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A Report of the Health Care Personnel Shortage Task Force

December 2002

Health Care Personnel Shortage Task Force Members

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Diane Zahn, *United Food and Commercial Workers Union*

For Meeting Notes and Presentations see the Health Care Personnel Shortage Task Force Web Page: <http://www.wtb.wa.gov/HEALTHCARETASKFORCE.HTM>

For additional copies of this report, please go to www.wtb.wa.gov/publications



December 31, 2002

Governor Locke and Members of the Legislature:

Washington State is facing a severe shortage of health care workers in all areas of the state and in nearly all health professions. These shortages are affecting the quality of health care, and adding to the cost of health care services. Hospitals that cannot find enough staff to fill vacancies are turning away patients from emergency rooms and postponing or canceling scheduled procedures. Because the health care industry is one of the main economic drivers in the state, the shortages are also affecting the state's financial stability. As we look to the future, we see the demand for health care workers will increase because of our aging population and the numbers of health care workers reaching retirement.

In 2002, at the behest of four leaders in the House of Representatives, the Workforce Training and Education Coordinating Board convened the Health Care Personnel Shortage Task Force comprising key stakeholders from industry, education and labor. The Task Force met between July and November to learn from efforts to increase the number of health care professionals already under way in Washington and in other states, and to devise recommendations for the state. This report is a state strategic plan to address the critical shortages of health care personnel.

Increasing our state's health education and training capacity is the top priority. When we consider that Washington's unemployment rate is hovering around 7 percent, and we have a health care industry that offers high wage jobs and is clamoring for workers, it makes sense to train more high school graduates, dislocated workers, unemployed people, and others for health care professions. However, nearly all of the state's health care education and training programs report that they are turning away qualified students due to lack of capacity.

The Task Force meetings have provided increased visibility to this critical issue, matured the level of debate, and stimulated partnerships among state and local stakeholders. If the legislature and stakeholders implement the recommendations contained within this report, we believe we will make immediate and significant progress. We will reverse the current trend and alleviate this critical problem.

Thank you in advance for your attention to this critical issue,
Sincerely,

Brian Ebersole
Task Force Chair
(President Bates Technical College)

Dr. Bill Gray
Task Force Vice Chair
(Dean, Washington State University-Spokane)

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Executive Summary

HEALTH CARE PERSONNEL SHORTAGE OVERVIEW

Washington's health care personnel shortage is at a crisis level. It threatens the quality and accessibility of health care, the financial stability of the health services industry, and the financial stability of the state. This shortage is structural and different to previous shortages because of demographic changes: more health care workers will retire at a time when the state's aging population requires increased health care services.

As 2003 commences, health care facilities across the state are operating with critical staff shortages even though Washington reports one of the highest unemployment rates in the country, at more than seven percent. Occupations with critical shortages include nurses, medical aides, dental hygienists, laboratory personnel, pharmacists, physicians, radiology technologists, billers and coders, among others.

The shortage is so severe, industry has resorted to importing workers from other countries, and utilizing temporary employment agencies for regular staffing needs, despite exorbitant costs. These short-term activities have not been adequate to fill the gap between supply and demand, leading to undesirable outcomes. These outcomes include turning patients away from

emergency rooms and delaying scheduled procedures.

While health care employers search for staff, a large number of Washington's health care training programs report they are turning away qualified students because the programs lack the capacity, faculty and clinical sites to train them. Fifty-six programs offering nursing and allied health training reported waiting lists in 2001. For example, Washington State University's School of Nursing turned away two-thirds of its undergraduate applicants. Across the state, health care training programs have reached capacity. However, the number of people graduating from these programs does not meet our immediate or future needs. Increasing educational capacity should be a priority if the severe shortage is to be remedied.

In addition, the diversity of the health care workforce does not meet current or future health care access and workforce needs. Over 5,000 more minority licensed physicians, physician assistants, nurse practitioners and nurses are needed to reflect the diversity of Washington's residents. Racial and ethnic minority populations and people with disabilities are under-utilized labor pools.

A TASK FORCE IS CREATED

In response to these concerns, Representatives Phyllis Gutierrez Kenney (Chair, House Higher Education Committee), Eileen Cody (Chair, House Health Care Committee), Steve Conway (Chair, House Commerce and Labor

Committee), and Shay Schual-Berke (Vice-Chair House Health Care Committee) requested the Workforce Training and Education Coordinating Board convene a task force, comprising key health personnel stakeholders. Upon

"The health care personnel shortage has some very serious consequences for all of us in health care delivery. We have to spend more money hiring staff from temporary agencies, paying very large amounts of overtime pay and when we have staff calling in sick, we're in a real bind. Though we have not had to divert patients many of our peer hospitals have... there is just not enough staff to meet all our collective needs."

Terry J. Brennan,
PeaceHealth -
St. Joseph Hospital

"I tried to get into the RN program at Tacoma Community College but there are so many people applying you don't know whether you're going to get in or not."

David Ryhal,
Dislocated Worker

this request, the Health Care Personnel Shortage Task Force was established. The legislators charged the Task Force:

...to identify ways to increase the capacity of health professions in all areas, especially in the high demand areas, review training programs, which have well-designed career ladders, look at ways to improve recruitment and retention of students, ways to increase the diversity of health professions and to engage families transitioning from welfare to work, methods to encourage unemployed workers to seek employment in the health care field, and identify ways that state regulations, requirements, and statutes can be modified in a positive fashion to address the health care labor shortage.

In order to fulfill the charge, the Task Force held meetings from July to December during 2002, learning from a wide range of state and local efforts, and the experience of other states. The Task Force formed committees on educational capacity, and recruitment and retention, allowing the participation of a larger group of stakeholders. The committees incorporated recommendations from the Health Workforce Diversity Network to prevent duplication of efforts regarding diversity issues. Following recommendations from the committees, the Task Force developed this state strategic plan to increase the supply of health care personnel to meet current and future demand.



STRATEGIC GOALS

The recommended strategies developed by the Task Force address six goals:

- Goal 1:** Increase educational capacity and efficiency in health care training programs to enable more people to gain qualifications to work in health care occupations.
- Goal 2:** Recruit more individuals, especially targeted populations,¹ into health care occupations and promote adequate preparation prior to entry.
- Goal 3:** Develop a data collection and analysis system to assess health workforce supply and demand.
- Goal 4:** Retain current health care workers.
- Goal 5:** Enable local communities to implement strategies to alleviate the health care personnel shortage in their areas.
- Goal 6:** Develop a mechanism to ensure continued collaboration among stakeholders, track progress, create accountability for fulfilling this plan, and to plan for future health workforce needs.

¹ Targeted populations includes underserved populations such as rural communities; racially and ethnically diverse youth and adults; men and women; disabled, new immigrants, dislocated and incumbent workers; and military personnel.

Local Health Skills Panels

Health skills panels are comprised of local health employers, educators, and labor representatives. They meet to develop and implement local solutions for health care personnel shortages. Since 2000, the Workforce Training and Education Coordinating Board has issued SKILLS (Securing Key Industry Leaders for Learning Skills) grants to workforce development councils² for the purpose of supporting skills panels in industries that are significant for the economic development of the area. Eight workforce development councils have established health skills panels with the charge of identifying health personnel shortages in their areas, designing strategies to remedy the shortages, and implementing these strategies. (See Appendix C.)

WHAT YOU WILL FIND IN THIS PLAN

To accomplish these goals this plan outlines 40 strategies and identifies entities responsible for accomplishing each strategy. The Legislature, state agencies, educational institutions, and other public and private partners such as community-based

organizations are among the responsible entities. The complete recommendations are followed by 16 outcome measures to track progress. A complete list of recommendations and outcome measures begins on page 28.

PRIORITY RECOMMENDATIONS

The Task Force recommends four priority strategies that require immediate action to alleviate Washington's severe shortage of health care personnel:

- **Provide funds to health care education and training programs in order to expand capacity and allow for the higher costs of providing these programs.** Education and training providers report turning away qualified students. This is due to a lack of funding and facilities for key programs and services. Education and training programs must have more state general funds that account for the high costs of providing health care education and training programs. Funding programs located in underserved and rural communities is essential for training and educating health care providers who are more likely to practice in those communities.
- **Expand clinical training capacity.** While most health care education and training programs include a clinical training component, educational institutions report severe shortages of clinical sites and faculty to supervise clinical placements. Employers and educators are working together to overcome these barriers. Local health skills panels are developing coordinated clinical training placements among educational institutions and employers. These must be expanded to all health occupations and areas of the state experiencing clinical site shortages.
- **Empower local communities to address the shortage in their areas.** As of December 2002 health skills panels have been established in eight of Washington's 12 workforce development areas. These skills panels are collaborations of health employers; labor and education providers; and community-based organizations in local areas. They implement strategies to alleviate critical shortages. Funding should be provided to establish health skills panels in the four remaining workforce development areas, and to continue support for the existing health skills panels. There must also be coordination among local panels to enable them to learn from one another and for the state to continue to learn from them.
- **Provide compensation to health program faculty that competes with wages earned outside teaching.** A major barrier to expanding health care education programs is the lack of qualified faculty. In some local areas, employers and education institutions have been able to share employees. Education institutions working with the Legislature, labor and employers should identify ways to increase flexibility in faculty salary structures to compensate faculty competitively with wages earned outside teaching.

² The federal Workforce Investment Act of 1998 required that each state establish local workforce investment boards, known in Washington as workforce development councils. Washington has 12 workforce development councils that are each comprised of a majority of business representatives, with education, and labor representatives. These councils fulfill the state strategic goals for workforce development at the local level.

OUTCOME MEASURES

To ensure accountability for accomplishing the goals in this plan, the Task Force developed the following outcome measures:

1. Number and diversity of students enrolled in health care education and training programs.
2. Number and diversity of students completing health care education and training programs.
3. Number and diversity of students training to become faculty in health care education and training.
4. Amount of additional funds allocated to increase educational capacity in health care education and training programs.
5. Establishment of an ongoing statewide system for data collection and analysis.
6. Establishment of a campaign to market health care careers.
7. Establishment of a Web site to provide health care training/career mapping and financial aid information.
8. Numbers of workforce development councils that have established health care Skills panels.
9. Turnover rates for health care personnel.
10. Level at which health workforce diversity reflects the diversity of the populations served.
11. Numbers of incumbent health care workers receiving training to move up a career ladder.
12. Number of high schools offering health science programs, and the number of these that lead to certification.
13. Proximity of supply to demand of health care personnel.
14. Number of strategies in this plan that are successfully implemented.
15. Creation of a formal mechanism that oversees the implementation of Task Force recommendations, and holds responsible entities accountable.
16. Commitment by the Governor and legislature to target health professions education at the true cost.

EXCEPTIONS

The Task Force decided to exclude two significant issues from the discussion to ensure progress within a limited time frame. The two issues are reimbursement rates and scope of practice issues. The Task Force acknowledges that Medicare, Medicaid and private insurance reimbursement rates are serious issues that impact physician supply, the industry's ability to fund workforce development, and the entire health system. The state should examine reimbursement issues. However, the membership and time frame were inadequate to address these concerns. The Task Force also removed scope of practice issues from the discussion because

associated controversies could prevent progress on immediate, high priority issues.

While not outlined specifically in the charge provided by the legislators, Task Force members recognize another issue that is also very important: retaining current health care workers. This is discussed in Appendix A.

Health care personnel shortages are impacting all areas of the state, the stability of the health care industry, and the state's economy. All Task Force members agreed that the priority for alleviating the health care personnel



shortage is increasing educational capacity. With increased capacity in health care education and training programs, this crisis could develop into

an opportunity to prepare many of the state's dislocated and unemployed workers for high-wage jobs in health care, and boost the economy.

Overview

Health care employers statewide report severe shortages across all health professions and all types of health care facilities. The shortages are not only threatening the quality of Washington's health care system and access to health care services, but the stability of Washington's economy. In 2001, Washington's acute care hospitals, the largest employer of nurses, reported a shortage of approximately 2,000 staff registered nurses (RNs). (This figure under-estimates the shortage of registered nurses because the study did not include private clinics, federal, rehabilitation psychiatric hospitals, and other settings where registered nurses are employed.)¹ Washington's nursing homes reported a vacancy rate of nearly 20 percent for staff RNs and nearly 15 percent for licensed practical nurses.² Shortages of this magnitude endanger patients and increase health care costs.

In 2001, 55 percent of emergency departments turned away patients because they did not have enough nurses.³ According to the Joint Commission on Accreditation of Health Organizations (JCAHO), the primary accrediting body of hospitals and community health centers, staffing levels have been a contributing factor in 24 percent of the reported unanticipated events occurring that resulted in death, injury or permanent loss of function.⁴

In understaffed facilities, health care

workers must work longer shifts, more overtime and be responsible for more patients. Studies of nurse satisfaction rates report that a high percentage of nurses are thinking of leaving their jobs.⁵ When describing sources of dissatisfaction, health personnel consistently describe the workplace as highly pressured and difficult.⁶ Turnover rates for nursing staff working in nursing homes are as high as 95 percent for nursing assistants and 69 percent for staff RNs per year.⁷ Washington's hospitals are reporting a turnover rate of about 17 percent for their staff RNs.⁸

As a result of the shortage, health care facilities have watched operating costs increase astronomically. In 1995, contract nursing expenses for hospitals in Washington were just over \$11 million, or about \$120,000 for an average hospital. Four years later, in 1999, the figure had grown to over \$40 million, or an average of over \$400,000 per hospital.⁹ Short-term solutions, such as sign-on bonuses, hiring nurses from other countries, and more use of temporary help to fill vacancies are very expensive and part of the reason that costs have increased at health care facilities. Because facilities must pay these higher costs, they put fewer resources into developing long-term strategies for filling vacancies and retaining staff, such as offering educational opportunities and work redesign.¹⁰

"In surgery we have a higher ratio of nurses to patients. When a co-worker has a day off and then one or two others calls in sick, it is extremely difficult to find staff. Even the temporary staffing agencies are short – there is just not enough qualified staff out there."

Ken Cameron,
RN, Group Health

Health care is one of the largest industries in Washington. Given this, the shortage of health care personnel could have serious implications for the economic vitality of the state. Over 207,000 people are employed in health services representing eight percent of the state's workforce.¹¹ The health care industry provides over \$6.2 billion in wages each year. This is almost twice as much as the agriculture, forestry, and fishing industries combined. Between 2002 and 2008 there will be over 6,600 job openings in health care each year.¹² The National Rural Health Association estimates that 20-30 percent of a rural community's economy depends on its health care system because it is usually either the major or the second major employer in the community.¹³

The shortage is threatening Washington's competitiveness as a desirable place to live and work. Businesses want to locate in communities with a high quality of life. Access to health care is a fundamental component in determining a region's quality of life.

To address this crisis, four legislative leaders in the State House of Representatives requested that the state's Workforce Training and Education Coordinating Board convene a task force to address the health care personnel shortage in Washington. The legislators requested that the task force include key labor, business, education and health care leaders and directed the task force to identify ways to increase the number of workers in health professions. The

legislators asked the task force to examine educational capacity; recruitment and retention, including recruitment of diverse populations; and changes to regulations for licensing and accreditation.

The Task Force reviewed initiatives and recommendations of previous efforts, including those of professional associations; national, state and local health care entities; and the experience of other states. The Task Force formed two committees to develop strategies for educational capacity, and recruitment and retention. Committee membership was expanded beyond Task Force members to encompass a wide portion of stakeholders from industry, labor and education (*see Appendix E for list of committee members.*) Committees examined a wide range of strategies, and determined they addressed:

- Rural and urban Washington
- Increasing the diversity of the workforce
- All types of health care facilities
- All health care occupations (or occupational specific)
- Impact on quality of health care, and cost v. benefit

The Task Force asked the Health Workforce Diversity Network to make recommendations to the Educational Capacity and Recruitment and Retention Committees on increasing the diversity of the health care workforce.¹⁴

“The health care sector is an important economic driver due to its size, projected growth, average wages and concentration. Health care is not only an important economic driver in each region, but also for the state as a whole.”

**Dr. Paul Sommers,
Deena Heg,**
Occupational Demand and
Supply by Industry Cluster
and Region

Task Force members narrowed the range of topics open for discussion to ensure progress could be made on key issues. For example, Medicare, Medicaid, private insurance reimbursement costs, and scope of practice issues can impact the supply of health care personnel but the Task Force purposefully did not address these. While Task Force members acknowledge these are important issues that the state should examine, they were beyond the charge of the Task Force. The Task Force prioritized educational capacity and recruitment issues.

The members of the Task Force agree that the priority for alleviating the shortage is increasing educational capacity. Education and training institutions must be given the funding to expand their programs,

secure state-of-the-art facilities, train a larger number of qualified applicants, and prepare for a large number of students to be served by health care programs. In order to have sufficient capacity, health care education and training faculty must be compensated at a level that competes with industry wages. In addition, local education institutions, employers and labor must receive assistance to enable them to craft solutions that address their specific needs.

This report discusses key issues and challenges Washington faces in working through this shortage and recommends strategies for the Legislature to pursue. It also serves as a strategic plan for state agencies, educators, labor, employers and workers to take immediate action.



The Demand for Health Care Personnel

THE SHORTAGE OF HEALTH CARE PERSONNEL IN WASHINGTON

Washington is experiencing a severe shortage of health personnel in all areas of the state. Health occupations that face critical shortages include nurses, medical aides, dental hygienists, billers and coders, laboratory personnel, pharmacists, physicians and radiology technologists, among others. In 2001 the Center for

Health Workforce Studies at the University of Washington and the Washington State Hospital Association conducted a survey of the 83 acute-care hospitals in Washington.¹⁵ Results shown by workforce development area, provide evidence of the statewide problem (see Figure 1.)

Fig. 1: Difficulty of Recruitment in Washington Hospitals: Workforce Development Area (See map in Appendix C)

	(1) Olympic	(2) Pacific Mountain	(3) Northwest	(4) Snohomish	(5) King	(6) Pierce	(7) Southwest	(8) North Central	(9) TriCounty	(10) Eastern Washington	(11) Benton Franklin	(12) Spokane
Newly Trained RNs												
Experienced RNs												
Licensed Practical Nurses												
Nursing Aides												
Medical Technologists / CLS												
Medical Lab Technicians / CLT												
Radiology Technologists												
Ultra Sound Technologists												
Nuclear Med. Technologists												
Radiation Ther. Technologists												
Medical Records Technologists												
Medical Records Coders												
Licensed Pharmacists												
Pharmacy Technologists												
Physician Assistants												
Dieticians												
Physical Therapists												
Occupation Therapists												
Respiratory Therapists												

KEY: Percent of hospitals reporting "very difficult" to recruit: 0% 1% to 49% 50% to 100%

(1) Clallam, Jefferson, Kitsap (2) Grays Harbor, Lewis, Mason, Pacific, Thurston (3) Island, San Juan, Skagit, Whatcom (7) Clark, Cowlitz, Skamania, Wahkiakum (8) Adams, Chelan, Douglas, Grant, Okanogan (9) Kittitas, Klickitat, Yakima (10) Asotin, Columbia, Ferry, Garfield, Lincoln, Pend Oreille, Stevens, Walla Walla, Whitman
 Source: Washington State Hospital Association and Center for Health Workforce Studies, University of Washington, 2001 Survey of Acute-Care Hospitals in Washington.

Data on supply and demand of registered nurses demonstrates the severity of the shortage. In 1999, there were 52,497 licensed registered nurses in Washington.¹⁶ According to a 2002 report by the U.S. Department of Health and Human Services, Health Resources and Services Administration, if the demand for nurses continues to outstrip supply at its current rate, Washington is forecast to experience a shortage of 25,451 full-time equivalent registered nurses by 2020.¹⁷ Registered nurses and licensed practical nurses comprise almost a quarter of the occupations employed in health services.¹⁸ When combined with nursing aides, orderlies and attendants, this figure rises to about a third of the health care workforce.

The survey of acute-care hospitals estimated a shortage of 1,987 staff nurses needed to fill 1,401 vacant full-time equivalent positions in 2001. Hospital registered nurse vacancy rates were 9.2 percent statewide, with rural hospitals reporting vacancy rates of 8.9 percent, and urban reporting vacancy rates of 9.6 percent.¹⁹ When asked to identify the primary reason for nurse vacancies, more than 80 percent of hospitals said there were either not enough applicants or a lack of qualified applicants.²⁰

Hospitals reported difficulty recruiting both newly trained and experienced nurses. More than 74 percent of hospitals reported difficulty in recruiting newly trained registered nurses and 97 percent reported

difficulty recruiting experienced registered nurses. More rural hospitals than urban hospitals reported it was “very difficult” to recruit newly-trained nurses (38 percent rural, 12 percent urban.)²¹ Hospitals indicated that the most difficult registered nurse specialties to recruit were intensive care unit/critical care unit, anesthesia, emergency, operating room/recovery, and labor and delivery.

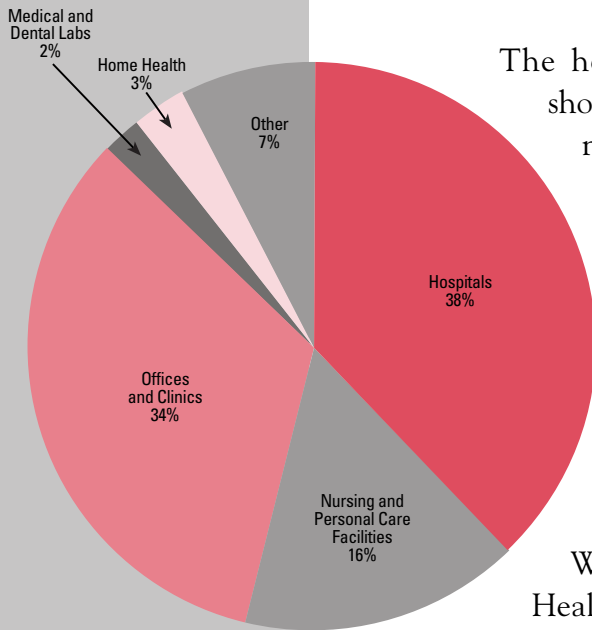
High rates of burnout contribute to the critical workforce shortages. In 2000 and 2001, the average nursing staff turnover rate in Washington’s rural and urban hospitals was 16.6 percent per year. While a high proportion of hospitals reported using a wide range of recruitment and retention incentives such as supplemental pay, tuition reimbursement, and flexible hours, fewer hospitals reported that these were effective. In Washington’s nursing homes the annual average turnover rate for registered nurses was 69 percent. For nursing assistants the turnover rate was 95 percent (*see Appendix A for a discussion on retention issues.*)²²

Projected retirements imply the shortage will become more severe unless supply is increased. The average age of registered nurses in Washington is 47 compared to the national average age of 45. Sixty-nine percent of registered nurses employed in hospitals in Washington are 40 or older.

The results of the 2001 survey of the state’s acute-care hospitals describe only part of



Fig. 2: Health Services Employment by Place of Work: Washington



Source: The Bureau of Labor Statistics, 2001

the picture. More than 40 percent of health personnel work in non-hospital settings (see Figure 2.)²³ Fifty-four percent of registered nurses work in non-hospital settings, while about 77 percent of licensed practical nurses work in non-hospital settings (39.5 percent in long-term care).

The health care personnel shortage in Washington is not limited to nurses. Other occupations are experiencing severe shortages as well. A survey of dentists conducted jointly by the Washington State Dental Association and the University of Washington's Center for Health Workforce Studies, demonstrates that shortages of dentists, dental assistants, and particularly dental hygienists are spread throughout the state.²⁴

Half of urban dentists reported they planned to retire by 2013. Thirty-three percent of general dentists anticipate allowing no increase in patient volume, citing lack of available dental hygienists, and dental assistants among the reasons. On average there are 41 dental hygienist vacancies per 100 general dentists. The study reports greater shortages of dentists and dental hygienists in rural areas compared to the general population with

57 percent of rural dentists indicating they planned to retire by 2013.

Washington's dental hygienist vacancy rate was 24.5 percent with the highest vacancy rates in rural areas (29 percent) and along the Puget Sound I-5 corridor. The study estimates that Washington will require about 360 dental hygienists to enter practice each year through 2010 to eliminate vacancies, 210 more than currently supplied by college programs.

As Washington's population ages there is a growing demand for pharmaceutical services, and the roles for pharmacists are expanding to long-term care facilities, community health centers, managed care organizations and hospital settings.²⁵ The 2001 hospital survey shows that hospitals in all areas of the state report shortages of pharmacists.²⁶ A study by the National Association of Chain Drugstores reports that chain and community practices in Bonney Lake, Chehalis, Eastern Washington, Moses Lake, Olympia, Seattle, Spokane, Southwest Washington, Sunnyside, Tacoma, Tri-cities area, Yakima, and Walla Walla are experiencing severe shortages.²⁷ Each year the two schools of pharmacy at the University of Washington and Washington State University produce about 140 graduates. At the same time about 100 pharmacists are retiring each year.²⁸ The reported shortages in hospitals, chain drugstores and community practice suggest that 40 additional pharmacists each year are not enough to meet demand.

CONSEQUENCES

Health care personnel shortages have made it extremely difficult for health care facilities to maintain adequate staffing levels. This threatens the quality of care given to patients; negatively affects the safety and well being of existing staff; and significantly increases health care facilities' cost of providing care. Hospitals and other health care facilities' operating costs are skyrocketing, as they must contract for expensive temporary help through temporary employment agencies. Major consequences of health care personnel shortages are emergency room overcrowding, diverting patients to other hospitals, discontinuation of services, delaying elective surgeries, reduced availability of hospital beds, waiting lists for appointments, and increased worker burnout and turnover rates.

In 2001, 66 percent of urban hospitals, and 46 percent of rural hospitals went on "divert status," turning away emergency department patients because they did not have enough nurses.²⁹ As a result, emergency patients had to travel further and emergency treatment was delayed. Low staffing levels have caused Washington hospitals to cut back and/or postpone scheduled procedures. In 2001, a large regional hospital in Seattle had to cut back its surgery schedule by 50 percent because of a lack of anesthesiologists.³⁰ Delaying elective surgeries may mean prolonging a patient's discomfort and increasing the risk of complications.³¹

Recent surveys of Washington's hospitals and nursing homes reveal high turnover and vacancy rates of essential personnel, which lead to higher patient-to-nurse ratios. According to a study recently published in the *Journal of the American Medical Association*, surgical patients with conditions that require high nurse-to-patient ratios are at higher risk of dying from complications because nursing staff is not available to respond quickly enough.³²

Low staffing levels have also been linked to job dissatisfaction and burnout. Higher emotional exhaustion and greater job dissatisfaction in nurses were strongly and significantly associated with high patient-to-nurse ratios in a recent survey. In the same survey, 43 percent of nurses who reported high burnout and were dissatisfied with their job intend to leave their current job within the next 12 months.³³

Hospitals' operating costs have increased dramatically as nursing and other essential staff vacancies become harder to fill. In order to keep staffing levels acceptable, administrators must contract for temporary staff at a much higher cost to the facility. These expensive short-term solutions are necessary to ensure that patient care is not compromised. Because facilities are paying higher recruiting costs, they are less able to put resources into developing long-term strategies for filling vacancies and retaining staff, such as work redesign and offering staff educational opportunities.³⁴



Challenges and Opportunities for Addressing the Shortage

"I am 55 years old, and out of work from the shutdown of the Reynolds Metals Company (Longview Aluminum LLC.) I have taken all of the prerequisites for the nursing program, but have not been accepted as of yet. I have been applying for two quarters in a row, without success."

Bob Callos,
Dislocated Worker

Alleviating the shortage of Washington's health care personnel will require overcoming significant challenges. The state's population is aging and becoming increasingly diverse. In order to meet these challenges, we must expand capacity in health care education and training programs.

Washington had the second highest unemployment rate in the nation (7.4 percent as of October 2002). Unemployed workers could be recruited into health care professions. Individuals receiving Temporary Assistance to Needy Families (TANF), served through the state's WorkFirst program, are also in need of career opportunities. The job vacancies in health care can provide the

types of career opportunities that unemployed workers and TANF recipients need. And because Washington's unemployment rate is high, Washington is receiving increased federal funding through the federal Workforce Investment Act (WIA) that can be utilized to support and expand programs to prepare workers for health care occupations.

The following section outlines the major challenges and opportunities for alleviating the shortage of health care personnel and examples of initiatives already underway in the state. The Task Force examined these initiatives with the intention of building a state plan based on previous successes.

THE AGING POPULATION INTENSIFIES THE SHORTAGE

The current shortage of health care personnel is different from previous cyclical shortages because it is structural. Washington's aging population will dramatically increase the demand for health care. The aging population includes health care personnel who will retire just at the time when more health care workers are needed.

In 2000, Washington's population over age 65 was 662,000. By 2020, there will be more than 1.22 million people over age 65.³⁵ The impact of this increase on our health care system will be

immense. Older adults use 23 percent of ambulatory care visits, 48 percent of hospital days, and 69 percent of home health services, and they represent 83 percent of the residents in nursing facilities.

Many health care workers are also nearing retirement age. The average age of registered nurses in Washington is 47, two years above the national average. Forty-eight percent of pharmacists are 45 or older, and about half of Washington's dentists report they plan to retire by 2013.



THE NECESSITY OF RECRUITING DIVERSE POPULATIONS INTO THE HEALTH WORKFORCE

It will be necessary to recruit more racial and ethnic minorities, people with disabilities, and men into nursing and other health professions. Non-white and Hispanic people represent the fastest growing segment of Washington's population. People with disabilities comprise a substantial under-utilized labor pool. Of the 557,000 working-age adults with disabilities in Washington, only about half are employed, and about a third of those employed report they are under-

employed.³⁶ In order to benefit from the availability of racial and ethnic minorities and people with disabilities, it will also be necessary to provide both sufficient preparation in math, science, and basic skills courses, as well as role models for these populations.

Currently, the racial and ethnic composition of Washington's health workforce does not reflect Washington's racial and ethnic diversity (see figure 3.)³⁷



“Solving the current health workforce shortage involves developing and recruiting from new pools of candidates. Racial and ethnic minorities constitute the fastest growing populations in the state. A growing body of research shows that when the diversity of the health workforce is reflective of the population served, access and health outcomes for racial and ethnic minorities improves.”

Vickie Ybarra
 State Board of Health
 Member and Yakima
 Migrant Community
 Center

Fig. 3: Percent of Racial and Ethnic Minority Populations in Health Workforce for Selected Occupation

Race / Ethnicity	Percent of State Population	Medical Doctors (%)	Physician Assistants (%)	Nurse Practitioners (%)	Dentists (%)	Dental Hygienists (%)
African American	3.2	1.0	2.4	1.1	0.9	0.5
American Indian / AK Native	1.6	0.5	1.2	0.6	0.7	1.1
Hispanic	7.5	2.0	4.5	1.6	0.7	1.7

Source: 2000 Census and Center for Health Workforce Studies, University of Washington, Data Snapshots

Registered nurses make up the largest single health profession, representing nearly 20 percent of all the health care workers. Historically women have chosen nursing as a career. Ninety-two percent of Washington's RNs are female.³⁸

Important strategies include encouraging diverse health care professionals to mentor students and offer job-shadowing opportunities. Health training programs can reduce potential cultural and language barriers by integrating English as a Second Language into the core health care training

curriculum. Two ongoing efforts to improve educational outcomes of minorities are the State Board for Community and Technical College's (SBCTC) strategy for increasing college completion rates of its minority students and the Office of Superintendent of Public Instruction's recent emphasis on improving methods of assessing English language proficiency.

Recruiting from these diverse populations will build a workforce that more closely reflects the increasing diversity of our state with the added benefit of improving health

“The problems for allied health professions are similar to those for nursing. We need more capacity in our education and training programs and we need to find ways of attracting qualified faculty.”

Diane Zahn,
UFCW

outcomes of underserved and minority populations. Racial and ethnic minorities in our state carry a disproportionate burden of disease, disability, and premature death when compared to the general population. A growing body of research shows that a diverse health care workforce can improve the health status of racial and

ethnic minorities because minority health professionals are more likely to provide health care to poor and underserved patients, and practice in underserved areas. In addition, studies demonstrate that a common language and/or ethnic background shared by provider and patient improves quality of care and health outcomes.³⁹

EDUCATIONAL CAPACITY IS INADEQUATE TO FULFILL DEMAND

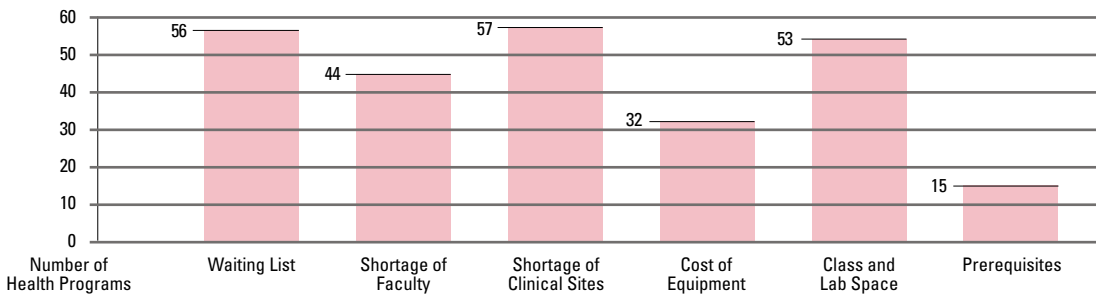
Expanding educational capacity in health care education and training programs is the key to eliminating the shortage of health care personnel. Currently, two- and four-year higher education institutions do not have the capacity to train all qualified applicants and are turning away many students. In addition, demand for higher education and training is projected to increase. Forecasted growth in the industry will require increased capacity beyond current demand, and there are likely to be additional students from the ranks of dislocated workers, TANF recipients, workers in low-income occupations, racial and ethnic minorities, and a growing number of students graduating from high school.

Educational capacity includes five elements:

- (1) Funding to support student enrollments,
- (2) Availability of qualified faculty,
- (3) Clinical Training capacity that includes sites at the workplace, clinical supervision faculty and clinical supervision staff at the workplace,
- (4) Equipment, and
- (5) Facilities for classrooms and laboratories.

Postsecondary institutions cite all these as limitations for expanding health care programs.

A large number of schools and colleges report turning away qualified students because they lack capacity in their health care education and training programs. Fifty-six separate nursing and allied health programs at community and technical colleges reported waiting lists in 2001 (see Figure 4, following page.) For example, Washington State University’s School of Nursing turned away two-thirds of undergraduate applicants and Seattle University’s Nursing program received 120 applications for 20 slots. Many programs report waiting lists. For example, students who want to enter the Medical Laboratory Technician Program at Clover Park Technical College in Tacoma are on a waiting list for two years. Only 12 students can be admitted each year because of lack of on-site clinical training opportunities and the need for additional equipment.

Fig. 4: Barriers to Expanding Health Care Programs at Community and Technical Colleges

Source: State Board of Community and Technical Colleges, Survey of Selected Allied Health Programs, December 2001

Health care education and training programs are more expensive than most other programs due mainly to faculty, equipment and facilities costs. Low student-to-faculty ratios are required in class and at clinical training sites for program accreditation and to ensure patient safety. Program costs include salaries for lab assistants and faculty with appropriate graduate degrees. Most health care programs require specialized equipment that can be extremely costly, such as x-ray machinery and instructional materials. At community and technical colleges the average cost of health care programs is about \$10,000 per full-time equivalent student, while other programs average between \$5,000-\$6,000. At the University of Washington, the cost for courses taken per full-time equivalent student per year is \$29,000 for a Bachelors in nursing (upper division) and \$41,000 for courses taken in the Masters in Nursing program.⁴⁰

Health care education and training programs have difficulty attracting qualified faculty because many health care

professionals are able to earn more working in the industry than as faculty. For example, according to the American Association of Colleges of Nursing, a nurse practitioner in private practice earns \$78,217 while similarly prepared nursing faculty earn an average of \$54,980. At community and technical colleges the average faculty salary is \$46,271.⁴¹

The increase in the number of faculty qualifications waivers the Washington Nursing Commission has granted in recent years is one indication of the shortage of qualified faculty. These waivers allow faculty to teach programs even if they have not yet attained a masters in nursing, as required for accreditation of programs. In 2002, most of the 17 nursing programs requesting waivers to employ faculty with Bachelors in Nursing rather than a Masters in Nursing were approved.

Another imminent concern is the average age of health program faculty. The average age of professors in four-year nursing programs nationwide is 56.3 years. Associate



professors are 53.8 years and assistant professors are 50.4 years.⁴² This suggests that the demand for qualified health care faculty will also increase.

The lack of clinical training sites is a major barrier to expanding health care education programs across many health professions. In some programs, the required ratio of student to clinical supervisor is very low. For example, radiology technology is one-to-one. Accrediting bodies also require specific supervision from faculty and staff on-site. Staff on-site must have certain qualifications, and often students have to take exams using on-site equipment.

In order to identify barriers to expanding capacity, SBCTC conducted a survey of all health care programs. Thirty-one schools responded and all indicated a need to expand their health care programs.⁴³ The survey found that a large number of programs were over-enrolled, had students on waiting lists, reported difficulty recruiting qualified staff, lacked clinical training capacity, and had high equipment costs. A smaller number reported that they did not have enough space for teaching classes, and that there was a lack of pre-requisites available in the school such as English as a Second Language, basic skills, math and science.

In 2002, SBCTC directed \$2.1 million in grants for health care program expansion or creation for 12 separate

projects. SBCTC received requests that far outnumbered the available funds, demonstrating the readiness of health program administrators to expand programs if funds become available.⁴⁴

The grants expand capacity in a variety of ways. Tacoma Community College received a grant to hire a clinical site coordinator. The college is examining the model implemented by Maricopa County Community Colleges, Arizona. This program provides one point of contact for health care employers providing clinical sites, assures a fair distribution of students, and increases capacity.

Tacoma Community College, in partnership with eight regional nursing programs and the Pierce County Health Services Careers Council, received two grants to support hiring a clinical site coordinator. The coordinator will centralize and maximize clinical training opportunities, including development of a Web-based planning system, such as is used in Maricopa County, Arizona.

Without compromising quality, greater efficiency in health care education and training can help expand capacity. For example, in Arizona, Maricopa Community Colleges transformed six separate nursing curricula into one curriculum. The allied health programs devised a common-core curriculum that covered subjects all students must

take, such as medical terminology, anatomy and physiology. These actions have helped increase efficiency among the schools by freeing up faculty time and other school resources without compromising quality. In Washington, some institutions are beginning to develop a core program approach. For example, in 2002 Spokane Community College received a grant to create seven basic online programs that provide a core curricula for allied health programs.

There are 55 health professions regulated by the Department of Health, either through the Secretary or the 16 professional boards and commissions. These entities approve education and training programs (working with national accreditation boards), hear complaints, and examine a variety of rules and regulations related to gaining and maintaining credentials. The Department of Health has been working with the boards and commissions to review professional regulations and identify barriers to entry into professions.

Another way to increase the efficiency is to improve articulation between institutions and programs, and increase recognition of competencies learned in a variety of settings including the work site. Increased points of entry and credit for competencies already achieved promote timely achievement of qualifications. One project in eastern Washington that received a grant from SBCTC aims to

develop articulated agreements in allied health between five community colleges in rural Washington.

Ensuring students are well prepared before they enter health care programs would also help increase retention and efficiency. At community and technical colleges where there is a policy of open enrollment, students must still take placement tests. If students are not sufficiently prepared, they must take basic skills or pre-requisite classes. Some colleges do not have enough capacity in pre-requisites such as physiology, or basic skills such as reading, writing, math or English language proficiency.⁴⁵

In response to studies that found that faculty diversity improves retention of diverse populations, SBCTC implemented a policy to increase the diversity of faculty. In addition, SBCTC conducted focus groups with faculty and students to identify causes for the high rate of attrition among racial and ethnic minorities in post-secondary education. The study led to the development and incorporation of curricula that is appropriate to diverse cultures.

Besides additional state funding for increasing capacity at two and four-year colleges and universities, there are other avenues for expanding capacity. Apprenticeship is one such avenue in some fields. The Apprenticeship Training Council of the Department of Labor and



“Doing the Health Occupations Program I had the opportunity to work with patients in a nursing home and job shadow doctors and others in the hospital. This encouraged me a lot and helped me determine that this is the right field for me and that I really want to become a medical doctor.”

Mynoc Son,
Premed Student, UW,
Former Health Occupations
Student, Sammamish
High School

Industries has been working with the Department of Health and the Dispensing Optician Board to create an Apprenticeship for Dispensing Opticians. Three students have completed the program with another 38 in progress. One of the barriers to expanding apprenticeships in health care is the misconception that all the training is done at the work site. Apprenticeship programs always include a significant classroom component. Usually a participant will work on-site during the day and attend classes at night. The health skills panel in Pierce County, of the Pierce County Health Services Careers Council, is planning to pilot an apprenticeship program for health unit coordinators.

Many examples exist of public/private partnerships that have resulted in increased capacity of health care education and training programs. When Kelso School District had difficulty finding qualified faculty to teach their health science courses in nursing, they approached St. John Hospital. The hospital agreed to enable four qualified registered nurses to teach at the high school. The teachers receive an hourly rate that is equivalent to an industry salary, but at reduced hours depending on the funds the school has available. The hospital pays benefits. Two of the teachers work almost full-time at the school, while the other two work 50 percent or less at the school and pick up hours working at the hospital. The arrangement enables students at the high school to take health science with a nursing specialty, and the

hospital is seeing the benefits of their investment having hired at least 40 employees that went through the program at Kelso High School.

Other examples of faculty sharing arrangements exist within the state. Some hospitals provide full or partial salary and/or benefits for faculty that may also work part-time in the hospital. Ideas for increasing faculty availability include joint appointments among educational institutions, faculty chair endowments, and the use of distance technology to enable remote faculty to teach classes. With limited state funding for faculty salaries, all colleges and universities need assistance in finding ways of attracting and retaining faculty.

Currently the Washington State Health Professions Scholarship and Loan Repayment Program devotes a portion of funds to aid students who intend to become nursing faculty. Additional funding for this program and the creation of similar programs funded privately, or through public/private partnerships, would help recruit faculty to serve in schools that are experiencing shortages of health care faculty.

Post-education and training employment outcomes demonstrate that jobs are readily available upon completion of their programs. In 2001, 88 percent of Washington’s Medicine Residency Graduates secured a position within one

month post residency.⁴⁶ Other health care education and training programs are at the top of the list with the highest employment rates (in the third quarter following completion) when compared to other employment and training programs. A wide range of allied health programs have employment rates of around 80 percent with dental hygienists at 96 percent employment and medical x-ray

occupations between 92 and 94 percent employment. It should be noted that this data does not include those students who gain employment outside the Pacific Northwest, or those who take time off before seeking employment.⁴⁷ These high employment rates following program completions correlate with other data sources showing shortages across a wide range of health care occupations.

RECRUITING AND PREPARING STUDENTS FOR OPPORTUNITIES IN THE HEALTH WORKFORCE —

A career in health care can be an attractive option because of the direct rewards of patient care and high salaries compared to other occupations. Becoming a health care professional requires a good foundation in math and science, postsecondary, clinical training, and in many professions, passing a certification or licensing exam.

Many high school graduates find they are not adequately prepared to enter health care education and training because they have not taken the necessary math and science pre-requisites. Some of these students choose other areas of study; others must spend their first year of postsecondary education completing pre-requisites they could have taken in high school. Dislocated workers or people transitioning from welfare to work, who may be interested in a health care career, find the training may take longer than what their program allows or what they can afford.

The Task Force recognizes there are many ways for people to enter into a health care career. Ideally, no matter which path one chooses, it should be as direct of a path as possible.

Washington's K-12 system has a Health Occupations Program, offered in high schools and skills centers around the state, that prepares high school students for entering into postsecondary education or directly into a health care career (*see Appendix D*). Students enrolled in a Health Occupations Program must complete academic and technical instruction, which is generally a 360-hour program. Academic instruction includes math, science, and medical terminology. Technical instruction includes practical application and clinical training and leads directly to certification.

The Health Occupations Programs offer the most direct path to entry-level health care careers from high school by providing job training to students ages 16 through

“The Health Occupations Program benefited me because I got to take medical classes and learn about being a nurse, which is what I really want to do—I want to be a nurse. I got my Nursing Assistant Certificate, which enabled me to get a job. I am only 18 and now have advantages that a lot of adults don't have due to the Health Occupations Program.”

Bethany Dietrich,
Certified Nursing Assistant,
Former Health Occupations
Student, Port Angeles
High School

Educational Pathways

Since 1993, all Washington schools must offer their students educational pathways. Although the schools must offer pathways, the students are not required to choose one. For example, the Renton School District has six pathways: Arts and Communication; Business Organization and Management; Engineering and Technology; Health and Human Services; Marketing and Entrepreneurship; and Science and Natural Resources. The District has developed materials to introduce all grade levels to future career options. Schools within the district can order a color and activity book with skin color crayons for the younger grades and a pathway-planning book for middle and high schools students and their families. The book begins with a quiz to assess interests and then links interests to appropriate pathways, careers and courses. It then guides the students to plan their required and elective coursework for graduation and offers options for after high school.

21 or in grades 11 or 12. They learn the technical knowledge and skills to either gain advanced placement in apprenticeships, private career schools, two- and four-year colleges and universities, or go directly to entry-level employment in the health care industry. All of the entry-level health care careers offered through the Health Occupations or Health Sciences Careers Programs are considered the first rung of a career ladder.

Students enrolled in a Health Occupations Program must take core health courses including anatomy and physiology, medical terminology, and infection control. Students also learn about the legal and ethical issues of providing health care and take communication and leadership courses.

Comprehensive programs such as a Health Occupations offer many of the important elements that attract and retain students, as demonstrated by the high number of students that continue their education at four-year colleges and universities or two-year community and technical colleges (*see Appendix D*).

All students, but especially academically at-risk students, have a better chance of succeeding in school if they have access to mentoring, counseling, outreach and other supportive services. The Health Occupations Programs

already provide many of these components. The programs are small and taught by a core set of teachers. The average class size runs between 15 and 25 students. The curriculum prepares students academically for higher education, and the internships provide students with mentors in the community and a sense of pride and accomplishment.

Schools that are not affiliated with a Skills Center or do not offer a Health Occupations Program can still offer students guidance toward a health care career and work-based opportunities by providing a health-component of the Health and Human Services Career Pathway. Ideally every high school student in Washington should have access to this type of program or pathway. Currently, there are Health Occupations Programs in about half of the high school districts.

Collaborating with schools to provide students with a Health and Human Services Career Pathway can be an excellent way for local employers, labor, community-based organizations, and higher education institutions to develop the health workforce of the future. Health care providers can provide job shadowing, internships, and mentoring of students. Health skills panels can be important mechanisms to advance such collaboration.

To recruit enough people to fill all of the health care vacancies requires reaching out to a wide variety of individuals. These include, but are not limited to, recently unemployed or dislocated workers, incumbent workers, individuals with prior training in other states or countries but not licensed in Washington, and military personnel and their spouses preparing to transition into the civilian workforce.

The state's service for individuals seeking new or better jobs is WorkSource. WorkSource, administered by the Employment Security Department at the state level and overseen by 12 local workforce development councils, provides one-stop shopping for employment-related services. Assistance includes information about job openings; instruction in how to look for work; career counseling; and assessments of skills, abilities, and interests. The federal WIA is the main source of funding. Services are available to unemployed workers, TANF recipients, incumbent workers who want a better job, and anyone else who wants employment assistance.

Some workforce development councils have already focused the attention of their WorkSource centers on jobs in health care. For example, the Northwest Health Alliance, which is addressing the health care worker shortage in Whatcom, Skagit, Island, and San Juan counties, has prepared a PowerPoint presentation that provides

occupation information such as job openings current and forecasted, wages, and educational requirements. The presentation plays continuously in the Whatcom County WorkSource office (*See Appendix C on local health skills panels*).

More people move into Washington than leave here for other states. Some are coming here as military personnel stationed at one of several bases representing all branches of our military. Some may have worked in a health care job in another state or country before moving here. In some cases, the training required in a different country, state, or branch of our military may not meet Washington's licensing requirements. The Department of Health, division of Health Services Quality Assurance has already begun to address these issues by working with the professional boards and commissions to review existing licensure requirements for any unnecessary barriers that might hinder recruiting efforts.

Instituting career ladders and training opportunities within health care organizations can help recruit individuals into entry-level positions and improve retention of existing personnel by providing them with career advancement opportunities, such as going from a CNA to a LPN to an RN. A career ladder identifies what an entry-level employee must do to move up a 'rung of the ladder'

In Pierce County
MultiCare Health System has partnered with WorkSource to fund an on-site career specialist to assist employees with progressing up career ladders. By August 2002 over 50 employees had started health care education and training programs. WorkSource career specialists are also on-site at Franciscan Health System, Good Samaritan Community Healthcare, and Madigan Army Medical Center.

"I had 16 students at the lab as part of a middle school program to provide exposure to career options. After the visit eight students wrote to me saying the experience inspired them to consider going into health care and four of those said they wanted to become lab techs or histologists!"

Patty Wood,
Medical Lab Technician
Port Angeles, WA

to a higher credential and higher paying position. In most cases, the employers also provide support in the form of financial aid and/or allowing a portion of the training to occur on-site.

Many health care employees have financial, family, or other responsibilities that prevent them from pursuing additional training. These individuals are more likely to attend education and training programs that are offered either at the work place or at the school in short modules, and at times that are suitable for working health care personnel. Modular education and training allows employees to climb up the career ladder by taking intermediate steps towards the next rung with the support and recognition of their accomplishments by the employer. Career maps have been developed to help health care workers identify how to move within a career, or to move to a parallel career, such as going from licensed practical nurse to ultrasound technologist.

The success of efforts to create career ladders and expand educational capacity in K-12 and higher education depends upon increasing the number of individuals who want to pursue or return to health careers. While there are waiting lists now to get into many education and training programs, in the long-run success requires enticing even more people to want a job in health care.

Some local and national public awareness campaigns have begun to get the message across that there are many great job opportunities in health care. Examples include local efforts such as KIRO's 'Nursing: Making a Difference Every Day,' KOMO's 'Nursing – A Career for Life,' and national efforts such as the Johnson and Johnson's 'Discover Nursing' campaign. The public needs to know about available jobs, educational opportunities, financial aid, and career ladders. The Web can be a valuable tool to reach a wide audience. Given the increasing diversity of our state, information needs to be available in a variety of languages. We need to reach out with messages that resonate with youth, adults of racial and ethnically diverse populations, new immigrants, people with disabilities, unemployed workers, and other under-utilized populations. Currently, however, there is no statewide coordinated effort to increase public awareness of the shortage of health care workers and the opportunities the shortage creates.

For some individuals, taking advantage of opportunities in health care depends on financial aid for education and training. Washington has a Health Professions Scholarship and Loan Repayment Program operated jointly by the Higher Education Coordinating Board and the Department of Health. It administers state funds and funds federal



Health Resources and Services Administration (HRSA) funds to students training to work in a health care profession. A committee convenes prior to each new funding cycle to determine which health professions should get priority funding based on shortages.

However, the program has been unable to serve current student demand. Between 1998 and 2002, the Health Professions Scholarship and Loan Repayment Program received 276 applications for scholarships and awarded 74. It received 193 applications for loan repayment and awarded 92.⁴⁸ In return for a scholarship or loan repayment graduates must agree to practice for at least three years in a federally designated underserved community.

In rural areas, local public hospital districts would like to provide education and training opportunities to recruit health care personnel. Without education and training opportunities provided by local hospital districts, many potential rural health care workers will not have the resources needed to obtain training. Currently state statute is unclear about the ability of public hospital districts to pay for training as a recruitment and retention strategy. Examples include paying for tuition expenses of a student in exchange for the student agreeing to work at the hospital upon graduation for a certain period of time, or paying recruitment related expenses for the family of a prospective new employee.

RETENTION AND THE WORKPLACE ENVIRONMENT

Efforts to increase the number of people entering into health care careers must be complemented by efforts to ensure that people employed in health care remain there throughout their professional lives. Consequently, efforts to recruit more

individuals into the workforce must also address retention.

Workplace retention issues are further discussed in the paper on retention (see *Appendix A*).

INFORMATION FOR FUTURE PLANNING

Although the Task Force has collected ample evidence to document the shortage of health care workers, it is only a snapshot at a point in time. The absence of a state health workforce information system threatens to hamper efforts to measure our progress and address future shortages. A

permanent, coordinated information system could collect health workforce data and statistics from various sources and fill gaps in data collection and analysis, while ensuring appropriate access and use. Currently, no comprehensive health workforce data system exists for the state.

Providence St Peter Hospital (Olympia) is offering registered nurses attractive opportunities in an effort to improve recruitment and retention. These include scheduling options:

- RN's who work 12 weeks of pre-determined night shifts receive four weeks off with pay.
- RN's who work two 12-hour or three eight hour weekend shifts will be paid for 30 hours.

*Providence St Peter
August 02 Newsletter*

A basic system for health workforce supply and demand information requires four major categories of data:

1. Number and type of health care personnel, by geographic location and employment setting;
2. Statistics on immigration and out-migration of the health workforce;
3. Number of students enrolled and completing health care education and training programs;
4. Employer demand for health personnel as measured by job openings, vacancy rates and difficulty recruiting workers.

In addition to information on health workforce supply and demand, the State also needs information concerning availability of health care professionals to assure people have access to the types of care they need. For example, are obstetrics and gynecology services available in rural communities or are patients required to travel great distances? Are dentists working full time? Are registered nurses providing direct patient care or are they working as administrators? Do people covered by Medicare have access to providers who accept Medicare patients?

Data on students and health care personnel's race and ethnicity, gender, and other demographics will be needed to evaluate the effectiveness of efforts to address goals and objectives discussed in this report, and to measure outcomes listed on page 38.

The questions about whether health care employers can find enough qualified job applicants to fill their openings and whether the types of nurses, physicians and other health personnel are available to provide

care are different, although there is some overlap. The State needs to examine options to determine whether, or to what extent ongoing data collection and analysis efforts should be created that answer both access and labor market questions, and whether there should be a common data base. This examination requires a comprehensive cross-agency assessment of data needs and existing data collection efforts.

Pending recommendations regarding the best options for ongoing data collection and analysis, there are steps that can be taken now to update information about the health care labor market. Surveys can be conducted on health care personnel to obtain information on the current supply of health care workers. Surveys can also be conducted of health care employers to answer questions about demand. Education data can be examined to better identify the capacity of health care programs. These efforts can get underway now as the state examines the best options for an ongoing data system.



EMPOWERING LOCAL COMMUNITIES

Often, the best solutions for addressing the shortage of health personnel are devised and implemented at the local level. While policy-makers in Olympia can make certain actions happen, such as meeting the need to increase funding for higher education enrollments, there are other actions that local communities are better able to provide.

Beginning in 2000, the state Workforce Training and Education Coordinating Board has provided federal funding, authorized by the Workforce Investment Act (WIA), to Washington's 12 local workforce development councils to establish health skills panels. Health skills panels are partnerships of employers, labor, and education and training providers formed to address skill shortages in a particular industry or occupational cluster. Eight of Washington's 12 workforce development areas have health skills panels.

Health skills panels have been analyzing the labor supply gaps in their local areas and designing plans for addressing these

shortages. They have also begun to implement action steps and have leveraged funds from other sources for implementation. Health skills panels have used WIA funding provided by the Employment Security Department to provide customized training to incumbent workers to move up career ladders. Panels have used state funds provided to community and technical colleges to create new health care programs.

Health skills panels that have been operating for over a year in Northwest Washington, Pierce County, Pacific Mountain, Benton-Franklin, and Olympic workforce development areas have already implemented a wide number of initiatives that have positively affected the health personnel shortage in their areas. Newer panels in Seattle-King County, Snohomish County, and Southwest Washington have begun meetings of stakeholders and conducted surveys to identify priority skill shortages (*see Appendix C for additional information on local health skills panels*).

each year beginning in 2003 to perform this role and make further recommendations as changes in circumstances demand. Alternatively, the state could explore more formal mechanisms to monitor and support progress.

PROVIDING LEADERSHIP TO OVERSEE THE PLAN

The critical shortage of health care personnel requires the plan presented in this report be carefully monitored for several years to ensure responsible entities are held accountable for accomplishing their assignments. The 2002 Task Force could be instructed to meet several times

The Olympic Health Care Alliance, one of eight local health skills panels in Washington, identified dental assisting as one of its top three shortage areas. After meeting with health science instructors at the Port Angeles school district and dental health professionals, the Alliance decided it was feasible to support dental assisting and dental hygiene programs at the new North Olympic Skills Center. As the focus of the program has expanded to address community access, so has community interest. Recently the Lower Elwha S'Klallam Tribe and Local Community Action joined the Alliance. The Alliance is currently determining startup costs, developing a timeline, and looking at a variety of funding opportunities for these health care education and training programs at the Skills Center.



While the Task Force process in 2002 spurred changes among various state and local entities, and created a state plan for addressing the shortage, it is possible that advances could end here unless there is some formal mechanism to take responsibility for progress in the future. The continuation of a formal entity, such as the current Task Force, would

help reassure Washington citizens and businesses that the state will continue to address the health care personnel shortage and implement workforce development strategies to prevent shortages in the future. This is the minimum oversight recommended. The Task Force favors a more formal monitoring structure.

Recommendations and Outcome Measures

TASK FORCE RECOMMENDATIONS

Task Force members reached consensus on the following goals and strategies that form a plan to alleviate Washington's health care personnel shortage and build the workforce for the future. The plan requires coordinated

efforts among health care stakeholders. Strategies that require immediate action are highlighted "priority." The plan notes where state general funds (GF-S) and legislation (L) are required.

GLOSSARY

- **Responsible Entities** are listed after each strategy. These include Legislature, state agencies, local health skills panels, and/or public and private partners that are responsible for continuing efforts to accomplish the strategy.
- **High Demand** refers to occupations where employer demand exceeds labor supply.
- **Underserved** refers to federal health professional shortage area designations known as Medically Underserved Areas (MUA's), or Medically Underserved Populations (MUP's).
- **Skills Panels** are health skills panels. As of December 2002 eight have been established in 12 local workforce development areas. The panels are comprised of health care employers, education and training providers, and labor. Their purpose is to identify shortages in their local areas and devise solutions (see Appendix C).
- **Professional Boards and Commissions** refer to the 55 health professions regulated by the Department of Health either through the Secretary or the 16 professional boards and commissions. They are among the responsible entities named for reviewing regulations related to program accreditation, faculty qualifications, clinical training, articulation of programs, apprenticeships, among other issues.
- **Articulation** refers to the recognition by educational institutions of prior education and training that students receive at other educational institutions or on-the-job, and allow these to count as credits towards a certificate, diploma or degree.
- **HECB** is the Higher Education Coordinating Board.
- **SBCTC** is the State Board for Community and Technical Colleges.
- **OSPI** is the Office of Superintendent of Public Instruction.
- **AHECS** are Area Health Education Centers. They exist across the United States and receive both federal and state funding. Washington has AHEC centers in western and eastern Washington. Their mission includes providing linkages between health care delivery systems and educational resources in underserved communities.





GOAL 1. Increase educational capacity and efficiency in health care training programs to enable more people to gain qualifications to work in health care occupations.

OBJECTIVE 1.1: Increase funding and continue to reallocate resources to provide more capacity in new and current health care education and training programs.

PRIORITY STRATEGY 1.1.1: Increase current funding and support new funding initiatives that increase the capacity of high demand health care programs, taking into account the higher costs of these programs. Give priority to programs situated in medically underserved areas. (GF-S)

RESPONSIBLE ENTITIES: Legislature, SBCTC, HECB, four-year colleges and universities.

STRATEGY 1.1.2: Develop apprenticeship opportunities in health care.

RESPONSIBLE ENTITIES: Department of Labor and Industries, labor, employers, Department of Health, professional boards and commissions.

OBJECTIVE 1.2: Increase the availability, diversity and retention of health care faculty in high demand health care programs that have difficulty recruiting faculty.

PRIORITY STRATEGY 1.2.1: Increase the flexibility of faculty salary schedules or allocations to provide health program faculty with compensation that is competitive with industry wages. (GF-S.)

RESPONSIBLE ENTITIES: Legislature, SBCTC, HECB, four-year colleges, universities, labor and employers.

PRIORITY STRATEGY 1.2.2: Provide additional financial support, such as scholarships and loan repayments for students who intend to become health care *faculty* for high demand health care programs experiencing faculty shortages. (GF-S.)

RESPONSIBLE ENTITIES: The Legislature, SBCTC, HECB, Department of Health, four-year colleges and universities, private partners or foundations.

PRIORITY STRATEGY 1.2.3: Implement faculty sharing arrangements among education providers, or among industry and education providers.

RESPONSIBLE ENTITIES: Health skills panels working with employers, labor and education institutions.

STRATEGY 1.2.4: Develop alternate pathways to gain teaching qualifications for nursing faculty and other health program faculty.

RESPONSIBLE ENTITIES: Professional boards and commissions, Department of Health, SBCTC, colleges and universities.

STRATEGY 1.2.5: Provide financial and other incentives to employers or self-employed professionals for providing faculty resources, e.g. tax incentives and increased reimbursement rates. (L) (GF-S)

RESPONSIBLE ENTITIES: Legislature.

OBJECTIVE 1.3: Increase clinical training capacity.

PRIORITY STRATEGY 1.3.1: Coordinate clinical training sites for nursing and allied health professions.

RESPONSIBLE ENTITIES: Health skills panels working with employers, labor and education providers, AHECs.

STRATEGY 1.3.2: Provide financial and other incentives to employers or self-employed professionals for providing clinical training resources: sites and faculty supervision. (L) (GF-S)

RESPONSIBLE ENTITIES: Legislature.



STRATEGY 1.3.3: Identify and eliminate barriers to expanding clinical capacity, and to expand opportunities for training, testing, and certification through multiple delivery modes such as distance learning, and at multiple sites (e.g., the workplace), and make recommendations to state and national accreditation bodies.

RESPONSIBLE ENTITIES: Professional boards and commissions, Department of Health, education institutions, AHECs.

OBJECTIVE 1.4: *Increase efficiency and maintain quality of health care education and training programs to enable students to complete programs in a shorter time span and to reduce program costs.*

STRATEGY 1.4.1: Develop and implement “common core” health care curricula.

RESPONSIBLE ENTITIES: SBCTC, HECB, colleges and universities, OSPI, Department of Health and professional boards and commissions.

STRATEGY 1.4.2: Expand articulation among health care programs based on competencies learned in a variety of education and training settings, including on-the-job and in the military. *(See Goal 4 for education and training modules strategy that leads to promotion within the workplace.)*

RESPONSIBLE ENTITIES: Health skills panels, SBCTC, HECB, OSPI, colleges and universities, Department of Health.

STRATEGY 1.4.3: Improve program completion rates by blending basic skills including English as a Second Language, and occupational skills, adjusting instructional methods, incorporating cultural awareness, and improving support services.

RESPONSIBLE ENTITIES: SBCTC, colleges and universities, community-based organizations.

GOAL 2. Recruit more individuals, especially targeted populations* into health care occupations, and promote adequate preparation prior to entry.

OBJECTIVE 2.1: Provide more opportunities for people to enter health care careers.

**The following recommendations focus on underserved populations such as rural communities; racially and ethnically diverse youth and adults; men and women; disabled, new immigrants, dislocated and incumbent workers; and military personnel:*

STRATEGY 2.1.1: Expand and/or leverage financial aid for individuals pursuing health care training, and disseminate information on available financial assistance.

RESPONSIBLE ENTITIES: Legislature (GF-S) and/or private companies, HECB, employers, foundations, local health skills panels.

STRATEGY 2.1.2: Support proposed changes to regulations that allow more individuals to enter or re-enter health care, and identify refresher courses and/or alternative opportunities that recognize prior training and experience for obtaining licensure.

RESPONSIBLE ENTITIES: Department of Health working with health professional boards and commissions.

STRATEGY 2.1.3: Allow regulated health care entities flexibility in developing recruitment and retention programs that are effective for their communities.

RESPONSIBLE ENTITIES: Legislature, Department of Health working with Association of Washington Public Hospital Districts.

OBJECTIVE 2.2: Raise awareness of opportunities in health care careers, and provide information on technical and financial resources available for training.

STRATEGY 2.2.1: Establish career ladder opportunities in health care through collaboration among employers, labor, and education.

RESPONSIBLE ENTITIES: Local health skills panels, Department of Health, professional boards and commissions, professional associations.



**STRATEGY 2.2.2:**

Train frontline WorkSource staff to inform unemployed workers or transitioning individuals (e.g., military) of opportunities in health care careers, including providing information on required courses, referrals to appropriate programs and available resources.

RESPONSIBLE ENTITIES:

Employment Security Department and local workforce development councils.

STRATEGY 2.2.3:

Create smooth transitions for military trained personnel to enter the civilian workforce.

RESPONSIBLE ENTITIES:

Local health skills panels working with the military and education providers.

STRATEGY 2.2.4:

Develop a statewide healthcare marketing plan to raise awareness of the wide range of career opportunities. Communicate the plan in a variety of languages and ways.

RESPONSIBLE ENTITIES:

Private foundations and associations, community-based organizations.

STRATEGY 2.2.5:

Create and promote a web site that demonstrates different jobs in healthcare, the coursework required for each job, schools that provide that education, and sources of possible financial aid. Career mapping templates should identify multiple points of entry and advancement, including places along a path that allow crossover to other health professions.

RESPONSIBLE ENTITIES:

Private foundations and associations.

OBJECTIVE 2.3: Promote K-12 programs that provide opportunities to explore a variety of health care careers and prepare students academically so they can complete postsecondary health sciences programs.

The following recommendations target K-12 students and their families:

STRATEGY 2.3.1: Support local school districts and communities in strengthening primary and middle school students' math and science skills and in building health science career programs in high schools, including increasing the number of work-based learning opportunities for students, creating health care-focused mentoring programs, increasing the number of core health science and math programs, and increasing the number of programs that lead to industry certification and employment in health care careers.

RESPONSIBLE ENTITIES: OSPI working with local school districts and boards, higher education, community based organizations, local camps, health care employers, local workforce development councils, local youth development councils, the AHECs, and labor organizations.

STRATEGY 2.3.2: Support efforts of local school districts, communities and higher education institutions to raise student achievement in math and science to assure students are prepared for post-secondary studies in health sciences programs.

RESPONSIBLE ENTITIES: OSPI working with local school districts and boards, higher education, community based organizations, local camps, health care employers, local workforce development councils, local youth development councils, the AHECs, and labor organizations.

STRATEGY 2.3.3: Identify and maximize opportunities to provide students and their families, equitable access to academic assistance and resources needed to pursue a career in health care.

RESPONSIBLE ENTITIES: OSPI working with local school districts and boards, higher education, community based organizations, local camps, health care employers, local workforce development councils, local youth development councils, the AHECs, and labor organizations.



GOAL 3. Develop a data collection and analysis system to assess health workforce supply and demand.

STRATEGY 3.1.1: Conduct a comprehensive cross-agency assessment of data needs, existing data collection efforts and opportunities for collaboration and reduction of duplication.

RESPONSIBLE ENTITIES: Department of Health and Workforce Board working with health stakeholders.

STRATEGY 3.1.2: Analyze the options for creating and maintaining an ongoing centralized coordinated data system for information on both access to health care professionals, and labor market demand and supply for health care personnel.

RESPONSIBLE ENTITIES: Department of Health and Workforce Board working with health stakeholders.

STRATEGY 3.1.3: Collect workforce supply information through methods such as surveys of licensed professionals.

RESPONSIBLE ENTITIES: Department of Health and Workforce Board working with health stakeholders.

STRATEGY 3.1.4: Collect workforce supply information for non-credentialed health personnel.

RESPONSIBLE ENTITIES: Workforce Board working with Department of Health and health stakeholders.

STRATEGY 3.1.5: Collect data on students, enrolled and completing health care programs at high school, two-year and four-year public colleges, private career schools, and programs based at hospitals and long-term care facilities.

RESPONSIBLE ENTITIES: Workforce Board working with Department of Health, four-year colleges and universities, SBCTC, OSPI.



STRATEGY 3.1.6: Collect demand data by surveying health care employers.

RESPONSIBLE ENTITIES: Workforce Board working with Department of Health and health stakeholders.

STRATEGY 3.1.7: Analyze workforce supply and demand information for health professionals.

RESPONSIBLE ENTITIES: Workforce Board and Department of Health working with research universities.

GOAL 4. Retain current health care workers.

STRATEGY 4.1.1: Expand customized training opportunities for incumbent workers that enable them to move up a career ladder or move to other high demand health occupations.

RESPONSIBLE ENTITIES: The Governor and the Employment Security Department.

STRATEGY 4.1.2: Develop education and training modules that allow health care personnel to complete training in incremental steps, leading to recognized promotions and increases in wages.

RESPONSIBLE ENTITIES: Health skills panels, SBCTC, HECB, OSPI, colleges and universities, Department of Health.

STRATEGY 4.1.3: Develop other career mobility strategies within health care organizations, maximizing training opportunities and leveraging funds within regions and among employers and educators for this purpose.

RESPONSIBLE ENTITIES: Health industry, education and training providers.

STRATEGY 4.1.4: Reduce paperwork where possible by changing state regulations, department and agency directives, and implementing new technology.

RESPONSIBLE ENTITIES: DSHS, Department of Health, health industry.



STRATEGY 4.1.5: Implement strategies to enhance the workplace environment. (See Appendix A.)

RESPONSIBLE ENTITIES: Health employers and labor.

GOAL 5. Enable local communities to implement strategies to alleviate the health care personnel shortage in their areas.

PRIORITY STRATEGY 5.1.1: Provide continuing support to current Health Skills panels and expand the formation of Health SKILLS panels to cover all 12 workforce development regions.

RESPONSIBLE ENTITIES: Workforce Board.

STRATEGY 5.1.2: Facilitate communication among local Health Skills panels to enable coordination of efforts, and to communicate with state entities and the legislature.

RESPONSIBLE ENTITIES: Workforce Board.

GOAL 6. Develop a mechanism to ensure continued collaboration among stakeholders, track progress, create accountability for fulfilling this plan, and to plan for future health workforce needs.

PRIORITY STRATEGY 6.1.1: Reconvene the Task Force twice a year to establish an ongoing mechanism comprised of key stakeholders to oversee the Task Force recommendations, and hold responsible entities accountable. (L)

RESPONSIBLE ENTITIES: Workforce Board.

STRATEGY 6.1.2: Explore more formal mechanisms to monitor and support progress in achieving the goals in this plan. (L)

RESPONSIBLE ENTITIES: Legislature.

OUTCOME MEASURES TO TRACK PROGRESS

In order to evaluate the success of these strategies it is necessary to track our progress. The Task Force formulated outcome measures that provide a means for tracking progress and for holding responsible entities accountable. Each outcome measure may apply to one or several of the goals and strategies. The

most obvious measure for tracking progress is the number of students completing health care programs. By tracking this and other measures over time, it will be possible to assess progress and alter goals and strategies to be responsive to future health workforce needs.

Outcome measures:

1. Number and diversity of students enrolled in health care education and training programs.
2. Number and diversity of students completing health care education and training programs.
3. Number and diversity of students training to become faculty in health care education and training.
4. Amount of additional funds allocated to increase educational capacity in health care education and training programs.
5. Establishment of an ongoing system for data collection and analysis.
6. Establishment of a campaign to market health care careers.
7. Establishment of a Web site to provide health care training/career mapping and financial aid information.
8. Numbers of Workforce Development Councils that have established health care Skills panels.
9. Turnover rates for health care personnel.
10. Level at which health workforce diversity reflects the diversity of the populations served.
11. Numbers of incumbent health care workers receiving training to move up a career ladder.
12. Number of high schools offering health science programs, and the number of these that lead to certification.
13. Proximity of supply to demand of health care personnel.
14. Number of strategies in this plan that are successfully implemented.
15. Creation of a formal mechanism that oversees the implementation of Task Force recommendations, and holds responsible entities accountable.
16. Commitment by the Governor and Legislature to target health professions education at the true cost.

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- ⁸ Ibid 1.
- ⁹ Troy Huston, Taya Briley, *Who Will Care for You?: Washington's Hospitals Face a Personnel Crisis*, Washington State Hospital Association and the Association of Washington Public Hospital Districts, 2002, page 12.
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- ¹¹ U.S Department of Health and Human Services, Bureau of Health Professions, Health Resources and Services Administration, *HRSA State Health Workforce Profiles: Washington*, page 4.
- ¹² Workforce Education and Training Coordinating Board, *Washington's Economy*, January 2002.
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- ¹⁴ The Diversity Network began meeting in March 2002 to follow up on the State Board of Health's Committee on Health Disparities Final Report recommendations on reducing health disparities by improving health workforce diversity. The Network is chaired by Judy Huntington of the Washington State Nurses Association and Dr. Charles Weatherby of the Washington State Medical Association, and is made up of representatives from organizations, agencies, foundations and associations interested in diversifying the health workforce. See <http://www.doh.wa.gov/sboh/Priorities/disparities/disparities.htm> for more information and the State Board of Health's Final Report on Health Disparities.
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- ¹⁹ Ibid 1.
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- ²¹ This problem is significantly compounded by the fact that most rural hospitals in Washington State are public hospital districts and as such are presently limited (due to a recent statutory interpretation by certain state agencies) in their ability to engage in even the most common recruitment practices found at private hospitals. Email Communication with Taya Briley, Association of Washington Public Hospital Districts, December 2, 2002.
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- ²³ Data collected in local areas does not always correspond with the hospital survey because local surveys usually encompass a range of health employers, not just hospitals. For example, in Northwest Washington figure 1 shows that 0 percent of hospitals in that region reported it was "very difficult" to recruit licensed practical nurses while the local Health Skills panel, the Northwest Alliance for Health Care Skills, identified licensed practical nurses as one of the area's most severe shortage occupations among all health care employers in that region.
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²⁵ William E. Fassett, Ph.D, Dean Washington State University College of Pharmacy, Sidney D. Nelson, Jr., Ph.D., Dean, University of Washington School of Pharmacy.

²⁶ Ibid 1.

²⁷ National Association of Chain Drugstores *Chain Pharmacy Employment Survey Results*, July 2002. Approximately 60 percent of graduating pharmacists go into chain and community practice.

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³⁰ Elective surgeries are not optional, they are scheduled, non-emergency surgeries.

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³⁶ Workforce Training and Education Coordinating Board, "Our Changing Labor Force," 2001.

³⁷ Center for Health Workforce Studies, *Data Snapshots*: <http://www.fammed.washington.edu/CHWS>. For example, only 0.5 percent of Dental Hygienists, 1 percent of physicians, 1.1 percent nurse practitioners are Black/African American compared to 3.2 percent Black/African American population in Washington. Only 1.7 percent of Dental Hygienists, 2 percent of Physicians, and 1.6 percent of Nurse Practitioners are Hispanic compared to 6 percent Hispanic population in Washington.

³⁸ Ibid 16.

³⁹ See studies cited in State Board of Health report, Joe Finkbonner, R. Ph., M.H.A., the Honorable Margaret Pageler, J.D., Vickie Ybarra, R.N., M.P.H., *Final Report State Board of Health Priority: Health Disparities*, Committee on Health Disparities, May 2001 http://www.doh.wa.gov/sboh/Priorities/disparities/2001_HD_Report.pdf. See also The Key Ingredient of the National Prevention Agenda: Workforce Development, U.S.D.H.H.S., HRSA, 2001; "The Case for Diversity in the Health Care Workforce," *Health Affairs*, Vol. 21, 5, Sept/Oct 2002; Diverse Communities, Common Concerns: Assessing Health Care Quality for Minority Americans, Commonwealth Fund, March 2002; Room for Improvement: Patients Report on the Quality of their Health Care, Commonwealth Fund, April 2002, <http://www.cmwf.org/>; Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care, Institute of Medicine, March 2002, [http://www4.nationalacademies.org/news.nsf/\(ByDocID\)/019EBFFF2620394885256B820053A338?OpenDocument](http://www4.nationalacademies.org/news.nsf/(ByDocID)/019EBFFF2620394885256B820053A338?OpenDocument)

⁴⁰ Email communication with David Asher, University of Washington, December 2, 2002.

⁴¹ Email communication with Jim Boesenberg State Board for Community and Technical Colleges, November 12, 2002.

⁴² Nancy Frugate Woods. Presentation to Washington Nursing Leadership Council, July 2002.

⁴³ Programs included in analysis: Associate Degree Nursing, Practical Nursing, Nursing Assistant, Medical Radiology Technology, Diagnostic Medical Sonography, Medical Records Technology, Phlebotomy, Medical Laboratory Technology, Pharmacy Technician.

⁴⁴ No similar grant program is available to baccalaureate institutions.

⁴⁵ Students who participate in programs that combine basic skills with occupational skills have better wage and employment outcomes post course completion. Workforce Board, *Workforce Training Results*, 2002.

⁴⁶ Susan Skillman, Deputy Director Center for Health Workforce Studies, presentation to the Health Care Personnel Shortage Task Force, September 4, 2002.

⁴⁷ Workforce Training and Education Coordinating Board, *Job Training Results* Data aggregated for health care employment rates. In 1998-2000 employment rates in the third quarter after program completion demonstrated health education and training programs had employment rates that were consistently higher than for most other programs. It should be noted that this does not include employment outside the Pacific Northwest, and does not include baccalaureate programs. The highest employment rates were for Dental Hygienists – 96 percent, Diagnostic Medical Sonography –94 percent, Nuclear Medical Technology — 92 percent, Radiation Therapy Technology – 92 percent, Radiology Technology-91 percent, Dispensing Optician – 90 percent, Histologic Technology – 88 percent, Surgical/Operating Room Technician – 87 percent, Physical Therapy Assistant – 87 percent, Associate Degree Nursing – 86 percent, Biological Laboratory Technician – 84 percent, Cardiac Invasive Technician – 84 percent, Practical Nursing – 84 percent, Medical Laboratory Technician – 83 percent, Pharmacy Technician/Assistant – 83 percent, Dental Assistant – 83 percent.

⁴⁸ Email communication with Kathy McVay, Washington State Department of Health, Office of Community and Rural Health, October 2002.



APPENDIX A: RETENTION OF HEALTH CARE PERSONNEL

Efforts to increase the number of people entering into health care careers must be complemented by efforts to address workplace retention issues. Some of the professions experiencing the greatest shortages are also the ones experiencing difficulty in retaining workers. Many studies and surveys document the nursing shortage and identify an array of complex factors contributing to the shortage, including the workplace. Unfortunately, there has not been the same effort to

document and explain the shortages in allied health and the other health professions. However, there are strong similarities between nursing and allied health, especially when describing the work environment. Health care workers consistently describe the workplace as highly pressured and difficult, many are thinking of leaving their jobs. Consequently, any efforts to recruit more individuals into the workforce must also address retention.

WORKER TURNOVER

Washington's nursing homes are the hardest hit when it comes to retaining nurses. According to a national survey, Washington nursing homes are experiencing turnover rates ranging from 38 to 95 percent for essential nursing staff¹ (see Table 1). Washington's hospitals recently reported a turnover rate of about 17 percent for staff registered nurses. Of the Washington hospitals surveyed, nearly 54 percent of urban hospitals reported increased turnover in the past year.² To make matters worse, a national survey of nurses found that one in three nurses under the age of 30 plans to leave the profession within a year.³

A survey of Washington clinical laboratories found that the reason technical employees (MT/CLS, MLT/CLT, cytotechnologist, and histotechnologist) leave their jobs is "for better pay." The majority of laboratories surveyed require

TABLE 1: Turnover Rates of Nursing Personnel in Washington State Nursing Homes

Nursing Personnel	Annualized Turnover Rates
Directors of Nursing	49.6%
Administrative RNs	38.0%
Staff RNs	69.3%
Licensed Practical Nurses	54.2%
Certified Nursing Assistants	95.1%

Source: Health Services Research and Evaluation, American Health Care Association, Results of the 2001 AHCA Nursing Position Vacancy and Turnover Survey, February 7, 2002

overtime to cover vacant positions until new personnel can be hired--usually a three month process. The main reason positions remain vacant for more than one month is an "insufficient applicant pool."

National health care-related associations and organizations such as the American Hospital Association (AHA), the American Nursing Association (ANA), the Joint Commission on Accreditation

of Healthcare Organizations (JCAHO), and the Service Employees International Union (SEIU) have recently released reports addressing worker retention. In addition, state and local health care professional organizations such as the Washington State Hospital Association (WSHA), Washington Nursing Leadership Council, Washington Health

Foundation, and Washington State Clinical Laboratories Advisory Council have also begun addressing the health care worker shortage and workplace retention issues. Along with recruiting more people into health care, these professional organizations recommend improving the workplace environment so that, once hired, they stay.

CONTRIBUTING FACTORS

Several national nursing surveys, conducted in recent years, point to a growing sense of job dissatisfaction among hospital nurses. Many of the same issues reported in the nursing surveys are applicable to the non-nursing health care workforce as well. A study conducted by Peter D. Hart Research Associates found the top reason why nurses leave, besides retirement, is to seek a job that is less stressful and less physically demanding. Additional reasons are more regular hours, more money, and better advancement opportunities. When practicing nurses were asked to identify the biggest problem with nursing, respondents cited understaffing (39 percent) and the stress and physical demands of the job (38 percent).⁴ This same group overwhelmingly reported that the most enjoyable aspect of nursing is helping patients and their families. The majority of nurses (74 percent) said they would stay at their jobs if the work environment improved. Increased staffing, less paperwork and fewer administrative duties were identified as the top three changes

they would like to see made.⁵

According to the 2000 National Sample Surveys of Registered Nurses, employed in hospitals, are the least satisfied among all nursing positions. Across all settings (hospitals, nursing homes and public health), one of every three reported that they were dissatisfied with their current job in 2000.⁶ Staff nurses bear much of the responsibility for coordination and continuity of care, yet they reported having little control over or support for many aspects of their jobs.⁷

These findings have motivated several hospitals across the country to adopt the Magnet Hospital Program, which encourages participation of staff at all levels. The program offers competitive salaries and benefits and promotes a positive image of its staff as professionals who provide quality care and are involved with their communities as providers of health care and as teachers.⁸ The American Nurses Credentialing Center (ANCC) magnet hospital program,

inspired by the original magnet hospitals, established the Magnet Services Recognition Program to recognize hospitals that had achieved excellence in providing nursing services.⁹ The characteristics of ANCC magnet hospitals include high nurse-to-patient ratios, substantial nurse autonomy and control over the practice setting, positive nurse and physician relationships, nurse participation in organizational policy

decisions, and strong nursing leadership.¹⁰ The nurses working in these hospitals report increased satisfaction, increased perception of giving higher quality of care, and an increased perception of productivity. The hospitals report increased RN retention rates, increased ability to attract and retain nurses, and lower rates of nurse burnout.¹¹ To date, the ANCC program has certified over 50 hospitals in the United States.

PAPER INSTEAD OF PATIENTS

The amount of paperwork required for each patient is overwhelming. A study commissioned by the American Hospital Association found that for every hour of patient care, 30-60 minutes were spent on required paperwork¹² (see Table 2).

According to the AHA report, although some of this paperwork is directly associated with clinical care, there has been a significant increase in paperwork needed to document regulatory compliance. This administrative burden, driven by complex rules and regulations, shifts the focus from patient care to paperwork and affects all who provide health care or services. To put this in

TABLE 2: The Paperwork Burden

Care Setting	Every Hour of Patient Care Requires:
Emergency Room	1 Hour of Paperwork
Surgery & Inpatient Acute Care	36 Minutes of Paperwork
Skilled Nursing Care	30 Minutes of Paperwork
Home Health Care	48 Minutes of Paperwork

PricewaterhouseCoopers survey of hospitals and health systems

perspective, more than 100 federal regulations affecting health care have been adopted since 1997.¹³ On top of these new federal regulations the state government has also passed a multitude of new regulations and agency directives, some of which conflict with the federal regulations.

THE STAFFING CHALLENGE

The health care personnel shortage has made it extremely difficult for medical and clinical facility directors to adequately staff their facilities. Inadequate staffing in health care facilities has a ripple effect throughout

the health care system. When nursing homes are inadequately staffed and cannot accept new patients, hospitals frequently must keep patients who would usually be discharged to nursing homes.¹⁴ This in

turn results in fewer resources (beds and staff) for new patients. Depending on the reason for their hospitalization, these new patients might be diverted to another hospital or be put on a waiting list until staff or a bed is available. A shortage of radiology or laboratory technologists can lead to delays in diagnosing illnesses. In a study commissioned by the American

Hospital Association, respondents reported that the nursing shortage has caused emergency department overcrowding in their hospitals (38 percent); diversion of emergency patients (25 percent); reduced number of staffed beds (23 percent); discontinuation of programs and services (17 percent); and cancellation of elective surgeries (10 percent).¹⁵

HEALTH AND SAFETY ON THE JOB

Health and safety have always been a particular concern for health care workers. A recent study by the American Nurses Association found that more than 70 percent of nurses indicated that continuing severe stress and overwork were among their top health-related concerns. Forty percent of nurses reported having been injured on the job; 17

percent experienced physical assaults while working and 75 percent of the nurses surveyed stated that unsafe working conditions interfere with their ability to provide quality care. Nearly 90 percent of the nurses indicated that health and safety concerns influence the type of nursing work they do and their likelihood to continue to practice.¹⁶

NATIONAL EFFORTS

As bad as it is, this problem is not unsolvable. Nurses and other health care providers want to do the jobs they were trained to do. They want the focus of their job to be caring for patients and supporting families, which is what they do best. They want to have the time to provide quality care and they want to work in a safe environment. There are many professional organizations and industry leaders recommending ways to improve workplace retention.

Recently Congress passed the Nurse Reinvestment Act, which recognizes

retention as a critical component in solving the nursing shortage. Two provisions contained in the Act specifically address workplace retention: A provision that provides grants to health care facilities to implement the American Nurses Credentialing Center Magnet Recognition Program; and a provision that provides grants to hospitals to establish career ladder programs. There is no comparable federal legislation for allied health professions.

The Joint Commission on Accreditation of Organizations (JCAHO), well known for its large volume of paperwork required

of hospitals to prove compliance with its standards, recently launched an in depth review of its hospital standards and requirements for demonstrating compliance with those standards. As a result of this work, JCAHO has developed new standards to help health care organizations assess their staffing effectiveness. The tool provides facilities with an objective and evidence-based approach to assessing the number,

competency and skill mix of their staff by linking staffing effectiveness to clinical outcomes. The standards are effective for hospitals beginning July 1, 2002. Similar standards are being developed for long term care, assisted living, home care, ambulatory, behavioral health care, and laboratory settings. The JCAHO has also promised to take major steps in reducing the documentation burden of their accreditation process.¹⁷

OTHER STATE EFFORTS

To date, five states have reported that they have initiatives on job redesign for health workers, including nurses and certified aides. These include support for demonstrations and evaluations, and/or best practices conferences.¹⁸ In addition, several states have passed legislation prohibiting or limiting mandatory overtime and one state (California) has passed legislation mandating minimum nurse staff ratios in hospitals and nursing homes.¹⁹

The Texas Board of Health revised its hospital nurse staffing rules based on recommendations put forward by the Texas Nurses Association and the Texas Hospital Association. The rule now requires that hospitals implement a staffing plan.²⁰

Other state efforts to improve retention include wage pass-throughs; rate increases; shift differentials; bonuses and other assistance (e.g., insurance, childcare); staffing standards; and recognition programs.²¹

WASHINGTON STATE

Washington State has made important progress in improving the workplace environment for health care personnel. In May 2000, Washington implemented the "Ergonomics Rule" that will begin with nursing homes. The guidelines were released in April 2002. This past spring the state passed legislation regarding mandatory overtime for nurses.

The Washington Health Foundation has received a \$1 million federal grant for nursing retention. With this funding the Foundation plans to conduct a survey on nursing retention of 20,000 RNs from hospitals and skilled nursing facilities, which will be done through a partnership with the WSHA. The results of the survey are expected to lead to additional projects including a program on mentoring at

Affiliated Health Services and providing 32 scholarships to attend a leadership institute for mid-level nurse managers.

THERE IS MUCH WORK TO BE DONE

There are additional opportunities to help employers retain their health care workers. Washington State agencies can begin reviewing state regulations and agency directives and removing any that lead to duplicative or unnecessary paperwork. Additionally, some employers have begun to form retention committees.

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⁵ Ibid.

⁶ Sochalski, Julie, "Nursing Shortage Redux: Turning the Corner on an Enduring Problem," *Health Affairs*, Volume 21, Number 5, pp. 157-164.

⁷ Ibid.

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¹² American Hospital Association and PricewaterhouseCoopers, "Patients or Paperwork? The Regulatory Burden Facing America's Hospitals," May 1, 2001.

¹³ Ibid.

¹⁴ Washington State Hospital Association and Association of Washington Public Hospital Districts, "Who Will Care For You?" Washington Hospitals Face a Personnel Crisis, page 26.

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¹⁶ American Nurses Association, *Health and Safety Survey*, September 2001.

¹⁷ Joint Commission on Accreditation of Healthcare Organizations, *Facts about staffing effectiveness standards*, 6/02.

¹⁸ University at Albany, SUNY, School of Public Health, The Center for Health Workforce Studies, "How Are States Responding to Health Worker Shortages?" An Interim Report, July, 2002.

¹⁹ Ibid.

²⁰ Texas Nurses Association Website: www.texasnurses.org

²¹ Ibid 18.

APPENDIX B: HOW ARE OTHER STATES RESPONDING TO THE HEALTH PERSONNEL SHORTAGE?

The health personnel shortage is a national problem. According to an interim report by the Center for Health Workforce Studies at the University of Albany other states are engaging in a variety of response to the

shortage, such as forming task forces and commissions, increasing scholarship and loan repayment programs, and providing incentives to increase workplace retention.¹

TASK FORCES & COMMISSIONS

Forty-seven states have convened task forces, committees or commissions (includes Washington). In a few states, commissions led to more permanent

responses to address workforce shortages or state law and policy changes. Most states are still deliberating and policy responses are in the formative stages.

SCHOLARSHIP AND LOAN REPAYMENT INCENTIVES FOR EDUCATION AND TRAINING

Forty-two states reported renewed attention to scholarship and loan repayment programs. Twenty-five states targeted a broad array of health professionals (dentists, dental hygienists, and pharmacists), 29 states specifically targeted registered nurses, and 27 states targeted physicians. Other strategies to expand the pipeline include increasing education and training capacity; expanding scholarship and loan

repayment programs; developing career ladders; implementing faculty improvements; conducting out of state/foreign recruitment; and launching media and Web-based career campaigns. Ten states have training and education initiatives that utilize H1-B Visa grants and the Workforce Investment Act (includes Washington). Several states have tapped Temporary Assistance to Needy Families (TANF) funding.

WORKFORCE DATA COLLECTION

Thirty-one states collect health workforce data. Most states survey their health professionals at the time of licensure or renewal, although some states regularly conduct provider needs assessments and collect data via surveys. State agencies are

the entities primarily responsible for collecting health professional data but in some states data is collected by task forces, research centers, Area Health Education Centers (AHECs), or professional associations.

¹ National Academy for State Health Policy, Presentations at the session on health workforce shortages, August 4, 2002. The Center for Workforce Studies at the University of Albany reviewed state responses to health workforce shortages. The Center surveyed key state organizations, governors' offices as well as health, workforce development, labor, and education departments in all 50 states, the District of Columbia and Puerto Rico. In addition, staff reviewed state web sites and did follow-up interviews with state officials for information on efforts to address health workforce shortages. This comprehensive study resulted in an interim report, "State Responses to Health Workforce Shortages."

HEALTH CAREER MARKETING

Twenty-seven states have initiatives to market health careers; 11 states indicated AHECs administered many of the initiatives, especially those targeting youth.

CAREER LADDERS AND WORKFORCE RETENTION

Twelve states and Washington, D.C. have developed or are developing career ladder programs targeting nursing. Other activities are improving workplace retention through wage pass-throughs; rate increases; shift differentials; bonuses and other assistance (insurance, childcare, etc) workforce redesign; minimum staffing ratios/staffing standards; and recognition programs. Five states have job redesign initiatives for

health workers, including nurses and CNAs. These initiatives include support for demonstrations, evaluations and best practice conferences.

Several states have passed legislation prohibiting or limiting mandatory overtime and one state (CA) has passed legislation mandating nurse ratios in hospitals and nursing homes.

OTHER INITIATIVES

Some states are implementing initiatives to improve productivity such as reducing paperwork. In an attempt to reduce the need for health care, some states are focusing on prevention and promoting healthy behaviors. Other system changes

include conducting analysis and evaluation of programs and initiatives; and mandating collaboration and coordination among departments of labor, education, health, human resources, and welfare to work programs.

STATE HIGHLIGHTS

Minnesota: Continuation of Efforts - Minnesota's Health Professions Workforce Partnership added local partners from 11 communities in 2001 to develop solutions to the health shortage. The state increased the number of individuals receiving financial assistance and loan forgiveness programs, and the amounts available. This pertains to the Medical Education and Research Costs program and the Graduate Medical Program. The state created a health career information Web site for

both educational and employment opportunities and developed a core curriculum for a health career ladder program. Minnesota began collecting health workforce data coordinated with licensing in the 1990's. Ongoing data reports help the state to measure progress and inform planning for health workforce needs. New initiatives include a university-sponsored Health Workforce 2013 redesign project, an H1-B grant for training

incumbent workers and data collection changes that will improve regional

planning and emergency preparedness.

Georgia: System Changes - Georgia established a short-term workforce committee in late 2001. The committee report, *Code Blue*, led to legislation that created an ongoing health workforce shortage committee with subcommittees on education, data and forecasting, work environment and productivity, and recruitment and marketing. Committee accomplishments include increasing the health careers loan program; funding a research project that evaluates educational capacity and innovation; increasing the

nursing faculty loan program; developing a bridge from certified nursing assistant to licensed practical nurse to registered nurse; and creating private sector scholarships. They also created a Data Consortium to oversee a data research center, and funded regional forums and a workforce environment and productivity report. Recruitment and marketing initiatives include the Teach Academy, health care summer camps and youth training, a health workforce Web site, and a health care careers media campaign and manual.

California: Nurses & Direct Care - In 2001 California launched the Long-Term Care Council, the Aging with Dignity Initiative, and two Caregiver Training Initiatives and provided additional funds in 2002. A five-year grant of state and local funds supports the Los Angeles Health Care Workforce Development Program. The Nurse

Workforce Initiative received a three-year grant for training, education capacity, media, and prerequisite standardization. In addition, the state established linkages among the Office of Statewide Health Planning and Development, the Employment Development Department and the Employment Training Panel.

New York: Healthcare Workforce Recruitment and Retention Act - In 2002, the New York State legislature allocated \$1.85 billion to ensure an adequate supply of health care workers. The funds supported Medicaid rate add-ons and grant programs for disadvantaged hospitals, nursing homes, home health care services and clinics. The state share is \$774 million; federal and local funds total \$1.1 billion. Resources

to fund the initiative include a cigarette tax increase, a covered lives assessment, increases in federal upper payment limits, and Medicaid match and funds from a Blue Cross/Blue Shield conversion to a for-profit company. Anticipated savings include \$694 in state funds from a shift in public health costs. to fund the initiative include a cigarette tax increase, a covered lives assessment, increases in federal upper

payment limits, and Medicaid match and funds from a Blue Cross/Blue Shield conversion to a for-profit company.

Anticipated savings include \$694 in state funds from a shift in public health costs.

Texas: Nursing Shortage Solutions - A rider in the 2002 appropriations bill included monies for a Nursing Growth carve-out. Five million dollars a year was allocated for community colleges, \$5.6 million for universities, and \$723.7 thousand for public nursing programs in health science centers. More than \$4 million in Tobacco Settlement funds were

allocated for recruitment and retention and increasing pay for faculty overloads for both private and public nursing programs. The Texas Medical Association, the Texas Nursing Association, and the Texas Hospital Association Coalition on Workplace Issues created a “Zero Tolerance” policy on physician abuse of RNs.

Maryland: Nursing Legislation - Maryland increased its nursing scholarship award and allowed nurses to receive more than one state scholarship and be charged in-county tuition for out of county programs. In addition the state

increased its Medicaid budget by \$25 million to increase long-term care nursing staff salaries. A Nursing Support Program provides \$6 million to hospitals for nursing recruitment and retention.

ADVICE FROM OTHER STATES

The current shortage is not a short-term problem. Policy makers should expect shortages to be on state agendas for many years to come. It is important to consider the whole system. Accurate workforce data is important for appropriate planning, monitoring progress, and evaluating ongoing efforts. Workforce initiatives should include increasing

diversity, bioterrorism and emergency preparedness. Workforce and workplace issues are inter-related. However, retention and productivity issues are politically difficult and scope of practice issues can derail other efforts. Collaboration and coordination among players is key; one agency or organization must lead the effort.

APPENDIX C: LOCAL HEALTH SKILLS PANELS

ALLEVIATING THE HEALTH CARE PERSONNEL SHORTAGE IN LOCAL AREAS

Collaboration between the health industry and educators is vital for solving the health care personnel shortage. Skills panels in health provide an effective avenue for implementing change at the local level. Since 2000, the Workforce Training and Education Coordinating Board has issued SKILLS (Securing Key Industry Leaders for Learning Skills) grants to workforce development councils¹ for the purpose of supporting skills panels that are working

partnerships between industry and education. Each skills panel addresses skills gaps for a particular industry cluster such as health, technology or food processing. In Washington, eight workforce development councils have established skills panels in health with the main purpose of identifying health personnel shortages in their areas, designing strategies to remedy the shortages and implementing these strategies.

EIGHT HEALTH SKILLS PANELS IN WASHINGTON

Workforce Development Area (Counties) <small>(See map, page C5)</small>	Health Skills Panel
Benton-Franklin <small>(Benton and Franklin)</small>	Benton-Franklin Community Health Alliance
Northwest Washington <small>(Whatcom, San Juan, Skagit and Island)</small>	Northwest Alliance for Health Care Skills
Olympic <small>(Clallam, Jefferson and Kitsap)</small>	Olympic Health Care Alliance
Pacific Mountain <small>(Grays Harbor, Lewis, Mason, Pacific, Thurston)</small>	Pacific Mountain Health Care Partnership
Tacoma-Pierce County <small>(Pierce)</small>	Pierce County Health Services Careers Council (PCHSCC)
Seattle-King <small>(King)</small>	Healthcare Industry Panel
Snohomish <small>(Snohomish)</small>	Snohomish County Health Care Industry Skills Panel
Southwest Washington <small>(Clark, Cowlitz, Skamania, Wahkiakum)</small>	Southwest Washington Allied Health Care Skills Panel

Note: As of December 2002, health skills panels were not established in the Tri-Counties, Spokane, North Central or Eastern Washington workforce development areas.

¹ The federal Workforce Investment Act of 1998 required that each state establish local workforce investment boards, known in Washington as workforce development councils. Washington has 12 workforce development councils that are each comprised of a majority of business representatives, with education, and labor representatives. These councils fulfill the state strategic goals for workforce development at the local level.

FUNDING SOURCES

Apart from the initial SKILLS grants from the Workforce Education and Training Coordinating Board, health skills panels have received funding from other sources:

- The State Board for Community and Technical Colleges: To expand or establish health care education and training programs.
- The Employment Security Department: To train incumbent workers in health care occupations.
- The U.S Department of Labor: To train incumbent workers in health care occupations.
- Local Workforce Development Councils: To expand capacity in local health care education and training programs.
- Local Industry: To support various initiatives
- The Governor's Office: To establish or expand programs that prepare students for health care occupations.

See Table 3, page 51 for information on skills panel, State Board for Community and Technical College and Employment Security grants.

HEALTH SKILLS PANELS INITIATIVES

Recently established health skills panels in Seattle-King, Snohomish, and Southwest are at the beginning stages of identifying occupations with the most severe shortages by assessing local labor market information and

conducting local employer surveys. Health skills panels in Tacoma-Pierce, Northwest, Olympic, Pacific Mountain and Benton-Franklin have begun implementing initiatives that have primarily focused on:

- Increasing educational capacity of nursing and allied health programs;
- Increasing clinical training capacity;
- Creating career mobility by providing training opportunities for incumbent workers to move up the career ladder; and
- Developing recruitment strategies to encourage more students to enter health care education and training.

INCREASING EDUCATIONAL CAPACITY: EXAMPLES

In 2002, the Tacoma-Pierce County Workforce Development Council dedicated a total of \$1.3 million federal Workforce Investment Act funding allocations to support the expansion of local health care training programs. The local health care industry has committed \$700,000 in cash and equipment to develop, sustain, and increase high demand training and health care employers have paid for staff time to teach in training programs. For example, MultiCare has employed a clinical coordinator to supervise LPN students from Bates Technical College during their on-site training at Tacoma General Hospital.

The health skills panel in Pacific Mountain received \$850,000 from Employment Security to expand education and training programs in health care at South Puget Sound, Grays Harbor, Centralia and Olympic Colleges.

In 2002, Tri-Tech Skills Center received a \$200,000 discretionary grant from the Governor's office to expand its pre-health professional programs thus creating more opportunities for students to take the course offerings. The Benton-Franklin Health Skills Panel supported the application.

The Northwest Washington health skills panel research on employer demand for imaging specialists supported a successful proposal by the Bellingham Technical College for a grant to develop a radiologic technologists program. Bellingham Technical College is leading the development of a community and technical college consortium of representatives from Skagit Valley Community College, Everett Community College, Edmonds Community College and Whatcom Community College to implement the program.

INCREASING CLINICAL TRAINING CAPACITY: EXAMPLE

Tacoma Community College, in partnership with eight regional nursing programs and the health skills panel in Pierce County is developing a system for centralized clinical site coordination to

maximize clinical training opportunities. The system will include Web-based planning, similar to the model developed by in Maricopa County Community Colleges in Arizona.

CREATING CAREER MOBILITY: EXAMPLES

The Pacific Mountain Health Skills Panel is utilizing an Employment Security grant to train 25 incumbent workers from

Providence St. Peter Hospital. Eleven certified nursing assistants will become licensed practical nurses by 2003, and 14

licensed practical nurses will become registered nurses within by 2004. These training funds have the additional benefit of enabling South Puget Sound Community College to open another class with space to train 12 more non-grant students in the registered nursing class.

Health employers and members of the health skills panel in Pierce County, partnered with WorkSource to provide

a WorkSource career specialist who is co-located at Good Samaritan, Franciscan and Multicare Health System, to provide incumbent workers with career development information: identifying career aptitudes and goals, appropriate training, and opportunities for financial assistance. Since 2001, over 500 workers have been assisted, and more than 50 are now in health care careers training.

RECRUITING INDIVIDUALS INTO HEALTH CARE OCCUPATIONS: EXAMPLES _____

Seattle-King, Snohomish, and Tacoma-Pierce Health Skills Panels coordinated with KIRO TV, and several large health care employers to develop a marketing campaign aimed at increasing community awareness, especially among youth and ethnic groups, about the opportunities available in health care. The initial campaign includes TV commercials and the development of a Web site, and is focused on nursing and the nursing specialties. Future campaigns plan to address other health care occupations shortages.

In 2002, the health skills panel in Northwest Washington created a financial assistance program to encourage workers into further education and training in order move up a career ladder. The skills panel will match employer scholarship funds; advance the money for tuition if

the employer's policy is to reimburse after class completion; provide coaches and tutors as career counselors or to assist with specific education needs, and provide funding for childcare and transportation.

As part of local marketing campaigns, Tacoma-Pierce, Olympic, and Benton-Franklin Health Skills Panels have developed Web sites that aim to recruit individuals into health care occupations. They provide information about local employment opportunities, career paths, education and training programs and financial aid.

Pierce County:

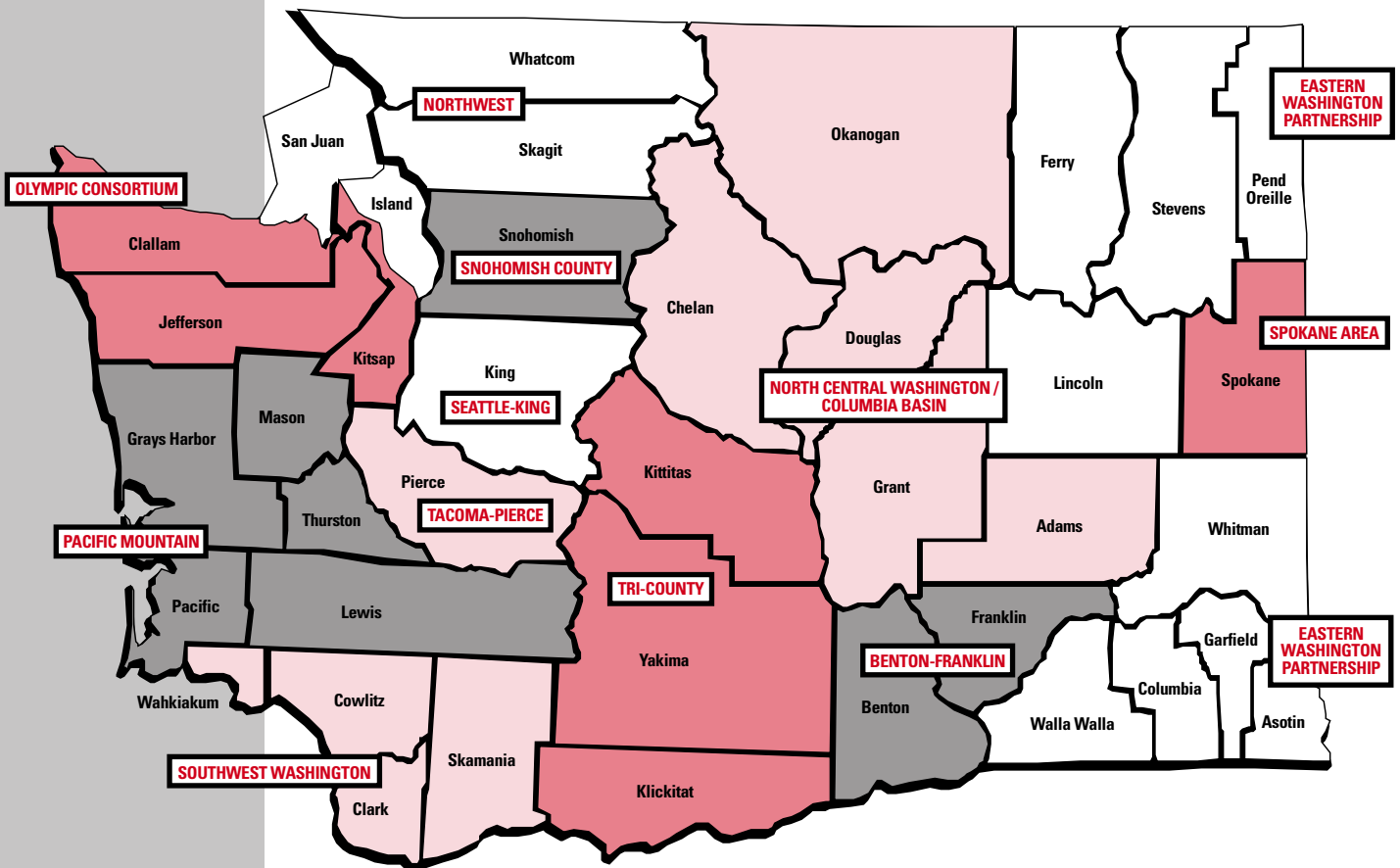
<http://healthjobsforyou.com>

Benton Franklin: <http://www.healthcareworx.org>

Olympic:

<http://www.practiceinparadise.org>

WORKFORCE DEVELOPMENT COUNCILS/AREAS IN WASHINGTON



OUTCOMES AT A GLANCE

Table 3: Workforce Training and Education Coordinating Board HEALTH CARE SKILLS PROJECTS 2000-2003

Workforce Development Council	Northwest	Olympic	Seattle/ King	Tacoma/ Pierce	Pacific Mountain	Benton/ Franklin	Snohomish	Southwest
Total WTECB Funding	\$46,000	\$71,375	\$135,000	\$135,000	\$102,000	\$68,000	\$85,000	\$71,347
Create skills panel	X	X	X	X	X	X	X	X
Analyze/validate regional labor market data	X	X	X	X	X		X	X
Identify specific occupations/skill gaps	X	X	X	X	X	X	X	X
Develop job ladders/wage progression	X		X	X				
Recommend/revise curricula		X		X	X	X		X
Catalyze development or expansion of college training program	X	X	X	X	X		X	X
Streamline process for identifying clinical sites	X		X	X			X	
Create articulation agreements							X	X
Integrate with existing partnership	X		X	X	X	X		
Develop marketing and recruitment tools	X	X	X	X	X		X	X
Sustainability plan	X	X	X	X	X	X	X	X
Identify issues requiring legislative action	X	X	X	X	X	X		X
State Board for Community & Technical Colleges Grants mainly for Expanding Educational Capacity	\$79,000 \$191,492		\$262,038 \$179,524 \$187,662	\$82,389 \$92,029	\$95,746	\$537,518**	\$191,492	
Employment Security Grants for Customized Training for Incumbent Workers	\$127,995	\$175,000	\$150,000	\$175,000 \$150,000	\$199,700			

* Other State Board for Community and Technical College Grants: Spokane Community College received \$150,00 for an articulated LPN-RN program, and with Spokane Falls \$95,746 for expanding education via distance learning. Yakima Valley received \$95,746 to expand nursing careers programs.

** Colleges located in three workforce development areas in Eastern Washington partnered (see Benton-Franklin above) to receive \$537,518 to expand allied health program capacity.

APPENDIX D: K-12 SCHOOLS OFFERING HEALTH OCCUPATIONS

There are 248 high school districts and nine Skills Centers in Washington. Of those, 124 (50 percent) have access to Health Occupations Programs either at the high schools or through affiliation with a Skills Center. Health Occupations Programs include Health Occupations Basic Core, Nursing Assistant, Dental Assisting, and Medical Assisting. The Skills Centers also offer an Emergency Medical Technologist (EMT) program. During the 2000/2001 school year, 3,229 11th and 12th graders were enrolled in a Health Occupations Program.

Students enrolled in a Health Occupations Program are required to take core health science classes in addition to the requisite math and science courses. These include medical terminology, anatomy and physiology, asepsis and AIDS education, vital signs, CPR/First Aid, growth and development: physical and emotional, communication, career awareness, safety practices, and student leadership. The students must also meet the core skill standards for health sciences established by the U.S. Department of Education Office of Vocational and Adult Education.

High school Health Occupations Programs provide students with excellent preparation for post-secondary health sciences programs. Many of these students take a state exam upon graduation and receive certification that enables them to immediately enter the health care workforce as a nursing assistant, dental assistant, emergency medical technician, or medical assistant. Some school districts and Skills Centers are considering adding programs that would train students as phlebotomists, pharmacy technologists and medical laboratory technicians. These students graduate high school with more career options than many adults who have been working for a number of years.

There are 124 high school districts whose students do not have access to the opportunities offered through the Health Occupations Programs. There are 40 Sports Medicine programs already in districts, however, which could be broadened to include the Health Occupations core areas of study. A one-time investment in the remaining schools not currently set up to offer Health Occupations Programs could allow them access to program courses through a variety of methods.

Table 4: Schools Districts Offering Health Occupations Programs

Health Occupations Only	Health Occupations and Nursing Assistant	Health Occupations and Dental Assistant	Health Occupations and Medical Assistant	Emergency Medical Services
Battle Ground	Kennewick	Kennewick	Seattle	Kennewick
Lake Chelan	Evergreen	Evergreen	Highline	Tumwater
Kelso	Grand Coulee	Mukilteo	Goldendale	
Kent	Chewalah	Spokane		
Bellevue	Northshore	Yakima		
Oak Harbor	Mukilteo	Vancouver		
Tacoma	Battle Ground	Highline		
Arlington	Bellevue	Goldendale		
Bellingham	Kelso			
Bethel	Kent			
Cape Flattery	Lake Chelan			
Central Kitsap	Port Angeles			
Centralia	Spokane			
Chehalis	Sunnyside			
Franklin Pierce	Tumwater			
Lynden	Wenatchee			
Tacoma	Bainbridge			
Vancouver	Yakima			
	Bremerton			
	Edmonds			
	North Kitsap			
	Oak Harbor			
	Peninsula			
	Stanwood			
	Tacoma			
	Tonasket			
	Walla Walla			
	Vancouver			

Note: 40 school districts offer Sports Medicine but this does not generally include a health occupations component with additional health sciences.

APPENDIX E: TASK FORCE COMMITTEE MEMBERSHIP AND PRESENTERS

TASK FORCE EDUCATIONAL CAPACITY COMMITTEE

Troy Hutson (Committee Chair), Washington State Hospital Association, Bobbie Berkowitz, University of Washington - School of Nursing, Monet Craton, Pierce County Health Services Careers Council, Dorothy Detlor, WSU - College of Nursing, Dana Duzan, Sacred Heart Medical Center, Maura Egan, Department of Health, William E. Fassett, College of Pharmacy, John Fricke, Higher Education Coordinating Board, Joan Garner, Washington State Nurses Association, Brian Jeffries, Office of Superintendent of Public Instruction, Pamela Lee, Tacoma Community College, Carol Mizumor, Pima Medical Institute, Jim Crabbe, State Board for Community and Technical Colleges, Sidney Nelson, School of Pharmacy, UW, Nick Parisi, Yakima Valley Community College, Lisa Pletcher, Pierce County Careers Consortium, Michael Ratko and Pamela Doss, Washington State Department of Labor and Industries, Susan Shoblom, Department of Health, Sue Skillman, Center for Health Workforce Studies, UW, Jody Smith, MultiCare Health System

TASK FORCE RECRUITMENT AND RETENTION COMMITTEE

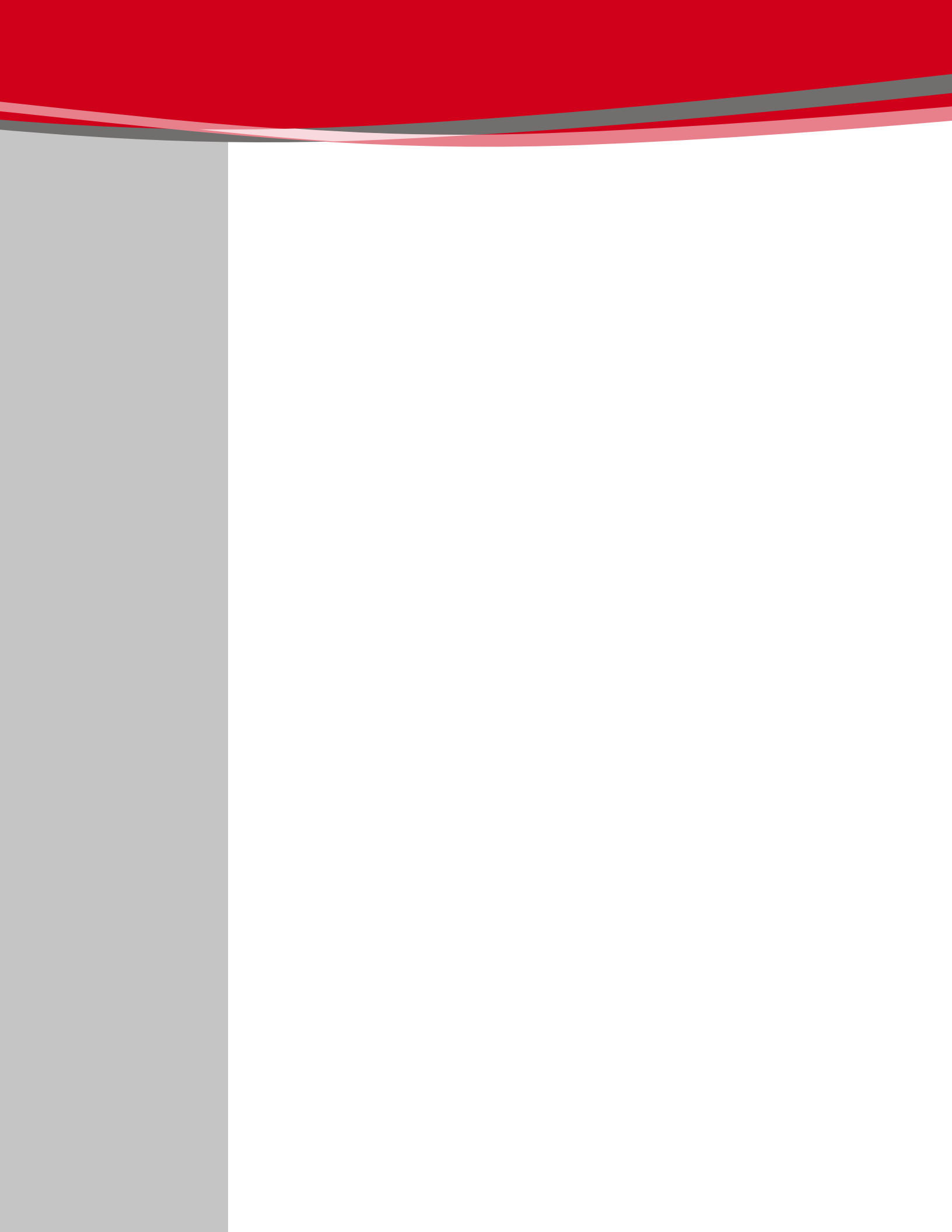
Gloria Rodriguez (Committee Chair), Association of Community and Migrant Health Centers, Elizabeth Floershim, Washington Health Foundation, Lee J. Forshey, WorkSource North Seattle, Patty Hayes, Department of Health, Mary Lampe, University of Washington, Brian McAlpin, Rockwood Clinic, Steve Meltzer, Area Health Education Center, Spokane, Jeff Mero, Association of Washington Public Hospital Districts, John Nagelmann, Group Health Cooperative, Linda Nguyen, Tacoma-Pierce County Workforce Development Council, Jody Palmer, Western Washington Area Health Care Education Center, Anne Tan Piazza, Washington State Nurses Association, Lisa Edwards Pletcher, Pierce County Careers Consortium, Ellen O'Brien Saunders, Workforce Training, and Education Coordinating Board, Susan Shoblom, Department of Health, Sue Skillman, Center for Health Workforce Studies, UW, Diane Sosne, SEIU/1199NW, Teresa Stone, Office of Superintendent of Public Instruction, Terry Takto, Western Washington Area Health Care, Evelyn Torkeleson, WA Rural Health Association, Karen Tynes, WA Association of Housing and Services for the Aging, Suzanne Wall, SEIU/1199NW, Audrey Woodin, WA State Residential Care Council, Diane Zahn, United Food and Commercial Workers Union

PRESENTERS AT TASK FORCE MEETINGS

Linda Nguyen, Pierce County Health Services Careers Council, Karen Hasse-Herrick, Northwest Organization of Nurse Executives—Washington Nursing Leadership Council, Mary Selecky, Secretary of Health, Pam Hayes, Kris Sparks, Department of Health, Sue Skillman, Center for Health Workforce Studies, UW, Ross Wiggins, Employment Security Department, Jim Crabbe, Kathy Cooper, State Board for Community and Technical Colleges and two High Demand Grant Managers from Columbia Basin College, Alex Kosmides and Larry Thompson, NW Alliance for Health Care Skills, Vickie Ybarra, State Board of Health Board Member—Diversity Network

WORKFORCE TRAINING AND EDUCATION COORDINATING BOARD AND TASK FORCE STAFF

Bryan Wilson, Madeleine Thompson, Donna Russell, Barbara Mix, Workforce Training and Education Coordinating Board; Thanks to Pam Hayes, Department of Health, who provided assistance for Appendix B; Marianne Seifert, staff for the Health Workforce Diversity Network.



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