment, additional barriers have elevated this challenge. Dental hygiene students must participate in at least 25-30 hours of instruction each week (in class, clinical, and lab-based), and practice their skills on live patients to ensure they can successfully apply what they've learned in their coursework. However, it can be difficult finding opportunities to get this hands-on experience. Dependent upon the location of the dental hygiene clinic, there can be difficulty finding qualified faculty or patients that meet the learning needs of the student.

This is further exacerbated by pandemic-related concerns and inequities in gender, racial, and socio-economic representation. Together, these factors have negatively impacted interest in pursuing dental hygiene as a profession.

Ideas for Consideration

To increase interest in the profession of dental hygiene, actions must be taken to address inequality issues and support students in overcoming barriers. Students should be supported in establishing a foundation for best possible success by removing, or decreasing, barriers such as the cost of education, childcare expenses, living expenses, and patient recruitment efforts.

It is time to create a system where recruitment inequalities are addressed, along with addressing financial and life barriers, such as childcare costs and living expenses. Career pathway information regarding the profession of dental hygiene, combined with financial and lifestyle support systems (scholarships, childcare, living expenses, etc.) could be initial actionable measures to provide a sustainable foundation for meeting current and future workforce needs for dental hygiene professionals.

Council Spotlight: Nursing Workforce

In 2021, the prolonged COVID-19 pandemic continued to stress the nursing workforce, raising issues of workforce retention. Washington Center for Nursing (WCN) contracted with Survey Information Analytics (SIA) to conduct an Impact of COVID-19 on the Nursing Workforce study to better understand the impact of COVID-19 on the nursing workforce in Washington. SIA surveyed 418 nurses who held active nursing licenses about their experiences during 2020.[27] Key findings include:

- 51 percent were laid off or furloughed from one or more nursing/healthcare jobs.
- 42 percent thought about or made plans to leave the field of nursing.
- 69 percent reported moderate or extreme COVID-19 related staffing concerns.
- 61 percent reported moderate or extreme concern for their friends'/family's safety.
- 42 percent believed their employers provided adequate quarantining for employees who may have been/were exposed to COVID-19.
- 67 percent agreed or strongly agreed their employer provided more telehealth nursing services during the pandemic in comparison to pre-pandemic services.
- 35 percent felt they were discriminated against in their primary nursing role because of accent/language barriers.

Themes in focus groups included the following:

- The need for better transparency in communication.
- How constant policy changes impacted work duties.
- The need for behavioral health services.
- Role/position changes and adaptations.
- Job/financial security.
- Diversity/equity in relation to the workforce.

Nursing Education Data

WCN is currently reviewing trends in nursing education data collected by the Nursing Care Quality Assurance Commission between 2014-2015 through 2019-2020 academic years. A preliminary analysis shows that nursing education capacity has not grown and, in some areas, declined prior to the pandemic. Examples are a gradual decline in practical nurses, a steady graduation rate of registered nurses from community colleges, and a slight decrease in baccalaureate degree registered nurses. Up to less than 50

[27] Because this study is based on a convenience sample, it may not be generalizable or representative of the entire nursing population in Washington. Findings may vary within different nursing sectors or licensures and more detailed methodological and analytical efforts may be needed to understand each group in more detail. This study's efforts to reach underrepresented nurses offers one preliminary approach to identifying patterns and differences among nurses.

percent of students who meet qualifications are granted admission into schools of nursing.

The COVID-19 crisis severely disrupted clinical training opportunities for nurses. Simulation technology was used to fill in the gaps for clinical nursing education. As result, a call for re-examination of clinical practice hours by the Nursing Care Quality Assurance Commission began in 2021. A statewide planning group of nurse educators is exploring what is an effective balance of clinical education versus simulated clinical education.

COVID-19 Sheds Light on Issues of Diversity and Equity in Nursing

Data on health disparities highlighted distressing trends and focus groups conducted during WCN's Impact of COVID-19 on the Nursing Workforce study explored experiences of discrimination by nurses of color. Considerable effort went into highlighting the voices of diverse nurses as part of this study. As a result, survey and focus group CNA, LPN, and RN respondent demographics were more diverse than the population of nursing students or practicing nurses in the state. Focus group participants shared their perspectives on the lack of inclusion of nurses of color, experiences of discrimination, and lack of diversity among nursing leadership.

Nursing Retention Needs

According to the WCN Impact of COVID-19 on the Nursing Workforce report, a significant number of lay-offs and furloughs were COVID-19 related. Key data points include:

- Some 51 percent of survey respondents were laid off or furloughed from one or more nursing/healthcare related jobs in 2020. Among them, 83 percent indicated their lay-off/furlough was a consequence of the COVID-19 pandemic.
- Focus group participants suggested nursing layoffs and hiring freezes are not strategic during a pandemic. As one school nurse noted, "It was really difficult to get people back; it's short sighted to let people go during that time."

Increased retirements:

- More than one-third of LPNs (34 percent) and RNs (37 percent) retired or thought about retirement earlier than originally planned.

Mental health needs of nurses:

- In a recent study, the 2020 International Council of Nurses (ICN) addressed the repercussions of the pandemic on the nursing workforce's health indicating healthcare workers face high levels of COVID-19 infections. Among the 59 countries in the study, the United States was among the countries with the

highest numbers of reported nurse deaths (ICN 2021). Additionally, because of increased responsibilities and exposure to the virus, nurses experience an "increasing risk of burnout, post-traumatic and other stress related disorders" (ICN, 2021, p.2).

- The WCN worked with employer workforce development forums such as the Health Industry Leadership Table shared strategies to support nurses' mental health through the COVID-19 crisis.

Items for Consideration

- The Council could consider a spotlight on strategies to diversity the nursing workforce, including exploring and promoting more refined race and ethnicity demographic surveys, to get a better picture of the diversity of Washington's nursing workforce.[28]
- Fortify clinical practice opportunities in acute care settings to be more resilient to disruption as a result of future public health crises.
- Examine clinical practice staffing structure and identify areas of increased needed support to build resiliency of organizations providing these experiences.
- Increase clinical practice experiences outside of acute care—specifically, community health, public health, long-term care, and ambulatory care.
- Support development of appropriate use of simulation, which includes creating a level playing field of equipment and faculty across nursing programs.
- Explore impact of out-of-state schools to nursing education capacity including impact on the availability of clinical sites.

[28] The WCN implemented more refined demographic surveys in its various workforce surveys and established an updated survey to be implemented in the Health Care Enforcement and Licensing Management (HELMS) health professions database, to be launched in the coming years.

Healthcare Personnel Data

Since forming in 2002, the Council has brought attention to current and projected shortages in skilled workers needed to fill key healthcare occupations, and proposed strategies to fill these gaps. Although progress has been made to close certain workforce gaps, continued shortages in key occupations remain pervasive in the healthcare industry, particularly when it comes to recruiting and retaining healthcare professionals in Washington's rural and underserved communities.

For this report, Workforce Board staff collected and analyzed the supply of individuals completing Washington healthcare education programs over the past five years. Research staff also reviewed employment data for key occupations to provide greater insight on the state's current and projected health workforce needs.

Healthcare Education/Training Program Completions

Education and training completion information in this report includes all Title IV public and private degree-granting schools in Washington as well as 300+ private career schools offering short-term training and certificates. Also included are individuals completing Home Health Aide training through SEIU 775 Benefits Group. The following table shows completions for over 80 healthcare education and training programs for a one-year period spanning July 1, 2019 to June 30, 2020 (labeled 2020 for ease of reading). The table includes the five-year average annual completion numbers for each training program for perspective.

NOTE: **Completion numbers do not necessarily translate to workers filling positions.** Some programs require additional training, clinical work, licensing/certification requirements, or residency after completion, so program completers may not immediately enter the workforce. In addition, some practice areas are experiencing more severe workforce gaps due to increasing demand for services, new regulations, challenges with recruitment and retention, and other factors. Frequently cited examples of healthcare areas with profound workforce challenges include long-term care and behavioral health.

Dramatic Decrease in Healthcare Program Completions in 2020

For many years, the state saw an increasing number of Washington residents enrolling in, and completing, healthcare programs to prepare for a variety of healthcare occupations. Healthcare has been a thriving occupation area for a range of training opportunities from the entry level to graduate and professional education. The state has successfully pushed to expand capacity in healthcare training programs, and in some cases, provided financial incentives, such as continued investment in the Health Professional Loan Repayment and Scholarship program. This program provides financial

support to eligible licensed health professionals through loan repayment or conditional scholarships to address health professional shortages in rural and underserved urban communities.[29]

The data in the table below illustrates an alarming drop during the last year in overall healthcare program completions, particularly in short-term programs (though some programs experienced a small increase). As recently as the 2019 reporting period, the Workforce Board tracked nearly 30,000 program completions. A year later, that number had dropped to 25,000 completions (a nearly 5,000 reduction) across a wide range of healthcare occupations. That works out to an average 16.6 percent drop in completions during the 2020 reporting period. As noted earlier, the time period covered in this report includes just the first half of 2020. So, while the COVID-19 pandemic is certainly an important factor in the drastically reduced numbers, including delayed program and testing/certification completions, this drop in overall completions will need to be carefully monitored and may need additional interventions as the state continues to recover from the pandemic.

The table includes completion numbers for both 2019 and 2020, as well as the average completions during 2016-2020, to provide a more comprehensive perspective on recent completion trends. For ease of reading, the 2019-20 Change column uses red for those programs that dropped in completions, and green for those that increased. The Council will be carefully monitoring the continued enrollment and completion challenges to the healthcare workforce pipeline. In 2022, the Council will provide recommendations to policymakers for the upcoming biennium and will continue monitoring completion numbers across a range of occupations to identify where appropriate changes or investments may be required to reverse worrisome downward trends in this sector.

Health Education Program Type	Average Completions 2016-2020	Completions 2019	Completions 2020	2019-2020 Change	Percentage Change 2019-20
Acupuncture and Oriental Medicine	65	71	50	-21	-29.6%
Athletic Training/Trainer	32	34	37	3	8.8%
Audiology/Audiologist and Speech-Language Pathology/Pathologist	50	50	46	-4	-8.0%
Clinical Laboratory Science/Medical Technology/Technologist	37	44	31	-13	-29.5%
Clinical Psychology	33	22	31	9	40.9%
Clinical/Medical Laboratory Assistant	45	38	40	2	5.3%
Clinical/Medical Laboratory Technician	30	33	30	-3	-9.1%

[29] https://wsac.wa.gov/washington-health-corps

Health Education Program Type	Average Completions 2016-2020	Completions 2019	Completions 2020	2019-2020 Change	Percentage Change 2019-20
Communication Sciences and Disorders, General	116	106	130	24	22.6%
Community Health Services/Liaison/Counseling	67	30	87	57	190.0%
Counseling Psychology	191	184	169	-15	-8.2%
Counselor Education/School Counseling and Guidance Services	115	127	90	-37	-29.1%
Dental Assisting/Assistant	1,029	1,076	943	-133	-12.4%
Dental Hygiene/Hygienist	196	210	93	-117	-55.7%
Dentistry	66	66	71	5	7.6%
Diagnostic Medical Sonography/Sonographer and Ultrasound Technician	78	74	85	11	14.9%
Dietetics/Dietitian	79	118	190	72	61.0%
Electrocardiograph Technology/Technician	31	54	14	-40	-74.1%
Emergency Care Attendant (EMT Ambulance)	677	766	214	-552	-72.1%
Emergency Medical Technology/Technician (EMT Paramedic)	304	277	301	24	8.7%
Environmental Health	45	58	50	-8	-13.8%
Health Information/Medical Records Administration/Administrator	55	68	51	-17	-25.0%
Health Information/Medical Records Technology/Technician	175	167	117	-50	-29.9%
Health Services Administration	39	46	47	1	2.2%
Health Services/Allied Health/Health Sciences, General	232	269	284	15	5.6%
Health Unit Coordinator/Ward Clerk	37	37	21	-16	-43.2%
Health/Health Care Administration/Management	132	132	133	1	0.8%
Health/Medical Preparatory Programs, Other	57	42	49	7	16.7%
Hearing Instrument Specialist	25	28	24	-4	-14.3%
Home Health Aide/Home Attendant*	6,273	6,422	5,084	-1,338	-20.8%
Hypnotherapy/Hypnotherapist	213	290	168	-122	-42.1%
Industrial and Organizational Psychology	34	30	33	3	10.0%
International Public Health/International Health	40	54	49	-5	-9.3%
Marriage and Family Therapy/Counseling	92	88	129	41	46.6%
Massage Therapy/Therapeutic Massage	829	597	531	-66	-11.1%

Health Education Program Type	Average Completions 2016-2020	Completions 2019	Completions 2020	2019-2020 Change	Percentage Change 2019-20
Medical Administrative/Executive Assistant and Medical Secretary	229	179	153	-26	-14.5%
Medical Insurance Coding Specialist/Coder	236	217	184	-33	-15.2%
Medical Insurance Specialist/Medical Biller	88	89	79	-10	-11.2%
Medical Office Assistant/Specialist	254	343	204	-139	-40.5%
Medical Office Management/Administration	66	54	48	-6	-11.1%
Medical Radiologic Technology/Science - Radiation Therapist	94	72	91	19	26.4%
Medical Reception/Receptionist	81	71	49	-22	-31.0%
Medical Transcription/Transcriptionist	53	46	12	-34	-73.9%
Medical/Clinical Assistant	1,927	2,050	1,534	-516	-25.2%
Medical/Health Management and Clinical Assistant/Specialist	31	28	29	1	3.6%
Medicine	235	253	262	9	3.6%
Mental and Social Health Services and Allied Professions, Other	189	155	34	-121	-78.1%
Mental Health Counseling/Counselor	53	59	79	20	33.9%
Naturopathic Medicine/Naturopathy	147	183	148	-35	-19.1%
Nursing: Licensed Practical/Vocational Nurse Training	410	244	244	0	0.0%
Nursing: Nursing Assistant/Aide and Patient Care Assistant/Aide	6,018	5,981	4,881	-1,100	-18.4%
Nursing: Registered Nursing, Nursing Administration, Nursing Research and Clinical Nursing, Other	181	235	217	-18	-7.7%
Nursing: Registered Nursing/Registered Nurse	3,373	3,391	3,142	-249	-7.3%
Occupational Therapist Assistant	88	104	69	-35	-33.7%
Occupational Therapy/Therapist	91	86	90	4	4.7%
Orthotist/Prosthetist	22	16	25	9	56.3%
Osteopathic Medicine/Osteopathy	122	134	140	6	4.5%
Pharmacy Technician/Assistant	257	227	139	-88	-38.8%
Pharmacy	222	229	258	29	12.7%
Phlebotomy Technician/Phlebotomist	680	682	561	-121	-17.7%
Physical Therapy Assistant	143	132	116	-16	-12.1%
Physical Therapy/Therapist	122	123	137	14	11.4%
Physician Associate/Assistant	141	157	129	-28	-17.8%
Pre-Physical Therapy Studies	45	41	37	-4	-9.8%

Health Education Program Type	Average Completions 2016-2020	Completions 2019	Completions 2020	2019-2020 Change	Percentage Change 2019-20
Psychiatric/Mental Health Services Technician	29	22	20	-2	-9.1%
Psychology, General	81	64	64	0	0.0%
Public Health Education and Promotion	26	32	23	-9	-28.1%
Public Health, General	342	368	344	-24	-6.5%
Radiologic Technology/Science - Radiographer	120	114	144	30	26.3%
Renal/Dialysis Technologist/Technician	20	19	0	-19	-100.0%
Respiratory Care Therapy/Therapist	24	23	27	4	17.4%
Respiratory Therapy Technician/Assistant	50	41	42	1	2.4%
School Psychology	44	70	52	-18	-25.7%
Social Work, Other	48	54	48	-6	-11.1%
Social Work	402	377	495	118	31.3%
Somatic Bodywork	26	28	7	-21	-75.0%
Speech-Language Pathology/Pathologist	109	110	110	0	0.0%
Sterile Processing Technology/Technician	46	53	33	-20	-37.7%
Substance Abuse/Addiction Counseling	296	330	249	-81	-24.5%
Surgical Technology/Technologist	131	133	107	-26	-19.5%
Therapeutic Recreation/Recreational Therapy	21	29	13	-16	-55.2%
Yoga Teacher Training/Yoga Therapy	218	227	193	-34	-15.0%
Youth Services/Administration	37	46	49	3	6.5%
Remaining Health Education Program Types (under 20 completions last 5 years) **	452	475	408	-67	-14.1%
Total Health Program Completions	**29,635**	**29,904**	**24,941**	**-4,963**	**-16.6%**

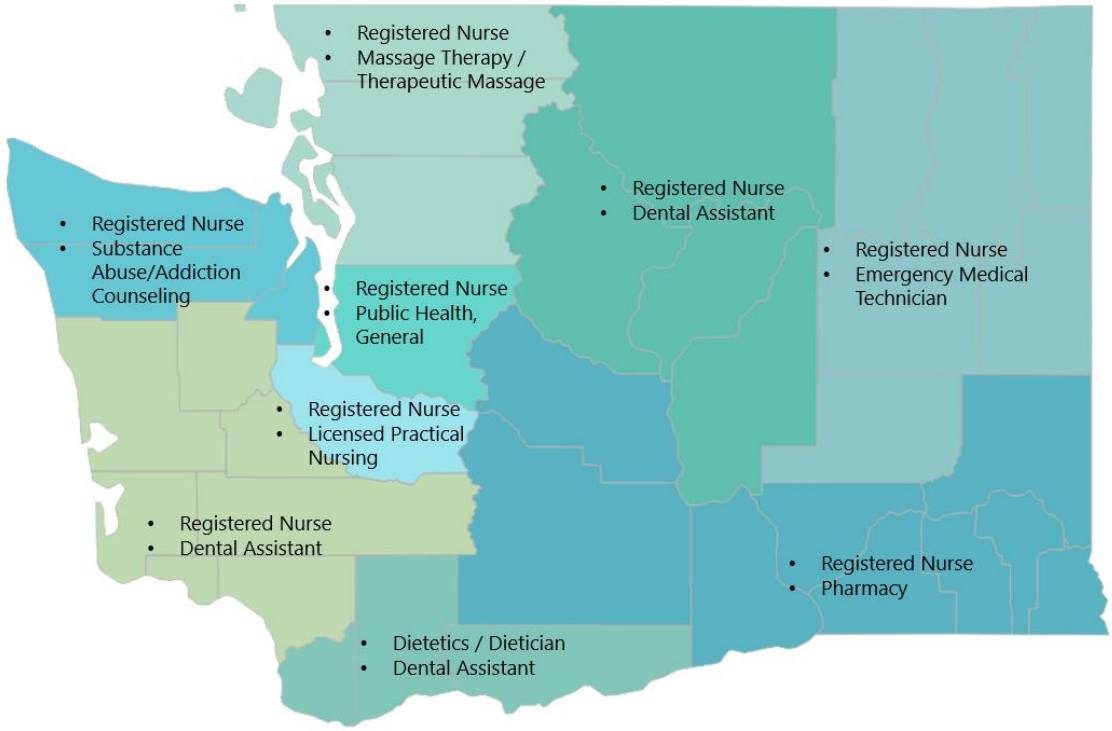
Data Source: The Integrated Postsecondary Education Data System (IPEDS) 2020; Workforce Board Data Reporting System 2020 for private career school completions.
* SEIU 775 Benefits Group contributed to data on home health aides.
** Includes multiple instructional programs.

Health Program Completions by Accountable Communities of Health

To provide regional data, healthcare program completers have been sorted into Accountable Communities of Health (ACH) regions based on where their education and training institution is located. It is important to note that data reflects where a student attended school, not their home address. Also, completers may ultimately work outside the geographic area where they trained.

Nursing assistant, home health aide, and medical assistant training programs by far produce the greatest number of completions in each of the state's nine ACH regions[30]. The **following map omits those programs** to better highlight regional education specialties. The map displays the next most common healthcare program completions for each of the state's ACH regions in 2020.

Figure 8. 2020 Most Common Completions by Accountable Communities of Health Region, Excluding Nursing Assistant, Home Health Aide, and Medical Assistant



Data Source: The Integrated Postsecondary Education Data System (IPEDS) 2020; Workforce Board Data Reporting System 2020 for private career school completions.

[30] ACHs respond to regional needs and issues, including COVID-19 responses and coordination. Launched in 2015, they were designed to be a neutral convener, coordinating body, and connection point between the healthcare delivery system and local communities.

Healthcare Employment Data

On behalf of the Council, the Workforce Board analyzes employment data and projected openings for select healthcare occupations. The data includes an analysis of approximately 100 healthcare occupations, including the reported average educational program requirement (*as reported by the U.S. Bureau of Labor Statistics*), current employment numbers for that occupation, the projected annual openings due to growth for that occupation, and finally, given career changes and retirements, a projection of actual annual openings expected for this occupation.

Health workforce data is complex and comes from many sources. Often, key data are spread across multiple agencies and organizations. Individual data elements may be held by a number of sources, such as state agencies and professional associations, or contained within licensing surveys. What might seem like a simple question about a specific occupation in a geographic area could involve any number of agencies and organizations tallying their data and calculating their findings slightly differently. Arriving at a firm answer to these types of labor market questions can be challenging.

State-level data on health occupations is generally available and accessible. Even so, this data often does not tell the whole story. Health workforce data without an analysis of additional contributing factors does not always provide the level of detail necessary to make sound decisions on where to invest in training programs and other areas of the health workforce pipeline. Washington's Health Workforce Sentinel Network (see p. 8 for more details) gathers ground-level feedback from Washington's healthcare providers on a regular basis, helping to provide a much-needed real-time perspective—particularly for regional data on emerging changes in healthcare personnel needs.

Not included in these data is information on individuals no longer practicing but retaining their license, or providers who serve Washington residents and practice through an endorsement of their license but reside in another state. Most significant is the challenge and expense of obtaining regionally specific data. There may be a distribution issue in some communities, where the number of educated healthcare professionals is higher than the number of available job openings, while other areas of the state struggle to fill open positions.

The analysis in the table below, performed by research staff at the Workforce Board and at the state's Employment Security Department, centers on what are known as projected "growth openings" or jobs within an occupation that are due to either expansion or openings from someone leaving the occupation (to another occupation or leaving the workforce). The adjacent column shows all projected job openings combined for each profession.

It is important to note that most of the data underlying these projections, particularly the rate at which employees leave the profession, were collected prior to when COVID-19 started to impact the economy (second calendar quarter of 2020). While anecdotal data suggest there has been a change in this rate, empirical data post-pandemic start is not yet available.

Occupation Title	Education Required	2020 Employment	Projected Annual Growth Openings 2024-29	Projected Annual Job Openings 2024-29
Ambulance Drivers and Attendants, Except Emergency Medical Technicians	High school diploma or equivalent	53	0	6
Anesthesiologists	Doctoral or professional degree	957	1	28
Athletic Trainers	Bachelor's degree	398	7	37
Audiologists	Doctoral or professional degree	364	4	26
Cardiovascular Technologists and Technicians	Associate's degree	1,063	12	79
Child, Family, and School Social Workers	Bachelor's degree	8,503	162	1,135
Chiropractors	Doctoral or professional degree	1,252	23	78
Clergy	Bachelor's degree	5,298	321	1,232
Clinical Laboratory Technologists and Technicians	Bachelor's degree	6,612	46	447
Community Health Workers	High school diploma or equivalent	3,218	111	589
Community and Social Service Specialists	Bachelor's degree	2,514	63	402
Counselors	Master's degree	12,007	313	1,862
Dental Assistants	Postsecondary nondegree award	8,446	128	1,179
Dental Hygienists	Associate's degree	5,944	93	571
Dental Laboratory Technicians	High school diploma or equivalent	859	-1	97

Occupation Title	Education Required	2020 Employment	Projected Annual Growth Openings 2024-29	Projected Annual Job Openings 2024-29
Dentists Specialists	Doctoral or professional degree	92	0	3
Dentists, General	Doctoral or professional degree	3,480	55	220
Diagnostic Medical Sonographers	Associate's degree	1,744	33	160
Dietetic Technicians	Associate's degree	232	3	25
Dietitians and Nutritionists	Bachelor's degree	1,510	27	156
Directors, Religious Activities and Education	Bachelor's degree	3,081	199	791
Educational, Guidance, School, and Vocational Counselors	Master's degree	5,746	86	747
Emergency Medical Technicians and Paramedics	Postsecondary nondegree award	4,130	17	281
Epidemiologists	Master's degree	536	6	54
Exercise Physiologists	Bachelor's degree	233	3	20
Family Medicine Physicians	Doctoral or professional degree	1,283	11	58
General Internal Medicine Physicians	Doctoral or professional degree	626	0	17
Genetic Counselors	Master's degree	95	3	12
Health Educators	Bachelor's degree	1,524	20	197
Health Information Technologists and Medical Registrars	Postsecondary nondegree award	4,709	55	363
Health Technologists and Technicians	Postsecondary nondegree award	3,205	43	329
Healthcare Diagnosing or Treating Practitioners	Master's degree	2,048	22	147
Healthcare Practitioners and Technical Workers	Postsecondary nondegree award	1,851	23	146
Healthcare Social Workers	Master's degree	4,454	78	577
Healthcare Support Workers	High school diploma or equivalent	3,254	52	487
Hearing Aid Specialists	High school diploma or equivalent	138	1	11
Home Health and Personal Care Aides	High school diploma or equivalent	62,049	2122	12,698
Licensed Practical and Licensed Vocational Nurses	Postsecondary nondegree award	7,952	84	753
Magnetic Resonance Imaging Technologists	Associate's degree	766	8	55
Marriage and Family Therapists	Master's degree	325	10	54

Occupation Title	Education Required	2020 Employment	Projected Annual Growth Openings 2024-29	Projected Annual Job Openings 2024-29
Massage Therapists	Postsecondary nondegree award	6,551	246	1,348
Medical Appliance Technicians	High school diploma or equivalent	467	6	70
Medical Assistants	Postsecondary nondegree award	15,639	308	2,400
Medical Equipment Preparers	High school diploma or equivalent	1,777	22	248
Medical Scientists, Except Epidemiologists	Doctoral or professional degree	5,948	68	607
Medical Secretaries	High school diploma or equivalent	8,443	102	1,139
Medical Transcriptionists	Postsecondary nondegree award	1,180	-8	117
Mental Health and Substance Abuse Social Workers	Master's degree	2,612	53	358
Nuclear Medicine Technologists	Associate's degree	277	3	20
Nurse Anesthetists	Master's degree	700	8	53
Nurse Midwives	Master's degree	110	1	8
Nurse Practitioners	Master's degree	3,934	209	681
Nursing Assistants	Postsecondary nondegree award	35,818	600	5,250
Obstetricians and Gynecologists	Doctoral or professional degree	386	3	17
Occupational Therapists	Master's degree	2,887	49	267
Occupational Therapy Aides	High school diploma or equivalent	115	1	15
Occupational Therapy Assistants	Associate's degree	690	19	118
Ophthalmic Laboratory Technicians	High school diploma or equivalent	1,007	0	117
Ophthalmic Medical Technicians	Postsecondary nondegree award	1,162	14	123
Opticians, Dispensing	High school diploma or equivalent	1,723	27	194
Optometrists	Doctoral or professional degree	1,162	21	81
Oral and Maxillofacial Surgeons	Doctoral or professional degree	231	3	13
Orderlies	High school diploma or equivalent	485	6	66
Orthodontists	Doctoral or professional degree	77	1	4

Occupation Title	Education Required	2020 Employment	Projected Annual Growth Openings 2024-29	Projected Annual Job Openings 2024-29
Orthotists and Prosthetists	Master's degree	169	2	15
Pediatricians, General	Doctoral or professional degree	764	6	34
Pharmacists	Doctoral or professional degree	7,144	67	431
Pharmacy Aides	High school diploma or equivalent	1,667	6	203
Pharmacy Technicians	High school diploma or equivalent	7,775	59	734
Phlebotomists	Postsecondary nondegree award	2,630	35	329
Physical Therapist Aides	High school diploma or equivalent	650	12	102
Physical Therapist Assistants	Associate's degree	1,552	29	243
Physical Therapists	Doctoral or professional degree	6,890	132	558
Physician Assistants	Master's degree	2,872	84	347
Physicians	Doctoral or professional degree	9,327	86	441
Podiatrists	Doctoral or professional degree	189	1	11
Probation Officers and Correctional Treatment Specialists	Bachelor's degree	2,050	13	183
Prosthodontists	Doctoral or professional degree	11	0	0
Psychiatric Aides	High school diploma or equivalent	485	20	104
Psychiatric Technicians	Postsecondary nondegree award	1,211	51	218
Psychiatrists	Doctoral or professional degree	484	9	33
Psychologists	Master's degree	5,220	87	513
Radiation Therapists	Associate's degree	318	4	25
Radiologic Technologists	Associate's degree	3,734	41	272
Recreational Therapists	Bachelor's degree	1,389	53	188
Registered Nurses	Bachelor's degree	60,167	780	4,700
Rehabilitation Counselors	Master's degree	4,621	23	486
Religious Workers	Bachelor's degree	1,161	76	321
Respiratory Therapists	Associate's degree	2,109	39	182
Social Scientists and Related Workers	Bachelor's degree	1,193	22	168

Occupation Title	Education Required	2020 Employment	Projected Annual Growth Openings 2024-29	Projected Annual Job Openings 2024-29
Social Workers	Bachelor's degree	806	4	79
Social and Human Service Assistants	High school diploma or equivalent	9,473	264	1,715
Sociologists	Master's degree	137	1	16
Speech-Language Pathologists	Master's degree	3,288	53	301
Surgeons	Doctoral or professional degree	1,222	11	57
Surgical Technologists	Postsecondary nondegree award	2,229	26	231
Therapists	Bachelor's degree	273	4	25

Sources: Washington's Employment Security Department, U.S. Bureau of Labor Statistics. Data for projected annual net increase and projected annual openings is for the time period spanning 2024-2029.

Data Details, Limitations, and Potential Discrepancies

Accurately responding to future changes in demand for healthcare workers is challenging. Many factors need to be taken into consideration, including monitoring changes in the healthcare system for labor market effects not predicted in the official projection. In general, this methodology tends to be conservative in predicting changes to recent trends.

Demand estimates are from occupational projections for Washington developed by ESD under a contract from the U.S. Department of Labor. This national methodology relies heavily on recent trends and national averages. Therefore, it may underestimate emerging overall changes or effects specific to Washington.

As noted previously, most of the data underlying these projections, particularly the rate at which employees leave the profession, were collected prior to when COVID-19 started to impact the economy (second calendar quarter of 2020). While anecdotal data suggest there has been a change in this rate, empirical data post-pandemic start is not yet available.