

## Long-Term Care Workforce Development Session #1

Tuesday, July 10, 2018

1:00 p.m. to 5:00 p.m.

Washington Department of Health, Tumwater Campus

Point Plaza East Rooms 152/153,

310 Israel Road SE Tumwater, WA 98501

# agenda

**Workgroup Members:** Tracy Rude, Representative Eileen Cody, Senator Steve Conway, Candace Goehring, Rachel McAloon, Trina Crawford, Lori Banaszak, Pamela Pasquale, Abby Solomon, Alexis Wilson, John Ficker, Patricia Hunter, and Alexis Wilson

**DOH Staff:** Paula Meyer, Mindy Schaffner, Amber Zawislak, Kathy Moisio, Bobbi Allison  
**Facilitator:** Porsche Everson

**Guest Speaker:** Sue Skillman, *University of Washington Center for Health Workforce Studies*  
Carma Matti-Jackson, *Representing WHCA*  
Cynthia Forland, *Employee Security Department*

**Please Read:**

- *Long-Term Care Workgroup Plan*
- *Packet of Relevant Data*

*Note: This is a significant amount of advance reading/review. It's okay if you don't complete everything by the first meeting, but you will likely find all of these resources to be valuable over time. Material is listed in suggested priority order. Links to the packet material can be found on the project website:*

<https://www.doh.wa.gov/LicensesPermitsandCertificates/NursingCommission>

**Meeting Goals**

- Clarify the legislative mandate and intent
- Establish common base of knowledge and understanding of existing data
- Understand the responsibility of the group and expectations of individuals
- Establish general principles, topics, and logistics
- Review project timeline
- Determine what work may be accomplished outside of scheduled workshops

# agenda

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1:00 – 1:15 p.m.	<b>Welcome</b>	Tracy Rude, NCQAC Chair and LTCW Chair  Paula Meyer, NCQAC Executive Director
1:15 – 2:00 p.m.	<b>Introductions</b> <i>--Overview of work and staff support. --What are your expectations for our work? --What do you bring to the workshops?</i>	Mindy Schaffner, Project Manager Porsche Everson, Facilitator
2:00 – 2:15 p.m.	<b>Guiding Principles and Ground Rules</b>	Porsche Everson, Facilitator
2:15 – 2:35 p.m.	<b>Data Presentation- What can the data tell us?</b> <i>Industry and occupational employment projections.</i>	Cynthia Forland
2:35 – 2:55 p.m.	<b>Data Presentation- Long-Term Care Nurse Workforce</b> <i>Recent supply and demand findings from the 2018 survey of Washington’s RNs and Washington’s Workforce Sentinel Network.</i>	Sue Skillman
2:55 – 3:15 p.m.	<b>Data Presentation- LTC Workforce: Data and Trends</b> <i>Workforce recruitment and retention.</i>	Carma Matti-Jackson
3:15 – 3:25 p.m.	<b>Break</b>	
3:25 – 4:25 p.m.	<b>Public Comment</b>	Porsche Everson, Facilitator
4:25 – 4:50 p.m.	<b>Moving Forward- DISCUSSION</b> <i>--Review and adopt work plan</i>	Porsche Everson, Facilitator Workgroup Members
4:50 – 5:00 p.m.	<b>Wrap Up and Next Steps</b> <i>--Action Items --Workshop Evaluation</i>	Porsche/Tracy

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**DRAFT**

# LONG-TERM CARE WORKGROUP PLAN

2018 Budget Proviso

Nursing Care Quality Assurance Commission  
Long-Term Care Workgroup

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## Introduction and Background

The baby boomer cohort, as described by the United States Census Bureau, has been a driving change in age structure of the national population for the last several decades and has contributed to a shift in the delivery of healthcare<sup>1</sup>. As the citizens of Washington State age, the need for healthcare providers in the sectors of skilled nursing homes, assisted living, and adult family homes correspondingly rises to keep up with demand. In 1997, the percent of Washingtonians over the age of sixty-five had been 11.4% of the total population<sup>2</sup>. By the year 2017, this number had increased to 15.3% of the population and the Washington State Office of Financial Management projects the population of Washingtonians over the age of sixty-five to reach 21.6% of the total population by the year 2037. In addition, chronic disease rates and human longevity continue to steadily increase, but the percent of working adults to support and care for the entire population is not.

The U.S. Department of Health and Human Services recently published a report on nursing workforce demand projections to determine the need for nurses in long-term care settings over the next decade.<sup>3</sup>

We have strong anecdotal evidence that long-term care providers in Washington State are struggling to fill vacancies; that retention is difficult; that career progression within LTC settings is problematic; and that training requirements and regulatory oversight needs to be reset. We recognize that we need data to confirm the magnitude of the known issues described here.

Addressing the shortage of healthcare workers in long-term care settings will be essential to the way in which Washington strategizes for the continued increase in care that will be demanded of the health system. Barriers need to be identified and solutions developed to address these barriers.

## Purpose of Workgroup Plan

The overall purpose of this workgroup plan is to describe the implementation of the requirements of the budget proviso allotted to the Nursing Care Quality Assurance Commission in Engrossed Substitute Senate Bill 6032. The budget proviso directs the Nursing Care Quality Assurance Commission to convene and facilitate a work group to assess the need for nurses and nursing assistants in long-term care settings and to provide recommendations in a report to the Governor and Legislature by December 15, 2018. Recommendations must pertain to worker recruitment, training, and retention challenges for long-term care providers in the sectors of skilled nursing facilities, assisted-living facilities, and adult family homes.

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<sup>1</sup> Colby, S. and Ortman, J. (2014). *The Baby Boom Cohort in the United States: 2012 to 2060: Population Estimates and Projections*. Retrieved from: <https://www.census.gov/prod/2014pubs/p25-1141.pdf>

<sup>2</sup> Washington State Office of Financial Management. (2017). *Washington Data and Research*. Retrieved from <https://ofm.wa.gov/washington-data-research/population-demographics>

<sup>3</sup> U.S. Department of Health and Human Services. (2018). *Long-Term Services and Supports: Nursing Workforce Demand Projections 2015-2030*. Retrieved from <https://bhwh.hrsa.gov/national-center-health-workforce-analysis>

## Mission, Vision, and Goals

### *Mission*

To identify barriers, develop solutions, and make recommendations regarding career advancement, reduced vacancies, increased retention and standardized training in long-term care settings to the legislature and governor.<sup>4</sup>

### *Vision*

Washington State citizens will have access to quality services provided by qualified and available nurses and nursing assistants in long-term care. Workers will have opportunities for career progression in long-term care settings.

### *Goals*

- 1. Develop pathways for career advancement for nurses and nursing assistants working in long-term care settings**
- 2. Decrease the number of vacancies in LTC settings**
- 3. Increase retention of long-term healthcare workers**
- 4. Standardize training for seamless academic progression in the long-term healthcare career pathway**
- 5. Ensure that additional barriers are not created<sup>5</sup>**
6. Strengthen providers' ability to meet regulatory requirements for staffing in LTC settings in Washington
7. Increase the pipeline of workers in LTC settings
8. Improve student exposure and access to LTC as a profession
9. Reduce barriers that drive workers from the profession
10. Reduce barriers within LTC settings to improve retention and attract new workers
11. Ensure quality of care and services to residents in LTC settings remain high

## Requirements of ESSB 6032

1. Assess the need for nurses, including nursing assistants, in long-term care settings
2. Make recommendations regarding worker recruitment, training, and retention challenges for long-term care providers in the sectors of skilled nursing facilities, assisted-living facilities, and adult family homes.
3. The workgroup must:
  - a. Determine the current and projected worker vacancy rates in the long-term care sectors compared to the workload projections for these sectors.
  - b. Develop recommendations for a standardized training curriculum for certified nursing assistants that ensures that workers are qualified to provide care in each sector, including integration into the curriculum of specific training for the care of clients with:
    - i. dementia
    - ii. developmental disabilities

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<sup>4</sup> The recommendations are due October 15, 2018. The final report is due December 15, 2018.

<sup>5</sup> Goals in bold are derived directly from the legislation. Other goals were established by a multi-stakeholder planning group.

- iii. mental health issues
- c. Review academic and other prerequisites for training for licensed practical nurses to identify any barriers to career advancement for certified nursing assistants.
- d. Identify barriers to career advancement for long-term care workers.
- e. Evaluate the oversight roles of the Department of Social and Health Services for nursing training programs and make recommendations for streamlining those roles.
- 4. The workgroup must meet at least three times, beginning no later than July 15, 2018
- 5. The Nursing Care Quality Assurance Commission must report the workgroup's assessments and recommendations to the governor and legislature no later than December 15, 2018.

## Project Organization and Stakeholders

### *Project Management Team*

<b>Project Management Role</b>	<b>Designated Individual</b>
Project Executive	Paula Meyer, Executive Director
Project Lead	Mindy Schaffner, Associate Director
Workgroup Chair	Tracy Rude, NCQAC Chair
Policy Analyst	Amber Zawislak
Education Consultant	Kathy Moisio
Project Assistant	Bobbi Allison
External Facilitator/Project Advisor	Porsche Everson, Relevant Strategies, LLC

### *Steering Workgroup Members*

<b>Members Required by ESSB 6032</b>	<b>Designated Individual</b>
Nursing Care Quality Assurance Commission	Tracy Rude, NCQAC and Workgroup Chair
Chair of House Health Care and Wellness Committee or designee	Representative Eileen Cody (Sending Thea Bird when unable to attend)
Chair of Senate Health and Long-Term Care Committee or designee	Senator Steve Conway (Sending Kimberly Lelli when unable to attend)

Assistant Secretary of Aging and Disability Support Administration of the Department of Social and Health Services or designee	Candace Goehring
Member of the Washington Apprenticeship and Training Council (Department of Labor and Industries)	Rachel McAloon (Sending Evan Hamilton when unable to attend)
Representative from the Health Services Quality Assurance Commission of the Department of Health	Trina Crawford
Executive Director of the Washington State Board for Community and Technical Colleges or designee	Lori Banaszak
Representative of largest statewide Nursing Agency	Pamela Pasquale (Sending Sharon Christor or Lynette Wells when unable to attend, representing WSNA)
Representative of largest statewide Home Care Workers Union	Abby Solomon (Representing SEIU)
Representative of largest statewide Assisted Living and Skilled Nursing Facilities Association	Alexis Wilson (Representing WHCA)
Representative of the Adult Family Home Council of Washington	John Ficker, Executive Director (Sending Karen Cordero when unable to attend)
Washington State Long-Term Care Ombuds or designee	Patricia Hunter

### ***Subcommittees Reporting to Steering Workgroup***

As much as possible, the work identified in ESSB 6032 will be performed by the whole steering workgroup. If it becomes necessary to appoint subcommittees to develop recommendations for the steering workgroup, subcommittee membership will be derived from the named members of the steering workgroup or their designees.

The subcommittees may choose to involve other subject matter experts to provide input and counsel but will retain the responsibility of deciding on recommendations for the steering workgroup.



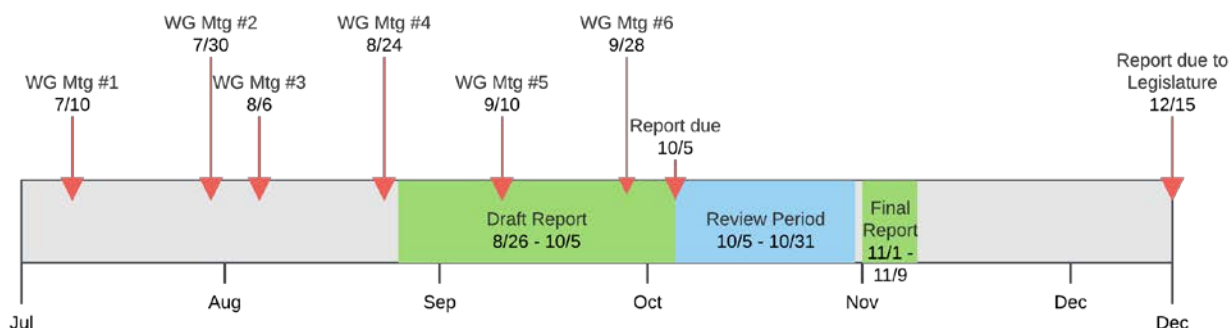
The following subcommittees, identified below, are proposed *if necessary to complete the work*. They will be chaired by a member of the steering workgroup approved by a majority of the steering workgroup. Membership of the subcommittee will be determined by member interest and by the project management team. The project management team will ensure a balance of stakeholder interests on the subcommittee.

The subcommittee's role will be to identify balanced recommendations and choices for consideration by the full steering workgroup. The subcommittees have no delegated authority to make decisions on behalf of the steering workgroup.

<b>Curriculum Subcommittee</b>
<p><b>Objective:</b> Develop balanced recommendations for standardized nursing assistant training curriculum. Identify barriers and solutions.</p>
<p><b>Potential Tasks:</b></p> <ol style="list-style-type: none"> <li>1. Develop (or Review) recommendations for a standardized training curriculum for certified nursing assistants that ensures that workers are qualified to provide care in nursing homes, assisted living, and adult family homes, including integration into the curriculum of specific training for the care of clients with:               <ol style="list-style-type: none"> <li>a. dementia</li> <li>b. developmental disabilities</li> <li>c. mental health issues.</li> </ol> </li> <li>2. Review academic and other prerequisites for training for licensed practical nurses to identify any barriers to career advancement for certified nursing assistants.</li> </ol>
<b>Career Advancement, Training, and Retention Workgroup</b>
<p><b>Objective:</b> Identify barriers and solutions for career advancement, training, and retention for LPNs and Certified Nursing Assistants.</p>
<p><b>Tasks:</b></p> <ol style="list-style-type: none"> <li>1. Identify barriers to career advancement</li> <li>2. Identify barriers and problems in nursing assistant training programs</li> <li>3. Identify barriers to retention in the field of long-term care</li> <li>4. Identify possible solutions to all identified barriers</li> </ol>

## High-Level Timeline/Schedule

### LTC Workforce Planning and Development Recommendations Timeline



Workgroup Meetings and Deadlines	
July 10, 2018, 1–5 pm	First Steering Workgroup Meeting
July 30, 2018, 1–5 pm	Second Steering Workgroup Meeting
August 6, 2018, 1–5 pm	Third Steering Workgroup Meeting
August 24, 2018, 1–5 pm	Fourth Steering Workgroup Meeting
September 10, 2018, 1–5 pm	Fifth Steering Workgroup Meeting
September 28, 2018, 8 am–12 pm	Sixth Steering Workgroup Meeting Review of draft report by Steering Workgroup
October 5, 2018	Report due for DOH review to meet December deadline
October 5-31, 2018	DOH report review period
November 1-9, 2018	Finalize report
December 15, 2018	Report due to Governor and Legislature

## Session Activity Plans



1. Orientation (July 10)
  - a. Sense of commitment, timeline, workload
  - b. How do we want to work together?
  - c. Scope and sequence of planned work
  - d. Identify the challenges we are addressing (share known data)
  - e. Current state and data overview
    - i. Stakeholder representatives to address 3-4 questions 15 minutes each
      1. What evidence or data do you bring that will inform this work?
      2. What efforts have you been involved in that relates to this work?
      3. Are you aware of examples of solutions outside the state of Washington that relates to this work? If so, what state and work?
2. Career Ladder (Pathways/Progression/Advancement) (July 30)
  - a. Theme: Making a career in LTC health care – pathways and progressions, recruitment and retention (HCA, CNA, LPN, RN)
  - b. Identify barriers to career advancement
  - c. Identify barriers and problems in nursing assistant training programs
  - d. Identify barriers to retention in the field of long-term care
  - e. Brainstorm potential solutions for further consideration
  - f. Identify additional work or research that may need to be done
3. Education and Training (August 6)
  - a. Theme: Developing a professional work force – 21st century vision
  - b. LTC CNA standardized training recommendations
    - i. Review existing state

- ii. Training needs for clients with dementia, developmental disabilities, or mental health issues
    - iii. LPN academic requirements and prerequisites, barriers to CNA progression
  - c. HCA training recommendations and pathways
  - d. Identify barriers
  - e. Brainstorm potential solutions for further consideration
  - f. Identify additional work or research that may need to be done
4. Issues and Opportunities (August 24)
  - a. Theme: Thinking broadly about workforce development
  - b. Review initial recommendations to date (if any),
  - c. Discuss DOH/DSHS oversight responsibilities
  - d. Identify issues and concerns within the regulatory environment
    - i. How does oversight help ensure quality and patient safety?
    - ii. How does oversight hurt efficient care delivery?
  - e. Brainstorm potential solutions for further consideration
  - f. Identify additional work or research that may need to be done
5. Draft recommendations (September 10)
  - a. Review data collected to date
  - b. Review draft recommendations related to Education and Training
  - c. Review draft recommendations related to Career Advancement and Retention
  - d. Review draft recommendations related to Oversight and Evaluation
6. Finalize Recommendations (September 28)
  - a. Theme: Creating positive change, a coherent strategy for LTC health care
  - b. Review draft report
  - c. Assess degree of support for each identified recommendation
  - d. Determine if new recommendations exist
  - e. Where necessary, identify majority/minority opinions for each recommendation without consensus support.

### **Constraints and Assumptions**

- Legislative deadline set for recommendations (October 15) and report (December 15)
- DOH needs significant time to have draft report go through internal review process
- First workgroup meeting must occur by July 15
- Scope and tasks are defined by legislation

### **Project Approach**

The steering workgroup is defined by the legislation and is comprised of people who represent various stakeholder groups. The steering workgroup will periodically receive input from other interested individuals and groups. The steering workgroup is responsible for identifying and deciding on recommendations.

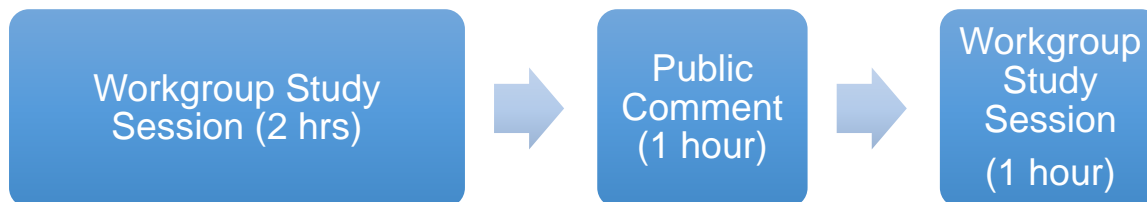
We will seek consensus in all steering workgroup and subcommittee decisions and recommendations. We will use “common interest” based conversations to reach consensus. If the

workgroup cannot reach consensus on a recommendation, and a recommendation has majority support, the recommendation will be listed in the report, along with a brief synopsis of majority and minority opinion about the recommendation.

DOH staff and other participants will provide background research and materials to help inform the work, within the constraints of available time and resources. Some preparation and follow up work will be necessary for steering workgroup members.

The steering workgroup may form subcommittees as necessary. Other interested stakeholders not in the workgroup may be invited to provide input to either the subcommittees or the steering workgroup.

Each steering workgroup session will follow a general pattern. The first half of the meeting will be devoted to workgroup work. The steering workgroup will then take public comment/testimony for up to an hour. This may include time set aside for invited guest speakers. The steering workgroup will then engage in another hour of work together.



The steering workgroup meetings and any subcommittee meetings are open to the public, and the public can observe, but not engage in the work of the workgroup.

### **Communication and Collaboration**

Meeting agendas, advance readings, and other materials will be stored on an accessible DOH project website page available to the public. Periodic drafts of deliverables will be sent to the DOH project lead, for distribution or publication as appropriate.

Most communication with the steering workgroup will occur via email from the DOH project lead, workgroup chair, or administrative contact. On occasion, the facilitator may send information directly to the workgroup.

The facilitator and project management team will meet regularly via web conference or phone conference to plan and evaluate workgroup sessions. At least once per month the external facilitator will check in with the project lead to address scope, schedule, budget, and quality issues as necessary.

### **Change Management**

We don't anticipate changes to the project. In fact, the scope, budget, and schedule are fixed in the legislation. However, scope, budget, or schedule changes may happen for reasons unforeseen at present.

The project management team will address any proposed changes to scope, schedule or budget as quickly as feasible and develop a plan. The overall goal will be to work within the established constraints as best as possible.



# Resources and Materials

LONG-TERM CARE WORKGROUP: SESSION 1

## Table of Contents

Resource Title and Description	Page #
<p><i>Washington's Health Workforce Sentinel Network Findings from Long Term Care Facilities. (2017)</i></p> <p>Representatives from long term care facilities (skilled nursing facilities, home health care service providers, nursing and personal care facilities and intermediate care facilities) provided information to the Washington State Health Workforce Sentinel Network every 4 to 5 months from July 2016 to October 2017. This report summarizes the information they provided.</p>	Page 1
<p><i>Washington's Health Workforce Sentinel Network Findings for Registered Nurses. (2017)</i></p> <p>Sentinel employers in Washington provided information to the Washington State Health Workforce Sentinel Network every 4 to 5 months from July 2016 to October 2017. This report summarizes the information they provided about Registered Nurses (RNs).</p>	Page 3
<p><i>Health Workforce Demand in Washington State: Employers' Current and Expected Needs for Home Care Aides, Medical Assistants, Nursing Assistants Certified, Licensed Practical Nurses, and Associate's Degree Registered Nurses. (2013)</i></p> <p>This study provides a snapshot of current and expected demand for home care aides, medical assistants, nursing assistants certified, licensed practical nurses, and ADN registered nurses in Washington State. Data used to inform this study was collected in 2013 by the WWAMI Center for Health Workforce Studies at the University of Washington Department of Family Medicine.</p>	Page 5
<p><i>Long-Term Services and Supports: Nursing Workforce Demand Projections 2015-2030. (2018)</i></p> <p>This report was developed by the Health Resources and Services Administration within the United States Department of Health and Human Service and published March of 2018. The report contains an analysis for demand projections of registered nurses and licensed practical nurses in the field of long-term care using the Health Workforce Simulation Model.</p>	Page 39





## Washington's Health Workforce Sentinel Network

### Findings from Long Term Care Facilities

Representatives from long term care facilities (skilled nursing facilities, home health care service providers, nursing and personal care facilities and intermediate care facilities) provided information to the Washington State Health Workforce Sentinel Network every 4 to 5 months from July 2016 to October 2017. This report summarizes the information they provided.

#### Occupations with exceptionally long vacancies or increased demand:



**Licensed practical nurses** and **nursing assistants** were the top occupations listed by long term care organizations as experiencing exceptionally long vacancies or increased demand from July 2016 to October 2017. **Home health aides, registered nurses, nurse practitioners** were also frequently mentioned. **Home care aides, clinical social workers,** and **supervisors** were mentioned, although less frequently.

#### New roles and new occupations

Several Sentinels mentioned the need to assign new administrative or supervisory roles to account for the regulatory requirements specific to long term care facilities, including updating internal policies and procedures, data collection and interpretation and organizing new training activities. In some cases, Sentinels indicated an effort to promote internally rather than bring in new hires.

*– “[We’re] grooming a NAC to become a scheduler and begin slowly taking on more responsibility and eventually becoming a Client Service Manager.”*

#### Examples of reasons for exceptionally long vacancies or increased demand:

- Low compensation /benefits compared to hospitals and other facility types.
- Not enough training programs for new workers.
- Challenge to fill positions that require non-traditional work schedules or shift work.
- Applicants with required experience or educational attainment are hard to find.
- State requirements for LTC workers are hard to meet.
- Workers can get equivalent wages in other professions with less strenuous work schedules and daily activities, so do not stay in healthcare.
- In rural areas, it’s hard to find enough local candidates.

*“[Our biggest challenges are] the wages we’re able to offer, our [rural] location and a 12-hour minimum shift.” [SNF, regarding RNs]*

*“New state requirements for 24/7 RN coverage has spiked demand. State makes it hard to bring in out of state or foreign nurses.” [SNF]*

## Orientation and training changes in long term care facilities:

About 50% of Sentinels reported changes in orientation/onboarding priorities for new employees or changes to training priorities for new employees.

*Examples of changes to orientation and training priorities:*

- More time devoted and more follow-up after initial orientation/training to limit turnover. Some sentinels mention mentorship, preceptor or residency programs.
- A lot of time spent on recent and upcoming regulatory changes so employees are aware of these requirements.
- Increased need for in-depth orientation due to hires with little prior experience.
- Focus on specific topics such as electronic medical records, new equipment, behavior training, dementia/mental health or other minimum required competencies.

– “[We’re] investing in our staff by offering more training.”  
[nursing and personal care facility, nursing assistants]

## LTCs were active participants in the Sentinel Network in all four data collection rounds.

Long term care facilities (skilled nursing facilities, home health care service providers, nursing and personal care facilities and intermediate care facilities) accounted for approximately 30% of all responses (169 of 575) in all four data collection rounds. The number of responses among LTC providers was highest from skilled nursing facilities (Figure 1). Sentinels representing LTC organizations responded from all 9 Accountable Communities of Health in each data collection period.

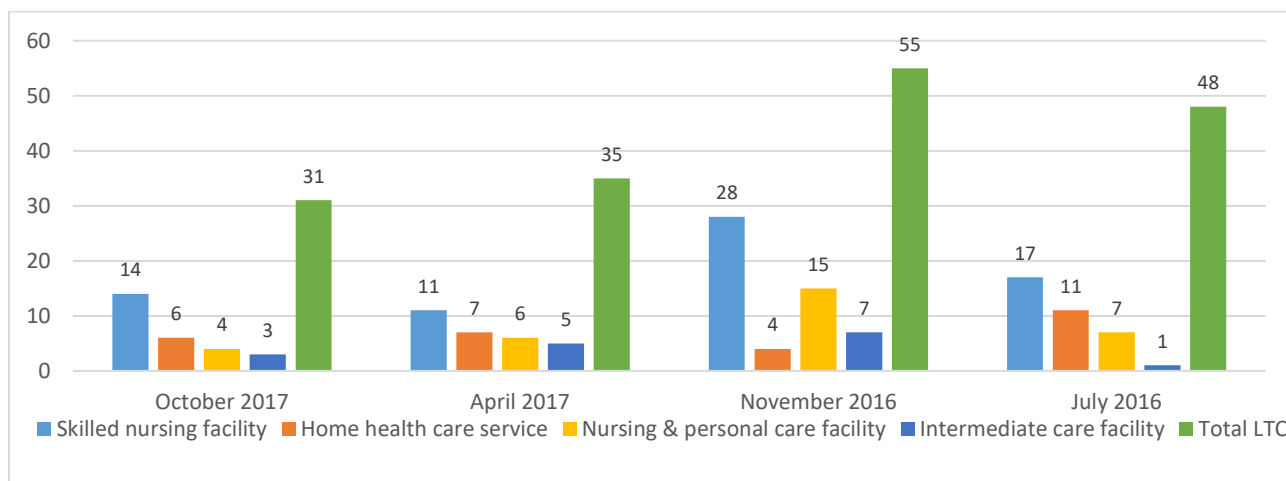


Figure 1: Number of Sentinel Network Responses from Long Term Care Facilities, July 2016 – October 2017

### About the Washington Health Workforce Sentinel Network

The Sentinel Network links the healthcare sector with policymakers, workforce planners and educators to identify and respond to changing demand for healthcare workers, with a focus is on identifying newly emerging skills and roles required by employers.

The Sentinel Network is an initiative of Washington’s Health Workforce Council, conducted collaboratively by Washington’s Workforce Board and the University of Washington’s Center for Health Workforce Studies. Funding to initiate the Sentinel Network came from the Healthier Washington initiative, with ongoing support from Governor Inslee’s office.

#### Why become a Sentinel? As a Sentinel, you can:

- Communicate your workforce needs and ensure that the state is prepared to respond to the transforming healthcare environment.
- Have access to current and actionable information about emerging healthcare workforce needs.
- Compare your organization's experience and emerging workforce demand trends with similar employer groups.

Interactive summary of findings: [www.wasentinelnetwork.org](http://www.wasentinelnetwork.org). Contact: [healthworkforce@wasentinelnetwork.org](mailto:healthworkforce@wasentinelnetwork.org)  
To provide information from your organization: <https://tinyurl.com/SNDataCollection>



## Washington's Health Workforce Sentinel Network

### Findings for Registered Nurses

Sentinel employers in Washington provided information to the Washington State Health Workforce Sentinel Network every 4 to 5 months from July 2016 to October 2017. This report summarizes the information they provided about Registered Nurses (RNs).

## Registered Nurses (RNs)

*By facility type:*

**RNs are the top occupation with exceptionally long vacancies recently reported by**

- Small acute care hospitals
- Home health care services

**RNs were also among occupations with long vacancies in:**

- FQHCs/community clinics
- Behavioral health/mental health clinics
- Psychiatric/substance abuse hospital
- Large acute care hospitals
- Schools
- Skilled nursing facilities
- Specialty medical clinics

*By geography:*

**RNs were the top ranked occupation with exceptionally long vacancies**

- July 2016: in 7 of 9 Accountable Communities of Health (ACHs)
- Nov. 2016: in 9 of 9 ACHs
- April 2017: in 7 ACHs (2nd in Better Health Together and 3rd in Greater Columbia)
- Oct. 2017: in 4 ACHs (2nd or 3rd in 4 other ACHs)

**Examples of reasons for RNs' exceptionally long vacancies:**

#### RNs in Hospitals

- New grads looking for acute care wage and experience; workforce does not meet demand.
- Difficulty in recruitment for more rural areas; lack of experienced specialty nurses who wish to come to a rural area.
- Nights hard to fill.
- Too many open positions elsewhere and traveling companies are scooping up what is out there promising them almost \$100 an hour.
- Increased need for EXPERIENCED RN's. Applicants are all new grads. Due to our size we cannot take on more than one new grad/year.
- We've been fortunate, but I anticipate that good fortune to wane in the next 2 years due to fewer program grads.
- We have not had any troubles staffing new graduate nurses into our Acute Care (general Med/Surg) Unit, but find experienced RNs difficult to recruit for specialty areas (i.e. ER, ICU & Surgical Svcs).

(examples of reasons for RNs' exceptionally long vacancies, cont.)

#### RNs in FQHCs/Community clinics

- Lack of qualified applicants; some offers turned down because of pay (can't compete with hospitals).
- Challenge to find RNs with FQHC or outpatient experience; need RNs with management/supervisory experience.
- ...seeking candidates that are bi-lingual in English and Spanish.
- ...far more openings in the local area than there are RNs to fill them, most go to the hospital.

#### RNs in Long Term Care (home health, skilled nursing, nursing and personal care)

- Not enough RN's for all the facilities and hospitals and a new regulation requiring skilled nursing facilities to have 24 hour RN coverage. (SNF)
- Nursing homes are unattractive to potential candidates, ... competition with local hospital (NH)
- A local hospital opened over 100 RN positions. Severe impact on community. (SNF)
- Lack of experienced RNs willing to work in this capacity (HH)
- Wage compression from new minimum wage (SNF)

#### RNs in Behavioral health

- Salaries not competitive.
- Hardships of working for a community mental health provider.

#### RNs in Specialty medical clinics

- High demand for RNs – newly created positions.

### **Changes in RNs' onboarding and training priorities – examples of comments:**

- EHR training and responsibilities; new EMRs; HIT. (hospital)
- Knowledge of quality data tracking. (FQHC)
- Customer service. (hospital)
- Behavioral training. (multiple facility types)
- Dementia knowledge. (SNF)
- Ongoing training to support nursing faculty in their roles as instructors. (hospital)
- Root cause/SBAR/Assessments/Care plans. (SNF)
- Investing in staff by offering more training. (SNF)
- Address needs of workers with little prior experience. (SNF)
- New grad nurses getting more orientation and training; we are spending more time with new employees during the onboarding/orientation process. (SNF)

### **About the Washington Health Workforce Sentinel Network**

The Sentinel Network links the healthcare sector with policymakers, workforce planners and educators to identify and respond to changing demand for healthcare workers, with a focus is on identifying newly emerging skills and roles required by employers.

The Sentinel Network is an initiative of Washington's Health Workforce Council, conducted collaboratively by Washington's Workforce Board and the University of Washington's Center for Health Workforce Studies. Funding to initiate the Sentinel Network came from the Healthier Washington initiative, with ongoing support from Governor Inslee's office.

#### **Why become a Sentinel? As a Sentinel, you can:**

- Communicate your workforce needs and ensure that the state is prepared to respond to the transforming healthcare environment.
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Interactive summary of findings: [www.wasentinelnetwork.org](http://www.wasentinelnetwork.org). Contact: [healthworkforce@wasentinelnetwork.org](mailto:healthworkforce@wasentinelnetwork.org)

To provide information from your organization: <https://tinyurl.com/SNDataCollection>

**Final Report #145**

**Health Workforce Demand  
in Washington State:  
Employers' Current and  
Expected Needs for  
Home Care Aides,  
Medical Assistants,  
Nursing Assistants Certified,  
Licensed Practical Nurses,  
Associate's Degree Registered  
Nurses**

**July 2013**

by

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This study was funded through the American Recovery and Reinvestment Act via a grant from the U.S. Department of Labor to the Washington Health Care Worker Training Coalition. The coalition was led by the Workforce Training and Education Coordinating Board. Two thirds of the funding, or some 66%, comes from the U.S. Department of Labor through a \$5 million grant.

**UWAMI CENTER FOR HEALTH  
WORKFORCE STUDIES**

UNIVERSITY OF WASHINGTON  
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DEPARTMENT OF FAMILY MEDICINE

## ABOUT THE WORKFORCE CENTER

The WWAMI Center for Health Workforce Studies is located at the University of Washington Department of Family Medicine. The major goals of the Center are to conduct high-quality health workforce research; provide methodological expertise to local, state, regional, and national policymakers; build an accessible knowledge base on workforce methodology, issues, and findings; and provide wide dissemination of project results in easily understood and practical form to facilitate appropriate state and federal workforce policies.

The Center brings together researchers from medicine, nursing, dentistry, public health, the allied health professions, pharmacy, and social work to perform applied research on the distribution, supply, and requirements of health care providers, with emphasis on state workforce issues in underserved rural and urban areas of the WWAMI region. Workforce issues related to provider and patient diversity, provider clinical care and competence, and the cost and effectiveness of practice are emphasized.

The WWAMI Center for Health Workforce Studies and Rural Health Research Center Final Report Series is a means of distributing prepublication articles and other working papers to colleagues in the field. Your comments on these papers are welcome and should be addressed directly to the authors. Questions about the WWAMI Center for Health Workforce Studies should be addressed to:

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## ACKNOWLEDGEMENTS

The authors would like to thank Jodi Perlmutter, Kelly Copp, Frank Kohel, and Mary Fusco of the Western Washington Area Health Education Center for managing all arrangements for the study's two employer forums and serving as facilitators. Thanks are also due to the other forum facilitators: Sue Dietz, Dan Ferguson, Corinne Corrigan, and Nico Patel. Thanks to Denise Lishner for her data collection assistance; Amanda Punsalan for her many contributions, including transcribing interviews; and Martha Reeves for her assistance, including report design and production. The authors also would like to thank Eleni Papadakis and Beth Meyer at the Washington State Workforce Training and Education Coordinating Board for providing the Center for Health Workforce Studies with the opportunity to conduct this study, and for their assistance in identifying and contacting employers as well as reviewing study findings. Finally, thanks to the many employers and stakeholders across Washington who took the time to discuss employment trends for these five occupations and attend the two study forums.

# Health Workforce Demand in Washington State: Employers' Current and Expected Needs for Home Care Aides, Medical Assistants, Nursing Assistants Certified, Licensed Practical Nurses, Associate's Degree Registered Nurses

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## EXECUTIVE SUMMARY

### INTRODUCTION

Little is known in Washington State about employer demand for five entry-level health care occupations:

- Home Care Aides
- Medical Assistants
- Nursing Assistants Certified
- Licensed Practical Nurses
- Associate's Degree Registered Nurses

This study provides a snapshot of current and expected demand for these key occupations in the state.

### METHODS

Employers statewide and across industry sectors were contacted and asked about their current and future needs for the five occupations. Between April and July 2013, the study conducted interviews with Washington employers and stakeholders selected from each industry sector, a variety of employment settings, different service delivery types, and diverse locations. Interview findings were integrated with insights gathered at two invitational forums, one held in eastern and one in western Washington during May and June 2013. A total of 86 employers took part in this study.

## KEY FINDINGS

### Who employs home care aides, medical assistants, nursing assistants certified, licensed practical nurses, and associate's degree nurses now? In the future?

Many employers are re-examining how best to employ entry-level workers.

- Among these occupations, hospital employers are predominantly relying on care teams composed of registered nurses and nursing assistants certified. Ambulatory/outpatient care practices are employing more medical assistants than other entry-level occupations. Both trends are expected to strengthen in the near future.
- The long-term care/home care sector relies heavily on nursing assistants certified and home care aides, as well as some licensed practical nurses and registered nurses. This pattern seems stable, with the demand for nursing assistants certified and home care aides expected to grow. Changing patient/client needs, along with regulatory and reimbursement challenges, may shift how these occupations are deployed and in what numbers.
- Larger employers, especially hospitals, are employing fewer licensed practical nurses. The market for this occupation is becoming increasingly centered on select geographic and industry pockets.

### What will employers need?

- Some employers expect higher patient volume and acuity, but are unsure about bringing on more workers, given financial pressures and uncertainty about upcoming changes in health care delivery systems.
- Some home care agencies and ambulatory/outpatient care facilities that have been expanding expect to add staff, including these five occupations. More expensive training and a higher credentialing bar for some entry-level occupations are leading many employers to screen applicants more carefully.
- Many employers want applicants with “soft skills,” such as customer service and communication skills and a commitment to caregiving.
- Experience is prized by smaller organizations that can least afford training, have limited staff, and need new employees to perform effectively shortly after being hired.
- Most employers need entry-level workers who are computer proficient, familiar with electronic health

records, and who are able to perform at the top of their training and scope of practice. Other specific needs vary by occupation and industry sector, as organizations rethink their staffing models and optimize their workforce to achieve both cost savings and good patient outcomes.

- Ambulatory/outpatient care employers need highly trained medical assistants, with skills that include delivering immunizations and performing blood draws, tasks more typically carried out by nursing staff in the past.
- Long-term care/home care employers need nursing assistants certified with upgraded skills and competencies to respond to patients’ greater acuity. These employers also need home care aides and nursing assistants certified with specialized training in mental health, memory disorders, and emergency care.

### How can existing problems be eased?

- Partnerships with local education institutions can be very effective. Many employers had strong ties to these assets and sought to expand them when possible. Online and in-house training help rural employers satisfy their demand for entry-level personnel, particularly home care aides, medical assistants, and nursing assistants certified.
- Strategies cited by employers to improve recruitment and retention of entry-level occupations included adequate pay and benefits, pathways for education and career advancement supported by internal opportunities, flexible scheduling, transferable education credits, tuition support, and loan repayment.

### To what extent will these occupations be tapped for care coordination?

- Where a need for a distinct patient navigator or care coordinator role has been identified, there is no consensus on which, or how many, of these occupations should fill this role. Employers vary greatly on whether care coordination functions will be performed by an entry-level position, or will require advanced education and/or credentials.
- Employers that are anticipating the greatest need for care coordination services expressed concern about adequate reimbursement to cover the costs of providing these services.
- Very few organizations have current job openings for patient navigator or care coordinator positions. Many employers are waiting to assess the needed functions, staffing, education, and reimbursement structures that relate to care coordination roles.



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## INTRODUCTION

While recent research has produced information on workforce supply trends for several health professions in Washington State (e.g., primary care physicians, physician assistants, nurse practitioners, registered nurses, and licensed practical nurses<sup>1-4</sup>), less is known about workforce demand, especially for five key entry-level occupations:

- Home Care Aides (HCAs)
- Medical Assistants (MAs)
- Nursing Assistants Certified (NACs)
- Licensed Practical Nurses (LPNs)
- Associate's Degree Registered Nurses (ADNs)

This study provides a snapshot of current and expected employer demand for these occupations in the state.

Each of the occupations plays an essential role in the state's current health care delivery system, and their roles are evolving as state and national trends reshape health care distribution and financing as well as health workforce dynamics. Among those trends:

- Washington State's population is growing and aging: the overall population is expected to increase from 6.8 million in 2012 to 8.2 million by 2030,<sup>5</sup> and the elderly population (age 65 and up) will double.<sup>6</sup>
- Chronic disease rates are increasing, imposing a heavier burden on health care delivery.<sup>7</sup>

- The health workforce is aging. For example, the average age of registered nurses and primary care physicians in Washington State is 48.5 years<sup>4</sup> and 49.3 years<sup>1</sup> respectively. Retirement is expected to reduce markedly the available supply of workers over the next decades.
- The economic downturn threatens workforce education, as rising tuition rates put higher education out of reach for many students.<sup>8</sup> Program capacity may also suffer under funding cuts.
- More access to care will be needed when the Patient Protection and Affordable Care Act (PPACA) is fully implemented in 2014.<sup>9</sup>
- New Washington State legislation affects training and certification for home care aides and credentialing of medical assistants.

Policymakers and educators need to anticipate how the demand for home care aides, medical assistants, nursing assistants certified, licensed practical nurses, and associate's degree registered nurses could change as they support employers preparing for industry transformations.

The key questions addressed in this study include:

- How will changes in the financing and organization of our health care system affect the demand for these five occupations?
- Who employs these occupations now? In the future?

- What will employers need?
  - More/fewer/same number of workers?
  - New/different skills/competencies?
- How hard is it to recruit workers in sufficient numbers/with the right skills? How can existing problems be eased?
- Will these occupations be tapped for new/emerging roles (such as patient care coordinator) or for expanded functions?

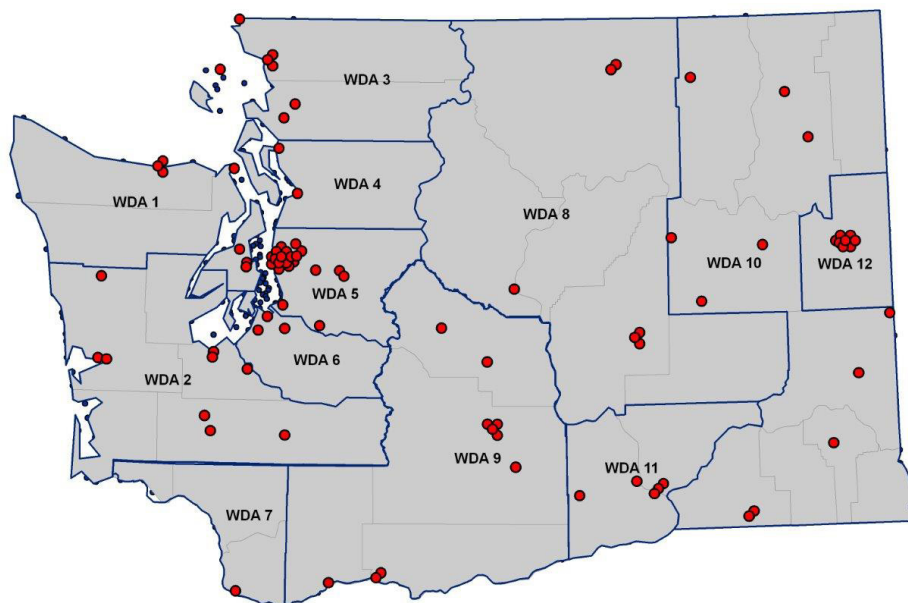
## METHODS

Health care employers statewide and across industry sectors were contacted and asked about their current and anticipated demand for home care aides, medical assistants, nursing assistants certified, licensed practical nurses, and associate's degree registered nurses.

For each employment sector we identified the most common employment settings for the five occupations, as follows:

- Inpatient care: acute care hospitals; mental/behavioral health facilities.
- Ambulatory/outpatient care: urgent care/retail clinics, tribal clinics, Rural Health Clinics, Community Health Centers, ambulatory surgical centers/other outpatient clinics (including mental/behavioral health and chemical dependency), correctional facilities, school districts, and medical practices not otherwise categorized.
- Long-term care/home care: skilled nursing facilities, extended care facilities (including rehabilitation facilities and long-term critical care hospitals), home care/home health agencies (including Washington State Department of Social and Health Services as the employer of record for home care aides who work as individual providers), and assisted living facilities.

**Figure 1. Participating Employers by Workforce Development Area (WDA)\*† (N = 86)**



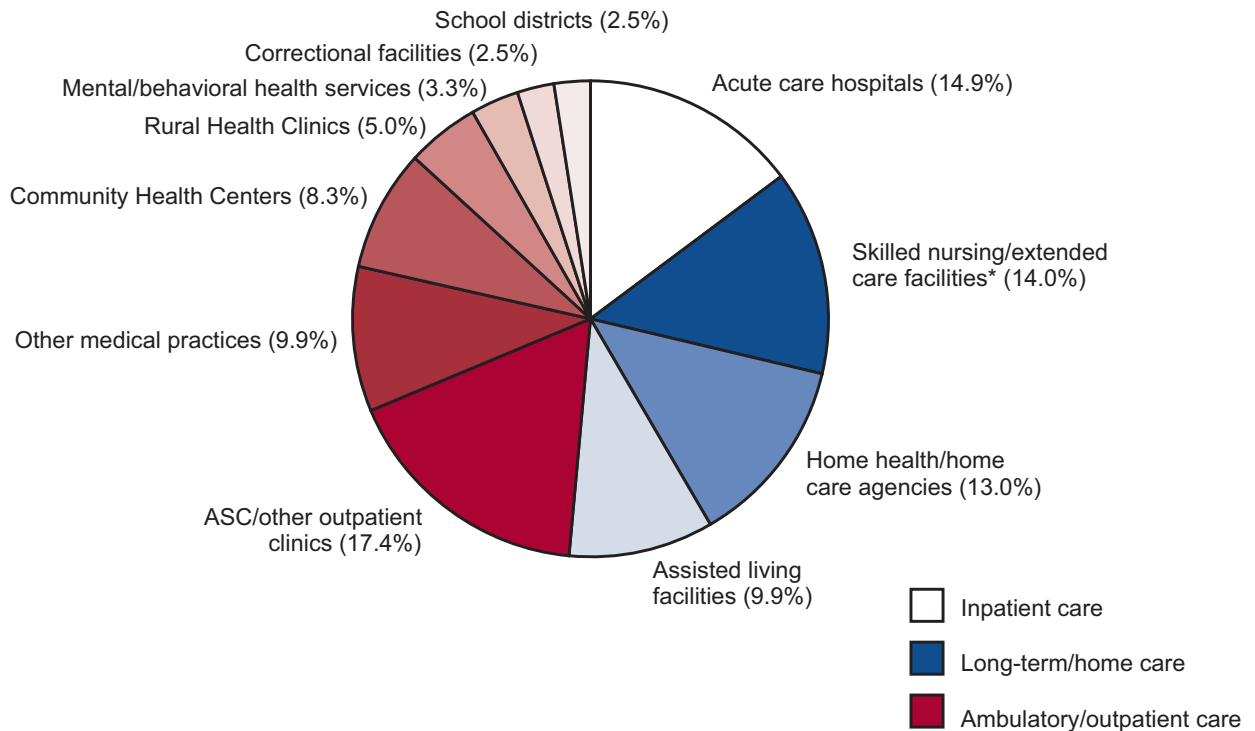
\* Counties comprising WDAs: 1 = Clallam, Jefferson, Kitsap; 2 = Grays Harbor, Mason, Thurston, Pacific, Lewis; 3 = Whatcom, Skagit, Island, San Juan; 4 = Snohomish; 5 = King; 6 = Pierce; 7 = Wahkiakum, Cowlitz, Clark; 8 = Okanogan, Chelan, Douglas, Grant, Adams; 9 = Skamania, Klickitat, Yakima, Kittitas; 10 = Ferry, Stevens, Pend Oreille, Lincoln, Whitman, Walla Walla, Columbia, Garfield, Asotin; 11 = Benton, Franklin; 12 = Spokane.

† Employers who provided data on multiple practice locations may appear more than once.

Source data:

1. Semi-structured interviews with key personnel knowledgeable about staffing issues. Interviews were conducted April-July 2013.
2. Employer forums held in May and June 2013.

**Figure 2. Participating Employers by Setting/Facility Type (N = 86)**



\* Includes long-term acute care hospitals.

Note: complex systems may be counted as more than one type.

Employers from across the state were selected to reflect regional differences in access to health care, health care workforce, and workforce education programs.

We used a two-pronged approach to data collection. Between April and July 2013, we conducted interviews with Washington employers and stakeholders selected from each industry sector, a variety of employment settings, many kinds of service delivery types, and diverse locations. Figure 1 shows the locations of the survey and forum participants and Figure 2 illustrates their diversity.

Responses from many employer types enabled us to capture industry-wide trends as well as a diverse range of employers' needs and perspectives. Interview findings were integrated with insights gathered at two stakeholder forums in May and June 2013, one held near Spokane on the eastern side of the state and one south of Seattle on the western side of the state. A total of 86 employers participated in this study. (See Appendix A for a more detailed description of study methods.)

## FINDINGS

Study findings are first discussed for each of the five occupations, followed by cross-cutting issues that surfaced from the interviews. Figure 3 summarizes demand findings for the five occupations, indicating whether employer demand is generally expected to grow, decline, or remain stable.

**Figure 3. Estimated Demand Findings by Occupation and Industry Sectors**

Occupations	Industry Sectors		
	Inpatient Care	Ambulatory/ Outpatient Care	Long-Term Care/Home Care
Home care aides	NA	NA	↑↑
Medical assistants	NA*	↑↑	NA†
Nursing assistants certified	◆◆	↓	↑↑
Licensed practical nurses	↓↓	◆	◆
Associate's degree registered nurses	↑	◆◆	◆

\* Medical assistants are infrequent in inpatient settings

† Medical assistants are infrequent in long-term care/home care settings

Key:

↑ = demand expected to grow (two arrows indicate strong trend).

↓ = demand expected to decline (two arrows indicate strong trend).

◆ = demand expected to remain stable (two diamonds indicate strong trend).

### FINDINGS BY OCCUPATION

This section illustrates employers' views and experiences with each of the five occupations and the various challenges that affect each position. Present roles and current and anticipated demand for home care aides, medical assistants, nursing assistants certified, licensed practical nurses, and associate's degree registered nurses depend on factors that include workforce supply, industry sector, geography, and regulations.

Each occupation is introduced by a short profile to provide helpful background and context for the study findings.

## Home Care Aides

**Home Care Aides Occupation Profile:** Home care aides provide services that help people with disabilities and the elderly remain in their homes. They also work in assisted living facilities and adult family homes. Home care aides assist clients in activities of daily living (ADLs) such as cooking, cleaning, dressing, grooming, medication reminders, and transferring into and out of beds. Clients with physical disabilities, dementia, developmental disabilities, and mental illness may require other kinds of assistance in order to live independently.

Prior to 2011, home care workers who provided home care for Medicaid clients had fewer training requirements and less on-the-job support than workers in residential institutions. In 2011 the public voted into law Initiative 1163, mandating new training standards intended to better prepare home care aides to deliver top-quality assistance to Medicaid clients.<sup>10</sup> The new requirements took effect January 7, 2012. According to rules under 18.88B RCW, a home care aide seeking certification must:

- Complete 75 hours of training using state-approved curriculum within 120 days of hire.
- Pass a state certification exam within 150 days of starting work.
- Complete a federal and a state background check.

More than 50,000 home care aides were estimated to be providing home care for Medicaid clients in Washington in 2010, and even more home care aides serve other populations.<sup>11</sup> Washington State Department of Social and Health Services serves as the employer of record for home care aides who work in clients' homes as individual providers and are paid directly by Medicaid. With over 32,000 home care aides registered as individual providers in 2010,<sup>11</sup> the Department for Social and Health Services is the largest employer of home care aides serving Medicaid clients in the state.

The need for home care aides will grow as the state's general population and its estimated home and community-based Medicaid client population increases. The physically demanding home care aide positions are typically low paid; many home care aides are part-time workers who receive few or no benefits.

The University of Washington Center for Health Workforce Studies estimated that Washington will need nearly 77,000 home care aides by 2030 to care for more than 88,000 Medicaid clients, a 56% increase over the next two decades.<sup>11</sup> The U.S. Bureau of Labor Statistics identified 1.878 million home care aides in the United States in 2010 and forecast a 70% increase in the number of positions, or 1.313 million jobs, between 2010 and 2020.<sup>12</sup>

### Findings:

**Employment Settings and Roles:** Home care aides, as discussed with employers and stakeholders for this study, worked in home and community-based settings as individual providers of home care services, employees of home care and home health agencies, and workers in adult supported living settings. A sizeable proportion (estimated range 40%-70%) of the home care aides working as individual providers delivered care to their own ill or disabled family members.

Home care agencies deployed home care aides to help clients with activities of daily living. In assisted living facilities, home care aides had duties as care givers and personal care attendants, helping residents with their daily activities, serving meals, and doing laundry and housekeeping. Home care aides were not employed in skilled nursing facilities.

**Legislative Impacts on Home Care Aides:** While the impact of health reform on home care aides is unclear, several employers expressed concern about how payment restructuring will affect the home care field through changes in Medicare and Medicaid reimbursement. Some employers who contract with the state talked about the effects of changes in Medicaid payment practices that have already taken place. For example, one employer commented that Medicaid now pays for smaller time units of caregiving than before, thereby affecting scheduling of home care aides, appropriate client coverage, and general work flow.

Many employers in this study described the training requirements as being onerous for themselves and their employees. Some employers noted that initial preparatory training for the position is no longer

possible on the job under the new law, and worried that the current demands for formal training and certification may be preventing some candidates from joining the field. A Washington State Department of Social and Health Services representative acknowledged that the costs associated with training and certification may be a barrier for home care aides who assist their own family members as individual providers.

Some employers feared losing new hires who fail to complete training or pass the certification test within the required 120 days. Training can be expensive and difficult to access in rural areas: many rural employers commented on lack of access to both training and testing sites, although alternative solutions such as online and employer-sponsored on-site training were reported to be increasing. Home care aides who assist their own family members who are Medicaid clients face many of the same challenges.

Employers who were certified by the state to become trainers themselves fared better in terms of employee recruitment than those who relied on outside training sources.

A number of employers stated that because of the legal requirements for home care aide training, they would rather hire nursing assistants certified as home care workers because to hold that title the worker would have already completed training (although in at least one case, the facility's preference for nursing assistants certified was simply due to the availability of recent graduates of a school just across the street). Education and certification for nursing assistants certified can also be challenging in rural areas but are perceived to be less so than for home care aides.

While problems persist, some employers and stakeholders suggested that improvement is taking place as the workforce, employers, and the training and certification system become accustomed to the new law. The planned doubling of the number of languages in which the home care aide certification test will be offered (to 12 languages) should improve passing rates among home care workers who speak English as a second language. The required training is expected to create a pathway to other health care careers that can make the occupation more attractive to potential candidates.

*Employment Sector:* Recruiting and retaining workers into the home care field presents similar challenges whether those workers are individual providers who assist clients other than their own family members, or are employed by facilities or home care agencies. Low pay, few benefits, training and certification requirements, and limited career options are common to many home care aides, regardless of employer. Aspects of the new law that are intended to alleviate some of these employment conditions may help to both attract and retain home care aides.

As reported by a Washington State Department of Social and Health Services spokesperson, the many individual providers under Medicaid contract who enter the home care workforce in order to care for a loved one may be less likely to stay in the field once their family's need is over. Home care aide turnover was reported to be an issue in employment settings outside of the state-run individual provider program, but less so for assisted living employers than for home care agencies.

A majority of employers in the long-term care/home care sector said that the training requirements for home care aides created recruitment difficulties in locations lacking easy access to training and testing sites, further restricting the pool of people willing to take a demanding and low-paying job. Costs associated with home care aide training and certification, such as for travel and administrative fees, were also reported to be a hurdle. But some employers expressed that they were adjusting to the requirements for training and certification of home care aides introduced by Initiative 1163.

Several employers mentioned training in memory disorders and mental and behavioral health as increasingly important for home care aides whether they worked in facilities or people's homes, and said that it should be made more readily available. Those seeking to hire home care aides with such specialized skills said that they faced significant recruitment problems.

Employers were most concerned with having an adequate supply of home care workers, but at least one large home care agency reported problems recruiting bilingual home care aides to work in areas with diverse populations.

*Geography:* The distribution of demand for home care aides across the state follows closely to that of the Medicaid population that many of them serve, and to general population density.

Although employers across different regions shared similar concerns, their severity was exacerbated in less urbanized places, especially for employers seeking to hire trained and certified home care aides.

Those who employed home care aides needing to undergo the training and testing said that their employees had a difficult time accessing the necessary resources. Online training may be a solution for home care aides in rural areas, but despite reported efforts to advertise different training options, some employers appeared to not be aware of or have access to them. Rural employers that are state-certified to train their home care aide workforce faced somewhat fewer recruitment obstacles but still reported a scarcity of available testing sites.

*Demand Trend:*

- **Demand for home care aides is expected to grow nationwide and in Washington State.**
- **Home care aide is a high-turnover occupation and most employers are continually recruiting** because client volumes and needs can be unpredictable and many home care clients need round-the-clock care, necessitating a well-staffed relief pool. In addition, some home care aides view the occupation as a first step onto the health workforce career ladder and quickly leave to pursue other health care careers (although this trend is not as clear as with nursing assistants certified). Many home care aides are individual providers who are trained and stay in the workforce only to care for their own family member who is a Medicaid client. The demand for home care aide training will continue to be high because of high turnover rates.

## Medical Assistants

**Medical Assistants Occupation Profile:** Medical assistants typically work in ambulatory/outpatient care settings, although they are sometimes found in inpatient services as well. Under the supervision of licensed medical professionals, they carry out fundamental and clinical procedures, collect specimens, provide patient care, administer medications and intravenous injections, and perform hemodialysis functions and capillary, venous, or arterial invasive procedures for blood withdrawal. Under new legislation that went into effect in Washington July 1, 2013, there are four categories of medical assistants in the state:

1. Medical assistant-certified.
2. Medical assistant-hemodialysis technician.
3. Medical assistant-phlebotomist.
4. Medical assistant-registered.

The newly credentialed medical assistant profession replaces the former health care assistant professional, although active credential holders automatically transitioned to the new credential. The legislation recognized the importance of medical assistants and provides statutory support for their duties.

Under RCW 18.360, a medical assistant seeking certification must:

- Complete an accredited program that includes a minimum of 720 clock hours of training, including a clinical externship of no less than 160 hours, or a registered apprenticeship administered by a department of the state of Washington.
- Submit proof of military training or experience that satisfies the training or experience requirements.
- Pass a certification exam.

The U.S. Bureau of Labor Statistics identified 527,000 positions for medical assistants nationwide in 2010 and forecasts a 31% growth rate, or 162,900 additional positions, by 2020.<sup>13</sup> In Washington State, the Employment Security Department estimates that demand for medical assistants will increase: 303 yearly job openings, on average, are projected between 2010 and 2015, corresponding to a 1.6% growth rate.<sup>14</sup>

### Findings:

**Employment Settings and Roles:** The great majority of employers deployed medical assistants in medical ambulatory/outpatient care settings. The mental/behavioral health field, long-term care facilities, and inpatient hospitals rarely employ medical assistants. Roles and functions of medical assistants, as described by employers interviewed for this study, spanned both clinical and administrative tasks. As an illustration, one employer praised profusely the versatility of the medical assistant role in staffing a small rural health clinic. Clinical duties were more prevalent, but even medical assistants assigned to clinical roles were reported by employers to be engaged in some administrative tasks in most practices.

Medical assistants were reported to give injections in practices that commonly administer immunizations, such as primary care, and may be asked to assist with lab work in small facilities with limited staff. Medical

assistants were required to handle health information technology in virtually all practices already using electronic health records or other computerized systems. Some employers in the ambulatory/outpatient care sector assigned medical assistants to care coordination functions, such as making hospital referrals. Community Health Centers most frequently used medical assistants for patient care coordination roles and were exploring new and expanded ways of deploying them in this area.

**The New Medical Assistant Legislation:** Employers expressed mixed reactions to the new state law establishing certification requirements for medical assistants. Acknowledgements that the law will help to protect patient safety by bringing much-needed criteria to a largely unregulated field were coupled with some anxiety about the change as well as some reports of the organizational challenges caused by adjusting to the



new rules. For example, incumbent medical assistants who are not currently certified must be assessed for their readiness to pass the state certification exam, and some employers worry that not all members of their medical assistant workforce may be up to the task. Concerns were raised about the emergence of a two-tier system in which incumbent medical assistants could be found to be less prepared for the new standards than recent graduates.

Other employers, however, described only a few bumps in the road. Those with a health care assistant workforce reported a mostly smooth transition of this staff toward acquiring medical assistant credentials. In a number of facilities, currently employed, non-credentialed medical assistants have been applying in large numbers to be registered as health care assistants in order to be grandfathered into the new medical assistant profession.

*Recruitment Issues:* Few employers had difficulty recruiting sufficient numbers of medical assistant applicants, but many struggled to find candidates with adequate training, sufficient skills and/or experience, and certification credentials. Each of these problems was usually worse in rural and, especially, isolated communities.

Employers noted most often the uneven quality of medical assistant education programs. Some programs may be too short to provide sufficient grounding in all the components of the medical assistants' scope of practice, and not sufficiently selective in their admission practices. *"We want [medical assistants] to come out of school being able to take vitals, [to have] that hands on with patients comfortably."* One employer commented that new graduates seemed better prepared for front office (i.e., administrative) work than for back office (i.e., clinically oriented) tasks. Another concern was that online programs did not provide enough hands-on training. In general there was a stated preference for graduates of longer, more comprehensive community college programs over shorter, private, for-profit programs. But there are some indications that the perceived quality of medical assistants' preparation may be improving, at least in King County, as one Seattle employer commented: *"The level of the MAs coming out of some of the schools now is much higher than it was in years past."*

Some remaining challenges included recruiting experienced medical assistants and medical assistants with bilingual skills to serve diverse populations.

*Employment Sector:* With rare exceptions, medical assistants were employed in medical offices and outpatient clinics, settings where demand for this occupation is projected to grow strongly. Medical assistants were deployed in clinical and administrative roles, with increasing requirements that they work to the full extent of their practice scope and, when possible, take over some of the registered nurse functions. In Community Health Centers especially—but not exclusively—medical assistants were expected to be involved in new or newly expanded patient coordination tasks. To support the expansion of the medical assistant role, some employers have explored—and in one case already implemented—the creation of a career ladder within

***We want [medical assistants] to come out of school being able to take vitals, [to have] that hands on with patients comfortably.***

their practice enabling medical assistants to progress from a junior Medical Assistant 1 position to a more experienced and broader Medical Assistant 2 role.

*Geography:* Medical assistants (or health care assistants who are being transitioned to the medical assistant profession) were employed by facilities of all sizes in every part of the state. Some recruitment challenges were also reported in all areas.

Employers in many small rural towns across the state reported having trouble finding certified medical assistants, especially experienced ones. One facility found recruiting certified medical assistants harder along the Oregon border, because Oregon residents who might make good medical assistants do not meet Washington new requirements. Some medical practices on the Olympic Peninsula that need medical assistants to administer immunizations have found that local education programs do not teach that particular skill, forcing them to look for applicants outside of their communities.

In urban areas around Puget Sound, some medical offices anticipated new challenges recruiting medical assistants once the new certification requirements went into effect, while a few large ambulatory/outpatient clinics with incumbent medical assistants expressed some worries that their long-term employees who were never formally trained might not qualify for certification.

Many organizations on both sides of the Cascades have or project medical assistant vacancies. This increase in demand stems from anticipated growth in services, patient volumes, and population transitions. Growth is also anticipated as a result of health care reform.

*Demand Trend:*

- **Employer consensus is that the demand for medical assistants in Washington will grow.** Facilities that employ medical assistants, including the great majority of hospital-affiliated clinics, plan to continue and possibly increase their staffing. Some small practices currently rely on other workers, such as podiatry assistants, radiology techs, or even office

staff to perform basic medical assistant functions, but expressed that they may consider hiring medical assistants to perform those tasks in the future

- **The health reform law is expected to accelerate the ongoing trend away from inpatient and toward ambulatory/outpatient-based care delivery, where the pairing of a provider with a medical assistant working under the provider's license is a growing trend.** The law's emphasis on primary care and cost containment, coupled with the projected influx of a newly insured patient population, will also fuel the demand for this occupation.

## Nursing Assistants Certified

***Nursing Assistants Certified Occupation Profile:*** Also known as certified nursing assistants, nursing assistants certified have basic training in patient care and use their skills in nursing homes, assisted living centers, ambulatory/outpatient care sites, and hospitals. Nursing assistants certified are supervised by registered nurses and in some circumstances\* licensed practical nurses. At one end of their scope of practice, they may make beds and organize rooms; at the other, they may monitor vital signs, maintain medical documentation, or care for a catheter.

To become certified as a nursing assistant in the state of Washington, applicants must:

- Complete a minimum of 85 hours of training through a state approved program, including/or also 7 hours of HIV/AIDS training.
- Pass a competency exam.
- Join the Washington Nurse Aide Registry, so that prospective skilled nursing employers can check the nursing assistants certified's status during the hiring process.

Many nursing assistants certified begin employment as nursing assistants-registered (NAR). They can work as nursing assistants-registered in assisted living and skilled nursing units for four months while they complete an approved training program and take the certification test, but they cannot handle tasks for which they have not been trained.

Reliable estimates of the size of the nursing assistant certified workforce in Washington State are not available. (Licensed professionals, who must renew their state licenses regularly, can more easily be counted than can certified workers for whom there are not comparable records maintained by the state.) Nationwide, the U.S. Bureau of Labor Statistics identified 1,505,300 nursing aide, orderly and attendant positions in 2010 and forecast a 20% increase in the number of positions, or 302,000 jobs, between 2010 and 2020.<sup>15</sup>

\* Under provisions of Washington Administrative Code 246-840-010.

### ***Findings:***

***Employment Settings and Roles:*** Employers interviewed for this study reported employing nursing assistants certified in long-term care, home care, and inpatient settings, but less frequently in ambulatory/outpatient facilities. One network of Community Health Centers is in the process of moving away from nursing assistants certified and toward medical assistants, reflecting an industry-wide preference for the broader scope of practice that medical assistants can bring to ambulatory/outpatient services. There are exceptions, however: one rural hospital deploys care teams composed of registered nurses and nursing assistants certified across both its inpatient and outpatient services to, in their view, preserve continuity and improve care coordination.

Employers reported that in most settings, nursing assistants certified are devoted to direct patient or client care (which often include assistance with activities of

daily living, such as bathing and getting dressed), and with back office tasks (preparing for examination and taking the vital signs of ambulatory patients). Other functions performed as needed included translating for non-English speaking patients, performing general administrative duties, and helping with facility meals and housekeeping. Nursing assistants certified may be handling health information technology if electronic health records are in use. They also perform care coordination tasks that range from making referrals to keeping track of patient or client medications, particularly in long-term care facilities.

Hospitals use nursing assistants certified as part of their inpatient care teams, where they are paired with registered nurses and work under their supervision in medical-surgical and, sometimes, critical-care units. Some hospitals that are phasing out employment of licensed practical nurses found that pairing registered

nurses with nursing assistants certified on inpatient floors was the most effective and efficient means of caring for their patients.

*Employment Sector:* Demand for nursing assistants certified seems mostly stable in inpatient care units. Typically, nursing assistants certified work under registered nurse supervision in medical-surgical departments and sometimes in critical care and the emergency department. In some inpatient care settings, employers reported that nursing assistants certified act as unit secretaries, pairing administrative and clinical duties. Some employers made specific reference to the effectiveness of acute care teams made up of registered nurses and nursing assistants certified, citing it as an important reason why licensed practical nurses are now infrequent in inpatient positions. Several employers in this sector had nursing assistant certified vacancies, but reported low turnover and few problems recruiting. Some stated that recruiting issues had more to do with finding candidates with the right experience and skills to interact with patients and their families than with having sufficient technically competent applicants. Others found that nursing assistant certified applicants with a long-term care background may be ill prepared for inpatient roles, and suggested that inpatient hospitals could collaborate with skilled nursing facilities to develop a nursing assistant certified workforce that can succeed in both settings.

Employers in the long-term care/home care sector employ nursing assistants certified extensively.

Most skilled nursing institutions have nursing assistants certified on staff and continue to recruit them heavily. Nursing assistants certified in these settings do nearly all the basic patient care and handling (e.g., moving, turning, lifting), which may put them at risk for injuries—one reason why skilled nursing employers reported vacancies in nursing assistant certified positions. But as patients in skilled nursing facilities have more care needs than in the past due to the trend toward shorter hospital stays, nursing assistants certified may need to learn new skills to handle the higher patient acuity. One employer suggested that this may lead to the employment of entry-level workers

other than nursing assistants certified to perform some routine functions such as feeding patients or helping them dress. This would free nursing assistants certified to focus on clinical tasks under their scope such as monitoring vital signs or caring for a catheter.

Turnover for this occupation appears to be lower in skilled nursing than in assisted living or home care organizations.

***We don't normally terminate or have people leave dissatisfied—they move on to bigger and better things...CNAs want to go to LPNs and become RNs for double the pay.***

Many skilled nursing employers prefer to hire nursing assistants certified with experience, but most will hire recent nursing assistants certified graduates either by necessity, because they further train new graduates in house, or because they have good relationships with education programs that give them first pick of the best students.

Due to the generally autonomous nature of the work, home health agencies that offer nursing services do not normally hire new nursing assistant certified graduates to work unsupervised in the patient's home. Turnover among nursing assistants certified seems to be relatively low in home health agencies.

Nursing assistants certified are often employed in substantial numbers in assisted living, where turnover is quite high, mostly attributed to low pay for a hard job and, in rural areas, to lack of training options to further their skills and to lengthy commutes: *"We don't normally terminate or have people leave dissatisfied—they move on to bigger and better things...CNAs want to go to LPNs and become RNs for double the pay."* Part-time work and lack of benefits also undermine retention.

Most assisted living employers will hire new nursing assistant certified graduates, although most cite a need for these employees to have more training and skills that include CPR, first aid, HIV, mental health, and dementia. The ability to handle clients with developmental and memory disorders is in especially high demand, and some institutions with the resources offer internal or online training in these skills, or fund attendance to classroom-based courses.

In both the skilled nursing and assisted living fields, advancement opportunities for nursing assistants certified appear limited. In this study there were rare cases of nursing assistants certified who were

administrators, and where they occurred, the employees had usually been with the facility many years.

Home care agencies stated a preference for nursing assistants certified over home care aides for entry-level positions because nursing assistants certified that perform home care aide duties are exempt from home care aide training requirements: *“We do love NACs because we don’t have to worry about the training process. If NACs apply, we get pretty excited!”* Under some circumstances, nursing assistants certified working for home care agencies provide nurse-delegated duties (e.g., bandage changing, administering diabetic injections, using a special lift chair) under registered nurse supervision.

The nursing assistant certified workforce may be less stable and more prone to turnover in home care because nursing assistants certified that are hired as home care aides receive low pay and are likely to leave for more remunerative positions. Nursing assistants certified are recruited heavily, but not always successfully, by home care employers that complain of a limited applicant pool.

While most employers expressed that they favored medical assistants in ambulatory/outpatient care settings, some nursing assistants certified were also on staff in ambulatory/outpatient care practices. Nursing assistants certified were most often utilized in a clinical capacity similar to that of medical assistants—preparing patients for examination and taking vital signs, for example—although the nursing assistant certified scope of practice is more limited (which is reportedly one reason why many employers prefer hiring medical assistants rather than nursing assistants certified). There were some exceptions to the pattern: a network of rural health clinics reported using its nursing assistants certified almost exclusively for administrative functions (e.g., medical records), while the one nursing assistant certified employed in a privately owned medical practice had the role of patient services coordinator. A small minority of ambulatory/outpatient care employers had current vacancies for nursing assistants certified.

*Geography:* Roughly half the employers surveyed along the I-5 corridor employed nursing assistants certified and did so in either acute care or long-term care/home care jobs. At least one home care services provider with multiple sites employed nursing assistants certified at most of its locations.

Two long-term care/home care employers on the Olympic Peninsula had nursing assistants certified on

staff and tended to hire from the community, a common trend in small towns.

On the east side of the Cascades, nursing assistants certified were typically on the staff of small and medium-sized hospitals, as well as assisted living and skilled nursing facilities. Some ambulatory/outpatient care settings also employed nursing assistants certified, but one network of Community Health Centers plans to phase them out of employment in favor of medical assistants. Skilled nursing facilities had more nursing assistants certified on staff than any other employer type and tended to recruit from the community whenever possible. Inpatient hospitals and affiliated clinics had little trouble attracting nursing assistants certified. Long-term care/home care employers experiencing recruitment problems fared better if they had connections to nursing assistant certified training programs or offered training themselves. Some facilities close to Idaho were successful in drawing applicants from across the border by offering higher pay.

*Demand Trend:*

- **The overall trend for nursing assistants certified seems to be moving away from ambulatory/outpatient care, with a stable presence of this occupation in acute care settings, and a growing demand in long-term care and home care.** Long-term care and home care employers are hiring nursing assistants certified and anticipate continuing to do so at a sustained pace. Several reported that they would rather have nursing assistants certified than home care aides in caregiving roles open to both occupations, in order to avoid the reported challenges of complying with the home care aide training and certification requirements introduced by Initiative 1163. Many employers in this sector struggle to fill their nursing assistant certified vacancies and retain current employees.
- **The skills and training needed in the nursing assistant certified workforce can vary by employer and available applicant pool.** Experience and adequate computer skills are required of those applying for hospital-based jobs.

Inpatient care employers need nursing assistants certified with training and skills that prepare them for the demands and fast pace of the acute care unit. They tend to prefer nursing assistants certified with inpatient experience and may be reluctant to hire those with only a long-term care/home care sector background. There are reports that some nursing assistant certified programs have begun offering

specialized training in acute care skills to support placement in inpatient units.

Providers of assisted living and skilled-nursing services need nursing assistants certified with upgraded competencies and skills more focused on direct patient care.

- **High turnover is a common problem with employment of nursing assistants certified in long-term care/home care facilities, although less so in skilled nursing than assisted living and home care.**

Employers in skilled nursing, assisted living, and home care reported losing nursing assistants certified to higher paying positions at nearby hospitals and other facilities, though hospitals that recruit nursing assistants certified from the long-term care/home care sector noted that the transition to working in inpatient care settings, with its much different pace, may be difficult.

Some employers were proud of their good retention rates for this occupation and cited strategies for their success. One assisted living facility, for example, described a careful screening and hiring process that includes telling employees that they are joining a family, followed by extensive onboarding and in-house certification training classes, if needed.

- **Nursing assistants certified use their occupation as a springboard to career advancement.** Some employers reported encouraging career moves for nursing assistants certified through internal ladders or other forms of support. In the long-term care/home care sector there were very few cases of nursing assistants certified who had experienced internal advancement and moved into administrative roles after being with the same facility many years. A common path for the nursing assistants certified in this sector seeking to advance their career is leaving to pursue nursing education.

The transition from an entry-level position to pursuing a nursing career may not be easy, however, and nursing assistants certified entering nursing degree programs may need a good deal of support to succeed.

- **Recruitment and turnover for nursing assistants certified are a problem for rural long-term care and home care employers, stemming from low pay and lack of access to nursing assistant certified training.** Some providers of assisted living and skilled-nursing services offer classes themselves if training is unavailable in their community.

In contrast, recruitment and turnover issues hardly exist in rural and urban hospitals because these are considered to be the highest paying and most satisfying employment sites available to nursing assistants certified.

## Licensed Practical Nurses

**Licensed Practical Nurses Occupation Profile:** Licensed practical nurses care for a variety of patients under the supervision of doctors or registered nurses and work in many different settings.

At the top of their scope of practice, licensed practical nurses conduct simple assessments, pass some medications, do some patient charting, and administer IV medications and fluids under supervision. At the other end of their scope they handle basic patient care such as toileting, feeding, dressing, and changing bed linens. In some circumstances, licensed practical nurses are allowed to delegate certain tasks to nursing assistants certified.\*

To become credentialed as a licensed practical nurse in Washington State, applicants must:

- Complete a Washington State Nursing program.
- Take and pass the National Council Licensure Examination for Practical Nurses (NCLEX-PN).
- Pass a background check.

Traditionally an entry point for many individuals into professional nursing, licensed practical nurses with licenses in Washington have been declining in number since 2008, when 13,751 licensed practical nurses with Washington home addresses were licensed in Washington. In 2013, 14% fewer (11,823) were estimated to be in the Washington State workforce.<sup>16</sup> The national trend appears different from Washington's. The U.S. Bureau of Labor Statistics identified 752,300 licensed practical nurse positions in 2010 and forecast a 22% increase in the number of positions, or 168,500 jobs, between 2010 and 2020.<sup>17</sup>

\* Under provision of Washington Administrative Code 246-840-010.

### Findings:

**Employment Settings and Roles:** Over half of the employers surveyed said that they had licensed practical nurses on staff. Despite a trend toward fewer licensed practical nurse licenses in Washington State, these entry-level workers are still relevant and sought after in rural areas, long-term care/home care (especially skilled nursing facilities), and in the mental health/chemical dependency field. Licensed practical nurses were also deployed in inpatient units and in ambulatory/outpatient care settings, including school districts, primary care and specialty clinics, Community Health Centers, and correctional facilities.

Most employers of licensed practical nurses deploy them for clinical functions and direct patient care, but some ambulatory/outpatient care practices also rely on them for administrative, health information technology-related, and care coordination tasks.

**Recruitment Issues:** Licensed practical nurses in many organizations are legacy employees whose positions will not be filled when they become vacant. However, employers that report they would hire licensed

practical nurses said that few apply for open nursing positions (“*We could hire an LPN—we just never had one apply*”), perhaps because new graduates of licensed practical nurse programs move on quickly to other nursing degrees. The experience of at least one employer in the mental health field suggests that some licensed practical nurse education programs may not be providing enough capacity to meet current and future student demand.

**Employment Sector:** There seems to be a consensus that licensed practical nurses are being phased out of hospitals, particularly (but not exclusively) those that are part of large urban facilities, and many hospital systems have laid off licensed practical nurse staff in recent years. One hospital-based employer provided a possible rationale for this shift, explaining that due to their more limited scope, licensed practical nurses were not as useful as registered nurses in the inpatient units, and were more expensive than medical assistants in the outpatient clinics.

Inpatient mental health services employ licensed practical nurses, although not in large numbers.

School districts, correctional facilities, and other ambulatory/outpatient care practices employ licensed practical nurses consistently, but the numbers are usually small relative to other entry-level occupations. An exception is the state's correctional system, where licensed practical nurses are the most numerous clinical occupation, second only to registered nurses. In ambulatory/outpatient care, the demand for licensed practical nurses seems to be diminishing, with some outpatient locations planning to replace them with registered nurses in roles requiring a nursing license. Some small medical practices surveyed were still looking to fill licensed practical nurse vacancies. Where employed in ambulatory/outpatient care settings, licensed practical nurses were relied on for their long experience and the diverse tasks they could perform under their scope of practice. This ability to be a sort of "jack-of-all-trades" was especially useful in small practices and rural facilities.

Outpatient mental health facilities employed licensed practical nurses for tasks including dealing with pharmacies and prescription paperwork, coordinating blood work, and supervisory duties. At least one mental health provider was recruiting for licensed practical nurse roles, but commented on how hard it was to find applicants with experience in psychiatric care.

Some observe that the long-term/home care sector is the one niche where licensed practical nurses retain the most value, given their scope of practice and skills. Providers of skilled nursing services, assisted living facilities, and (in smaller numbers) home care/home health agencies have licensed practical nurses on staff in mostly clinical nursing positions and sometimes performing patient navigator roles.

Licensed practical nurses were an especially substantial presence in skilled nursing facilities. One such employer described a great deal of success with having licensed practical nurses on staff: *"I have had my LPNs and master level nurses and some of my LPNs put those MA [master's level] nurses to shame. Depends on attitude, their willingness to learn and continue to grow. Couple that with a few years' experience and*

*you have a top-notch nurse."* Others remarked that the right "fit" for the position mattered more than whether applicants for nursing positions were registered nurses or licensed practical nurses.

These views were by no means universal: some employers expressed a need for more registered

nurses in nursing homes to replace licensed practical nurses as they age out of their current roles. Others considered the long-term care/home care sector's ongoing reliance on licensed practical nurses to be part of a repeating cycle in which a preference for the broader registered nurse scope of practice and skillset alternates with that for the lower-cost licensed practical nurses. *"They have tried for years to phase out LPNs...Every 10 years or so, [they say] 'we're going to go all RN.' Then that gets too expensive and they add back NACs and LPNs."*

*Geography:* The trend toward phasing licensed practical nurses out of many inpatient and some ambulatory/outpatient settings is reportedly stronger in urban areas of the state, but remains decidedly mixed. In southeastern Washington, one medical center debated whether or not to fill a recent licensed practical nurse vacancy, while another clinic with no licensed practical nurses on staff was looking to hire one. In contrast, licensed practical nurses were employed at extended care facilities and home care agencies in the Tri-Cities and the Spokane area, confirming that the long-term care/home care sector remains a viable employment niche for this occupation.

West of the Cascades, a few large inpatient and outpatient employers in King County have licensed practical nurses on their staff, but in varying numbers, and some are no longer hiring this occupation. Other ambulatory/outpatient practices and mental health facilities along the I-5 corridor employ some licensed practical nurses and are recruiting. In this area licensed practical nurses are employed in skilled nursing and home care agencies as well.

In rural Washington, some small, hospital-based systems employ and recruit licensed practical nurses, mostly in clinics and rarely in inpatient roles. In rural places both east and west of the mountains, and on the Olympic peninsula, small medical practices,

***They have tried for years to phase out LPNs...Every 10 years or so, [they say] 'we're going to go all RN.' Then that gets too expensive and they add back NACs and LPNs.***



Rural Health Clinics, and school districts also employ licensed practical nurses, as do skilled nursing facilities.

*Demand Trend:*

- **The demand trend for licensed practical nurses is far from clear.** Workforce supply statistics suggest a diminishing role for licensed practical nurses in the state's health care industry, and employers overall had few licensed practical nurse vacancies. However, some employers who still recruited licensed practical nurses reported having a hard time filling their open positions, indicating that overall low supply numbers may be contributing to the perception of a shrinking need for this occupation.

Many employers said that they did not have licensed practical nurses on staff and had no plans to hire them. Some employed a small number of licensed practical nurses who had been with them for many years, but were not anticipating any new hires.

Outside of the long-term/home care sector, employers reported employing smaller numbers of licensed practical nurses than other types of clinical occupations such as medical assistants, nursing assistants certified, and associate's degree registered nurses.

Long-term care/home care organizations reported an increased need for nursing skills but often expressed no preference for registered nurses over licensed practical nurses and more commonly employed licensed practical nurses to fulfill that need. Overall, the demand for licensed practical nurses is expected to continue in the long-term care/home care sector, where they can aspire to achieving leadership roles, such as supervisors and administrators.

Most employers agreed that licensed practical nurses were being phased out of hospitals, particularly large urban facilities. In these settings, their scope of practice is considered inefficient because it is more limited than that of registered nurses.

- **Licensed practical nurses' ongoing viability, where employed, may be attributed to their lower pay rate in settings such as school districts that are under severe budgetary constraints and have limited ability to pay registered nurse salaries.** A school district employer commented: *"If a student has a health condition with a physician order, the District tends to hire LPNs to come in since they are less expensive. The last time we hired an additional BSN was in 2000."*

## Associate's Degree Registered Nurses

**Associate's Degree Registered Nurses Occupation Profile:** Associate's degree registered nurses work across the health care delivery spectrum, including hospitals, skilled nursing homes, and ambulatory/outpatient care settings. Associate's degree registered nurses are involved in all aspects of patient care, including administering injections and medication, developing patient care plans, maintaining medical documentation, and interacting with doctors regarding patients. Associate's degree registered nurses also supervise nursing assistants certified and licensed practical nurses.

To become licensed as a registered nurse in the state of Washington (whether educated at the diploma, associate's degree or bachelor's degree levels), applicants must:

- Graduate from an approved nursing program.
- Pass the National Council Licensure Examination for Registered Nurses (NCLEX).

In 2008, slightly over half of all registered nurses in the United States had associate's degrees or nursing diplomas (15.5% diplomas and 36.2% associate's degrees).<sup>18</sup> The Institute of Medicine's *Future of Nursing* report<sup>19</sup> recommends that the proportion of nurses with baccalaureate degrees be increased to 80% by 2020.

Nationwide, the U.S. Bureau of Labor Statistics identified 2,737,400 jobs for all registered nurses in 2010 and forecast a 26% increase in the number of positions, or 711,900 between 2010 and 2020.<sup>20</sup>

### Findings:

**Employment Settings and Roles:** Associate's degree registered nurses in Washington are currently employed across inpatient care, ambulatory/outpatient care, and long-term care/home care settings.

Associate's degree registered nurses, as described by employers interviewed for this study, are usually a substantial proportion of the overall registered nurse staff in small and medium-sized facilities and in rural places. Large urban systems employ associate's degree registered nurses as well, but in diminishing numbers as their preference shifts toward hiring bachelor's degree registered nurses and/or encouraging associate's degree registered nurse employees to progress to the bachelor's level. Associate's degree registered nurses and bachelor's degree registered nurses often work side by side, and some employers were unable to distinguish between the two when they provided current employment and future demand information.

A number of facilities stated that they considered associate's degree registered nurses' education and skillset appropriate for most clinical nursing positions, though bachelor's degree registered nurses were frequently favored for specialty, administrative, and leadership roles.

Even employers who employ associate's degree registered nurses now and who plan to continue to do

so in the future maintain that the industry as a whole is moving toward hiring predominantly bachelor's degree registered nurses, often citing the Institute of Medicine's *Future of Nursing* report as one important reason for this trend. Some employers said that any future shortages of registered nurses could affect this tendency, as in past shortages that led employers to seek out available registered nurses regardless of education.

**Employment Sector:** The demand for associate's degree registered nurses is declining in many inpatient hospitals, where a preference for bachelor's degree registered nurses is taking hold. Some of the strategies cited for encouraging more bachelor's level registered nurses among the workforce include hiring only bachelor's degree registered nurses, hiring associate's degree registered nurses only on condition that they attain a bachelor's degree in nursing within a certain time period, and offering internal ladders and related help such as tuition assistance programs to support achieving that goal. Washington's Center for Nursing and the Washington Nursing Action Coalition, with support from the Robert Wood Johnson Foundation, are working with employers across the state to identify ways to encourage associate's degree registered nurses under their employ to attain nursing bachelor's degrees.

These trends seem stronger in urban areas, but are not unique to them. Some small- to medium-sized facilities in Central Washington are taking steps to achieve the 80% proportion of bachelor's degree registered nurses on their staff that is recommended by the Institute of Medicine report. However, other rural hospitals said that they did not plan to change how they staffed their registered nurse positions and continued to recruit associate's degree registered nurses.

Most privately owned medical practices, Community Health Centers, and Rural Health Clinics in this study employed associate's degree registered nurses. However, some of these settings have been looking to expand how they utilize their medical assistants, therefore shifting their registered nurses staff away from tasks such as administering immunization, and toward functions that only registered nurses can perform, such as triaging patients. This move away from registered nurses could have an effect on demand, although this is likely balanced out by the majority of employers of associate's degree registered nurses who plan to continue to hire this occupation. For example, a few rural primary care practices planned to increase their number of providers and will need more registered nurses (likely associate's degree registered nurses, as is often the case in rural Washington). Specialty practices were likely to have registered nurses on staff, as were some outpatient clinics in hospital-based systems, though it was unclear whether these were associate's degree or bachelor's degree registered nurses.

Registered nurses are an important presence in long-term care/home care, but employers did not often distinguish between associate's degree registered nurses and bachelor's degree registered nurses, stating sometimes that they did not favor one over the other, and that they preferred a mix in other cases. Registered nurses were relied upon to generate care plans—something licensed practical nurses cannot do—and tended to occupy care coordination or supervisory roles. At least one employer—a skilled nursing facility—mentioned the challenge of maintaining safe nurse staffing ratios, given the greater demands posed by growing patient acuity.

*Geography:* There is clear variability in employer demand for associate's degree registered nurses across the state, influenced by factors that can include distance from bachelor's nursing programs, whether the available hiring pool is limited to or extends beyond the local community, or pay differentials between associate's degree registered nurses and bachelor's

degree registered nurses in certain roles and facilities. Most geographic differences seem to fall along the rural/urban dimension, rather than reflecting regional variations. Employer size and population base also play a role: larger organizations or those based in denser population areas on both sides of the Cascades share similarities, with a trend toward hiring fewer associate's degree registered nurses, while they differ markedly from smaller providers and Critical Access Hospitals.

Rural employers are likely to hire associate's degree registered nurses for most nursing positions. While these employers may or may not express a preference for associate's degree registered nurses, their employment market may limit their access to bachelor's degree registered nurses, and they may be committed to hiring from local communities where most registered nurses have associate's degrees. However, even in small rural hospitals, bachelor's degree registered nurses tend to be preferred for specialty roles. Career ladders or organizational support for further education—particularly for associate's degree registered nurses to attain bachelor's degrees—are also scarcer in rural areas, although there are exceptions. For example, a rural employer in the northeast part of the state encouraged its nursing staff to participate in distance learning programs to advance their nursing education.

Such associate's degree-to-bachelor's degree educational and career ladders tend to be more common in large urban institutions, where the preference for bachelor's degree registered nurses is more widespread and pursuing an advanced degree may be a condition of employment for associate's degree registered nurses.

*Demand Trend:*

- **Most employers who use associate's degree registered nurses now will continue to do so.**
- **Overall demand for associate's degree registered nurses in the state can be expected to increase moderately.** The moderate demand growth for associate's degree registered nurses will likely not be uniform across sectors. Some inpatient care facilities, but not others, are showing a preference for bachelor's degree registered nurses. Some ambulatory/outpatient care employers who favor medical assistants in ambulatory/outpatient care roles are no longer hiring registered nurses or are planning to let their registered nurse staff dwindle by attrition. But others are still looking to fill registered nurse vacancies. In the long-term care/home care

sector, a need may be emerging for larger numbers of registered nurses relative to licensed practical nurses. One urban hospital described a high registered nurse turnover rate, but it is unclear whether retention of registered nurse staff is a widespread problem.

Employers in general continue to recruit registered nurses (especially for on-call duties, per diem positions, and less desirable shifts), despite easing of earlier shortages and reports of registered nurses without jobs. However, some employers fear a new looming shortage as many of today's registered nurses begin retiring soon, and this could also increase the demand for associate's degree registered nurses.

Demand for specialty nurses can increase the market for associate's degree registered nurses. In the highly sought-after specialties, experience is

usually considered more important than length of education alone. Specialty nurses, especially those with a psychiatric background or experience in the operating room, obstetrics, or intensive care, are frequently hard to find. There are reports of hospitals relying again on travel nursing to fill these roles, as they did during earlier nursing shortages.

Years of training may differentiate whether bachelor's degree or associate's degree registered nurses are tapped for patient navigator roles, especially when handling the needs of complex or high-risk patients and populations. Some employers believe that the role requires advanced critical thinking and problem-solving skills, which are thought to be harder to acquire from an associate's degree nursing program.

## CROSS-CUTTING ISSUES

### Health Care Reform: The Patient Protection and Affordable Care Act (PPACA) and Changes in Health Care Financing and Delivery

Many employers expressed uncertainty about the content and effects of the federal Patient Protection and Affordable Care Act. When asked about the law's ramifications, especially for workforce demand, health care industry representatives were generally hesitant to offer projections. Comments such as *"I don't know,"* *"It's hard to say,"* and *"We'll have to wait and see"* were widespread.

Exceptions were facilities interviewed for this study that relied heavily on Medicare and Medicaid payments, where good patient outcomes are understood to be linked to reimbursement. From hospitals to Community Health Centers, many of these facilities are focusing on stepped-up care coordination efforts to deliver more efficient and effective care to high-risk patients, and bring costs and clinical outcomes in line with more stringent reimbursement rules. Community Health Centers and other organizations that anticipate an increase in patients due to expanded access to insurance coverage for Washington's residents are preparing *"because [they] have to"* due to their safety net role and commitment to serving all patients who seek care. Long-term care/home care settings such as skilled-nursing facilities talked about courting closer partnerships with nearby hospitals to ensure that re-hospitalizations are prevented. In most cases, the workforce implications of system changes brought on by the health reform law had yet to be worked out.

Still, among most respondents, little advance planning for workforce demand changes appears to be taking place. Some employers who expect growing workforce demand as a result of greater service utilization potentially enabled by the health reform anticipate a gradual rise that may not be truly visible until at least 2015. Some others, however, expect a rapid *"explosion"* of ambulatory/outpatient care and consequent demand for personnel to work in those settings.

Across all sectors, employers seemed to expect that payment reform will mean a requirement to do more with less, which will affect their staffing decisions. This was especially true in long-term care facilities. Several employers noted that hospital stays have shortened in recent years, and nursing homes and skilled nursing facilities (where patients who are not yet ready to be moved home are being discharged for rehabilitation) are caring for patients with greater

medical needs than in the past. The occupations and skillsets needed to staff these facilities will likely change as a result.

### Care Coordination and Related Functions and Roles

The need for effective coordination of patient care across health services, pivotal to the system transformation now underway, will likely expand as the Patient Protection and Affordable Care Act and related reform measures go into full effect. Coordination ensures that information is shared among the people, and across the functions and sites, that deliver care in order to serve patients' needs and preferences as they interact with a complex system. The intended effects include higher patient satisfaction, better health outcomes, and cost savings. The goals of these efforts seem clear, but the functions and tasks comprising patient care coordination—and who should perform them—are less definite.

Descriptions of what constitutes care coordination seem as diverse as types of health care practices. Asked about care coordination in their organizations, respondents in this study cited many coordination functions:

- Insurance and/or provider referrals.
- Appointment scheduling/follow-up.
- Working with family members (cited as particularly important in long-term care settings).
- Helping patients manage different providers/services/medications.
- Tracking high-risk patients, including updating metrics and preparing reports on populations such as diabetics.

Some employers differentiated health coaching tasks (e.g., helping clients and patients adopt healthy behaviors) from care coordination functions while others did not. The spectrum of roles and occupations involved in care coordination appears equally diverse: case manager, referral coordinator, and patient navigator, are but a few designations. One mental health services organization delivers all its care using a team model that includes multiple treatment coordinators on each team. Other organizations also have adopted interdisciplinary teams as the fulcrum of their care coordination efforts. Front office staff—from clinic manager to billing specialists and receptionists—may engage in care coordination by trying to steer patients toward appropriate resources within the health care system as well as the community at large.

Community health workers—volunteer or salaried—have been tapped for such outreach functions as providing diabetes education and promulgating healthy lifestyle principles. Some rural clinic workers seek to reach migrant workers through “pre-medical” wellness community outreach. Other practices divide functions among multiple staff members. Some employers have created and staffed patient care coordination positions but have yet to finalize the official title or job description.

Depending on health care sector, employment setting, and type of care provided, a clinical background may or may not be required to perform care coordination functions. As mentioned by employers and stakeholders, all of the occupations targeted in this report can be found in formal or informal patient care coordination roles. Home care aides, for example, were reported to engage in routine but informal and often unrecognized care coordination functions. Often the person who tends most closely to his/her client’s daily needs, the home care aide is likely to help with medication reminders, alert providers or family members when something is amiss, and arrange transportation to the next doctor’s appointment. Among the employers interviewed for this study, medical assistants and registered nurses are being tapped for coordination roles in ambulatory/outpatient care, registered nurses in inpatient care, and licensed practical nurses and registered nurses (and to a somewhat lesser extent nursing assistants certified) in long-term care and home care settings. Regardless of the official title, several interviewees reported that the professional responsible for care coordination tended to have many years of experience, often within the particular setting.

Some employers reported long-term use of care coordinators of varying types. In one case, a patient navigator role was in place that used one or more persons coordinating services across clinics and settings for high-risk populations such as diabetics. Other organizations have deployed patient navigators in dedicated roles to assist cancer patients, either in the context of their medical services or to help navigate community resources. At least one urban hospital-based system reported finding that care coordination efforts that encourage patients to stay healthy and avoid unnecessary services result in more efficient resource utilization. One rural long-term care/home care employer noted that in their community a patient’s family used to take on care coordination, but as the community has changed, the responsibility has fallen more on the care providers.

## Adoption and Use of Health Information Technology (HIT)

Providers are in varying stages of navigating the transition to use of electronic medical records and health information technology within their practices. In order to better understand the workforce impact, employers were asked about their adoption of health information technology and its use by entry-level workers. Except in some of the smallest offices, electronic health records are widely in use. Other computerized systems to support care delivery vary across clinical settings and can range from specialized systems for medication management to fully electronic charting, electronic referrals, and insurance billing.

Most workers in these five occupations handle some aspect of health information technology. The assumption that younger health care professionals have an easier ability to adapt to technology was a pervasive concept among the interviewed employers. Medical assistants and registered nurses were most likely to have both front office and clinical duties requiring health information technology skills. Nursing assistants certified working in inpatient units are increasingly required to have the skills to use computerized systems. In fact, computer proficiency is one area where some employers considered nursing assistant certified education to be deficient. Employers did not cite computer-based tasks and related required competencies for home care aides at this time. Employees engaged in care coordination, regardless of occupational background, routinely were reported to use electronic health records and other forms of health information technology.

As a result, employers consider general computer proficiency an essential skill for new hires. One hospital-based rural employer preparing to adopt a health information technology system anticipated screening for electronic health records experience among its new applicants. A busy Community Health Center in a metropolitan area complained that specific training in electronic health records is difficult to find among most graduates of medical assistant programs. While many employers have provided on-the-job health information technology training for entry-level employees, doing so is difficult for organizations with limited staff or high patient volumes.

Even where health care workers receive training in an educational setting, the system they trained on may not be the one used in the clinic (electronic health records training simulators are reportedly not readily available). While having some health information technology training prior to employment is better

than having none, training a new graduate to use an unfamiliar electronic health records system on the job puts an additional burden on the employer.

### Partnerships with Local Education Institutions

Many employers look to partnerships with local education institutions as important tools for ensuring the availability of employees in sufficient numbers and with the skills they need. These partnerships take place in both urban and rural areas and can take various forms. Health care facilities may host clinical rotations or externships for nursing or medical assistant students; a facility staff member may serve as an instructor at a nearby education program or sit on its advisory board. Local education programs are also relied upon to help employees obtain continuing education required by credentialing rules and acquire needed specialized skills in areas such as dementia, developmental disorders, and mental health.

Employers who reported partnerships with educational institutions said that they benefitted from gaining access to pools of potential applicants. Success with these relationships seemed to influence their assessment of what workforce demand challenges may lay ahead.

Some employers proposed that another kind of partnership—one developed between health care organizations—could facilitate employees' movement and transferring of skills and training acquired in one organization to the other. This would help both employees, who would have access to a wider career path, and employers, who would benefit from the accrual of skills in the available workforce. Stated barriers to implementing a similar model included competitive market pressures and possible reticence to sharing proprietary organizational information.

Most employers expressed education needs that went beyond each of the five occupations' education requirements. For example, having a more sophisticated general education background was considered desirable by many employers. At least one thought that education in population health would help entry-level workers better understand their jobs as part of a continuum of care, rather than episodic care-delivery events.

### Recruitment and Retention: Issues and Strategies

Most health care employers face challenges in recruiting and retaining entry-level workers, but some locations and employment settings can exacerbate the situation. Turnover is high in the twelve correctional facilities that make up the state's prison system. Practices in small or isolated rural communities also face special problems attracting and retaining a health workforce that fits their needs.

For the occupations with low salaries, making the job more attractive to prospective employees is far from mysterious. Most employers agree that adequate pay and benefits are essential. Other valuable recruitment and retention tools reported by a number of employers include opportunities for professional development and learning new skills; having a path for moving up an established career ladder; being able to transfer education credits statewide; and flexible scheduling, tuition

support, and loan repayment programs that facilitate education. Although employees may leave to pursue professional advancement, some employers supported their employees' professional growth and accepted the turnover.

Careful hiring practices were cited as possible remedies to recruitment and turnover challenges: *"We're looking for folks who can not only do the right technical skill but also treat the patient or their family member in a respectful, customer-oriented way."* *"[It] really goes back to people's ability to apply critical thinking skills and the ability to handle change. ...health care is not a great vocation for folks that want things to be the same over and over again."* Employers also said that efforts to develop better supervisors and leaders in health care organizations could help improve employee retention. Long-term care institutions noted that high retention rates were often associated with such intangibles as a family environment, valuing employees' "soft skills," and varying employees' tasks to keep the work interesting. Larger organizations, despite citing turnover as a problem, seemed to understand and expect that lower-paid workers such as nursing assistants certified will move on either to become nurses or go to higher paying positions. Smaller facilities experienced more severe disruption from the rapid turnover of employees.

***We're looking for folks who can not only do the right technical skill but also treat the patient or their family member in a respectful, customer-oriented way.***

Employers acknowledged that a diverse workforce is needed to mirror the state’s population and deliver high-quality, culturally sensitive care. Some look for bilingual proficiency in new applicants. Others mentioned the importance of not just retaining but helping frontline workers from ethnic and cultural minorities advance, in order to change the workforce complexion at all organizational levels.

### Employment Sectors

Organization size and resources affected how inpatient care, ambulatory/outpatient care, and long-term care/home care employers deployed their entry-level workers and what tasks they performed. Versatility and being able to wear many different hats are at a premium in small settings. Nursing personnel in some of the smallest rural hospitals may be asked to alternate work on the hospital floor, the emergency department, or swing skilled nursing beds. In small ambulatory/outpatient care and long-term care/home care facilities, patient care coordination functions may be performed by different staff members based on availability and need. Larger organizations were more likely to define specific roles for their staff and to deploy specific occupations to cover those roles. For example, larger hospital-based systems mostly relied on medical assistants only (rather than nursing assistants certified or licensed practical nurses) to fill entry-level positions in their outpatient clinics, but did not report utilizing medical assistants in their inpatient units.

Employee turnover seemed higher in larger organizations than in smaller practices, but large employers, particularly urban ones, cited few problems recruiting applicants and usually filled their open positions quickly. Long-term care/home care facilities may be an exception to this pattern—many employers in this sector indicated that they struggled with recruitment and turnover issues, although the ensuing organizational disruption had greater affect on smaller facilities.

Larger and better-resourced employers tended to facilitate—and sometimes require—their entry-level employees’ career advancement or pursuit of further education and training. In contrast, some smaller

organizations mentioned encouraging those goals, but said they were unable to allocate funds to support them.

The patient population served also affected employers’ staffing choices and challenges, regardless of industry sector. A majority of employers stressed the importance of excellent caregiving skills for their employees, but this was especially important for those addressing the needs of vulnerable populations such as the elderly and the mentally disabled. Patient diversity led many employers to seek bilingual and culturally sensitive applicants, while facilities serving rural populations

preferred local applicants with close ties to the community. The limited patient base available to some rural facilities also tends to limit their resources, as does dependence on state and federal reimbursement structures, which in turn affects current and expected workforce demand.

### The Role of Geography

The main geographic differences uncovered from this study relate to rural-urban issues of access to the workforce pool, education resources, and reimbursement. These rural-urban differences were consistent among employers across the state.

***[It] really goes back to people’s ability to apply critical thinking skills and the ability to handle change. ...health care is not a great vocation for folks that want things to be the same over and over again.***

**Access to Employees:** Recruiting and retaining employees with desired skills in sufficient numbers ranks high on the list of rural employers’ concerns. Rural practices said that they preferred to hire personnel from within their communities whenever possible. But small communities offer a limited applicant pool for entry-level positions, a situation that some fear could worsen as some of these communities suffer population loss. Facilities in remote places cite few recruitment amenities (“*We don’t have a Costco*”), low wages, and long commuting distances from larger population centers as obstacles to recruiting already-trained and certified personnel from outside the community. For example, one outpatient clinic that hired a medical assistant from a nearby town after a long search still defines its staffing situation as “unstable” for fear that the new recruit will eventually tire of the commute and leave the job. A remote school district was also afraid of losing the last in a succession of school nurses due to commuting distance.



**Reimbursement levels are not enough to have sufficient staff in place.**

Because rural employers are often not in close proximity to education programs, their access to workforce supply is limited, creating another barrier to fulfilling demand for entry-level workers. On the plus side, rural employers who draw most of their entry-level workforce locally report a good deal of employee longevity, citing examples of staff with as many as 30 years of tenure.

**Access to Training:** Many long-term care/home care sector employers in rural areas said that they were affected by a lack of accessible education programs for nursing assistants certified and home care aides, who make up the bulk of their employees. To be certified, nursing assistants and home care aides must fulfill state-mandated training requirements within strict time limits after they are hired. Yet access to training and testing sites is reportedly problematic in many rural places. Some employers have overcome these barriers by offering training or continued education in house, particularly in rural areas where this strategy helped address nursing assistants certified shortages and comply with the new home care aides training requirements.

Difficulty accessing education is also responsible, in part, for the way rural employers staff their registered nursing positions. While other factors are at play, a lack of four-year nursing degree programs in rural communities means that associate's degree registered nurses continue to be a large percentage of the available applicant pool. That may be about to change, as more colleges are now offering distance-learning opportunities.

**Access to Reimbursement:** With the already-existing pressures to provide quality care more efficiently, some rural employers were especially concerned about funding sources for some of the new care coordination tasks and roles that are emphasized in the approaching health care system overhaul.

Because rural facilities are disproportionately dependent on Medicare and Medicaid reimbursement, which typically reimburse at lower rates than commercial insurance, they are especially vulnerable to rising costs and/or changes in federal and state payments flows and rates: *“Reimbursement levels are not enough to have sufficient staff in place.” “I don’t see how we could survive...without the Rural Health Clinic designation...we’re in a very old building. We’re tight, we’re cramped, we have no space...but it allows us to treat all the kids. If they took that designation away, I’m afraid we’d be in a different situation.”*

***I don’t see how we could survive...without the Rural Health Clinic designation...we’re in a very old building. We’re tight, we’re cramped, we have no space...but it allows us to treat all the kids. If they took that designation away, I’m afraid we’d be in a different situation.***

## SUMMARY OF KEY FINDINGS

### Who employs home care aides, medical assistants, nursing assistants certified, licensed practical nurses, and associate's degree registered nurses now? In the future?

Many employers are re-examining how best to employ entry-level workers.

- Among these occupations, hospital employers are predominantly relying on care teams composed of registered nurses and nursing assistants certified. Ambulatory/outpatient care practices are employing more medical assistants than other entry-level occupations. Both trends are expected to strengthen in the near future.
- The long-term care/home care sector relies heavily on nursing assistants certified and home care aides, as well as some licensed practical nurses and registered nurses. This pattern seems stable, with the demand for nursing assistants certified and home care aides expected to grow. Changing patient/client needs, however, along with regulatory and reimbursement challenges, may shift how these occupations are deployed, and in what numbers.
- Larger employers, especially hospitals, are employing fewer licensed practical nurses. The market for this occupation is becoming increasingly centered on select geographic and industry pockets.

### What will employers need?

- Some employers expect higher patient volume and acuity, but are unsure about bringing on more workers, given financial pressures and uncertainty about how they will be affected by changes in health care delivery systems.
- Some home care agencies and ambulatory/outpatient care facilities that have been expanding expect to add staff, including these five occupations.
- More expensive training and a higher credentialing bar for some entry-level occupations are leading many employers to screen applicants more carefully.
- Many employers look for applicants with “soft skills,” such as strong customer service and communication skills and a commitment to caregiving.

- Experience is prized by smaller organizations that can least afford training, have limited staff, and need new employees to perform effectively shortly after being hired.
- Most employers need entry-level workers who are computer proficient, familiar with electronic health records, and able to perform at the top of their training and scope of practice. Other specific needs vary by occupation and industry sector, as organizations rethink their staffing models and optimize their workforce to achieve both cost savings and good patient outcomes.
  - Ambulatory/outpatient care employers need highly trained medical assistants, with skills that include delivering immunizations and performing blood draws, tasks more typically carried out by nursing staff in the past.
  - Long-term care/home care employers need nursing assistants certified with upgraded skills and competencies to respond to patients' greater acuity. These employers also need home care aides and nursing assistants certified with specialized training in mental health, memory disorders, and emergency care.

### How can existing problems be eased?

- Partnerships with local education institutions can be very effective. Many employers maintained strong ties to these assets and sought to expand them when possible. Online and in-house training solutions help rural employers satisfy their demand for entry-level personnel, particularly home care aides, medical assistants, and nursing assistants certified.
- Employers cited a number of strategies to improve recruitment and retention of entry-level occupations. They include not only adequate pay and benefits, but also pathways for education and career advancement supported by internal opportunities, flexible scheduling, transferable education credits, tuition support, and loan repayment programs.

### To what extent will these occupations be tapped for care coordination?

- Where a need for a distinct patient navigator or care coordinator position has been identified, there is no consensus on which, or how many, of these

occupations should fill this role. Employers vary greatly on whether care coordination functions will be performed by an entry-level position or will require advanced education and/or credentials.

- Employers that are anticipating the greatest need for care coordination services expressed concern about adequate reimbursement to cover the costs of providing these services.
- Very few organizations have current job openings for patient navigator or care coordinator positions. Many employers are waiting to assess the needed functions, staffing, education, and reimbursement structures that relate to care coordination roles.

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## APPENDIX A: METHODS

Between April and July 2013, Washington health care employers were contacted statewide and across industry sectors and asked about their current and anticipated demand for five key occupations: home care aides, medical assistants, nursing assistants certified, licensed practical nurses, and associate's degree registered nurses. Employers' views were collected using a two-pronged qualitative approach: 1) semi-structured phone interviews guided by a common set of questions to focus and direct conversations; 2) two invitational forums to review and discuss preliminary interview results with employers and stakeholders and gather additional information to complement interview findings.

Employers to be contacted for interviews were selected from a list assembled by the researchers from a variety of web-based sources, such as facilities and provider listings available on state association websites (for example, the Washington Hospital Association\*) and from the Washington State Department of Health.† This resulted in a listing of well over 1,000 health care organizations reflecting a variety of employment sites across industry sectors statewide. They included:

- Inpatient care: acute care hospitals; mental/behavioral health facilities.
- Ambulatory/outpatient care: urgent care /retail clinics; tribal clinics; Rural Health Clinics; Community Health Centers; ambulatory surgical centers /other outpatient clinics (including mental/behavioral health and chemical dependency); correctional facilities; school districts, and medical practices not otherwise categorized.
- Long-term care/home care: skilled nursing facilities; extended care facilities (including rehabilitation facilities and long-term critical care hospitals); home care/home health agencies; and assisted living facilities.

Sample selection was driven by the study's goals of capturing both geographic variation and breadth of employment settings for the five occupations. Organizations included in the sampling frame were purposefully stratified by Workforce Development Area (WDA), industry sector, and setting/facility type, and assigned random numbers. Fifty-three employers were

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\* Washington State Hospital Association. Membership listing (alphabetically). <http://www.wsha.org/0111.cfm>. Accessed July 15, 2013.

† Washington State Department of Health. Home page. <http://www.doh.wa.gov/>. Accessed July 15, 2013.

<sup>37</sup> selected at first. Because of the initially low interview response rate, the process was repeated multiple times, aiming to obtain the desired target of 75 employer interviews. Another 300 employers were randomly chosen and mailed letters describing the study and inviting participation. In addition to using the sampling technique just described, employers were contacted based on referrals and existing industry contacts.

Stakeholders with relevant knowledge and expertise were also contacted for interviews. Employers and key informants were contacted up to three times via e-mail and/or by phone. Once contacted, those willing to participate were posed a set of questions informed by the study's aims. Each interview lasted between approximately 15 and 40 minutes. In all, 75 employers were interviewed for this study. Interview notes and transcripts were analyzed for themes salient to employers' current and projected workforce demand in different parts of the health care industry and the state.

Preliminary interview findings were validated by being presented and discussed at two forums: one on May 31, 2013, near Spokane Valley, in Eastern Washington, and the other on June 3, 2013, in Sea-Tac, in Western Washington. The forums were organized by the Western Washington Area Health Education Center through a sub-contract to the University of Washington Center for Health Workforce Studies.

Forum participants included industry hiring experts and other relevant stakeholders. This brought the total number of employers participating in this study to 86. Forum attendees were asked to react to the initial interview results and share their knowledge and experience in the course of facilitated group discussions. Key themes that emerged from these exchanges were collected, summarized, and integrated with interview responses to generate this report's findings.

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# **Long-Term Services and Supports: Nursing Workforce Demand Projections 2015-2030**

**March 2018**

**U.S. Department of Health and Human Services  
Health Resources and Services Administration  
Bureau of Health Workforce  
National Center for Health Workforce Analysis**



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### Suggested citation:

U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. 2017. Long-Term Services and Supports: Nursing Workforce Demand Projections, 2015-2030. Rockville, Maryland.

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## Overview

Long-Term Services and Supports (LTSS) are the paid and unpaid medical and personal care provisions that people need when they experience difficulty living independently and completing daily self-care tasks. These difficulties are generally the result of disabling conditions and chronic illnesses. LTSS are delivered in both institutional (e.g. nursing homes) and home and community-based settings (e.g. adult day centers). Combined, Registered Nurses and Licensed Practical Nurses currently represent about one quarter of the LTSS workforce. **This report contains demand projections for Registered Nurses and Licensed Practical Nurses working in LTSS.** A companion report, also prepared by HRSA, presents demand projections for Direct Care Worker occupations in LTSS.

The analysis is conducted using the Health Resources and Services Administration’s “Health Workforce Simulation Model.” This model is an integrated microsimulation model that can estimate current and future supply of and demand for healthcare workers from multiple professions and in multiple care settings.<sup>1</sup> The primary (or “baseline”) scenario in this model assumes that demand equals supply in the base year.<sup>2</sup> Demand for selected nursing occupations in LTSS is projected up until the year 2030, with 2015 serving as the baseline year. Two important limitations for demand projections in this baseline scenario are: (a) the underlying assumption that health care delivery and practices in the base year (2015) will not change substantially in the future (by 2030), and (b) that there will be stability in the current rates of health care utilization. A second, “alternative” demand scenario is also modelled for this report. This alternative scenario takes into account potential changes in population health and models the impact these changes would have on demand for nursing occupations in LTSS.

While this report does not provide projections for the future supply of Registered Nurses and Licensed Practical Nurses in LTSS, it does discuss current supply of those occupations. Forecasting the future nursing workforce supply in LTSS is challenging because future setting-

<sup>1</sup> For additional information about HWSM, please see the technical documentation at [Technical Documentation for Health Resources Service Administration’s Health Workforce Simulation Model](#)

<sup>2</sup> Ono T, Lafortune G, Schoenstein M. “Health workforce planning in OECD countries: a review of 26 projection models from 18 countries.” *OECD Health Working Papers, No. 62*. France: OECD Publishing; 2013: 8-11.

specific workforce supplies will likely be dependent on the competitiveness of wages, benefits, and workplace characteristics in LTSS settings,<sup>3,4</sup> as well as on fundamental workforce supply determinants (e.g., number of new entrants to the nursing workforce). The broad labor market factors that may affect health care providers' choice of work setting are not able to be estimated using the current HWSM, but future improvements to the model may support such complex analyses.

## Key Findings

*The increase in demand for nursing occupations in LTSS in the United States, although anticipated to be seen in all states, will be distributed unevenly across the nation. Specifically, projected demand growth for Registered Nurses and Licensed Practical Nurses between 2015 and 2030 varies substantially by state and region.*

- Under the Primary Scenario, demand for RNs will grow by 46% from 438,600 FTEs in 2015 to 638,800 FTEs in 2030 and demand for LPNs is projected to drive the workforce to grow by 46%, from 364,200 FTEs in 2015 to 532,900 FTEs in 2030.
- If current levels of LTSS care are maintained, Texas is projected to have the largest increase in demand for overall LTSS nursing care provided by Registered Nurses and Licensed Practical Nurses between 2015 and 2030.
  - For Registered Nurses, the states with the highest projected increases in demand include Colorado (76%), Utah (74%), New Mexico (72%), Arizona (72%), California (71%) and Texas (71%).
  - For Licensed Practical/Vocational Nurses, the highest projected increases in demand include Colorado (78%), Utah (75%), New Mexico (74%), Arizona (73%), California (72%) and Texas (72%).

<sup>3</sup> National Academies of Sciences, Engineering, and Medicine. 2017. Strengthening the workforce to support community living and participation for older adults and individuals with disabilities: Proceedings of a workshop. Washington, DC: The National Academies Press.

<sup>4</sup> Texas Center for Nursing Workforce Studies. 2016. Long-term care nurse staffing study: Recruitment and retention. Publication Number 25-14896. Retrieved December 28, 2017 from: <http://www.dshs.texas.gov/chs/cnws/Home-Health-and-Hospice-and-Long-Term-Care-Survey-Reports/>.

- The state projected to experience the smallest demand increase is Nebraska (4%), followed by New York (21%). These states have the same percentage of increase in demand for both Registered Nurses and Licensed Practical Nurses.
- Under an alternative scenario which takes into account possible improvements in population health, short-term demand for Registered Nurses and Licensed Practical Nurses in LTSS will likely decline. However, because of anticipated increases in longevity, long-term demand for LTSS is likely to rise by about 8% compared to baseline projections for Registered Nurses (increased by 49,800 Full Time Equivalents) and Licensed Practical Nurses (increased by 43,100 Full Time Equivalents).

## Background

Growth in the aging population due to demographic shifts, increased longevity, and a corresponding increase in disability prevalence will amplify the future need for Long Term Services and Supports (LTSS). In 2015, there were an estimated 47.8 million people in the U.S. age 65 or older, and by 2030 this number will rise to nearly 73 million (about one in five U.S. residents).<sup>5</sup> Disabling conditions and chronic illnesses are highly correlated with older age, and rapid growth in the number of older adults raises questions of whether the LTSS workforce will be sufficient to meet the future demand for services.

Registered Nurses (RNs) and Licensed Practical/Vocational Nurses (LPNs) perform a variety of patient care duties and are critical to the delivery of health care services across the long-term care continuum, from institutional care to home and community based services. Analysis of 2015 American Community Survey One-Year estimates suggests 45% of LPNs in the United States worked in LTSS in 2015. This is similar to estimates from the 2013 American Community Survey, but reflects substantial growth in employment of LPNs in LTSS since 2008.<sup>6</sup> Approximately 15% of RNs worked in LTSS settings in 2015.

According to the Health Resources and Services Administration's (HRSA's) 2017 report on nursing occupations in the U.S.,<sup>7</sup> nursing shortages represent a problem with workforce distribution across states, rather than a shortage at the national level. Examining the nursing workforce providing LTSS, this report continues a regional focus by describing the distribution of RN and LPN demand across states, as opposed to focusing solely on national-level demand projections. This study also supports the HRSA health workforce goals by presenting workforce demand projections for select nursing occupations working in LTSS. Furthermore, this study is

<sup>5</sup> U.S. Census Bureau. An Aging Nation. Accessed at [https://www.census.gov/library/visualizations/2017/comm/cb17-ff08\\_older\\_americans.html](https://www.census.gov/library/visualizations/2017/comm/cb17-ff08_older_americans.html)

<sup>6</sup> Coffman JM, Chan K, Bates T. (2015). Profile of the Licensed Practical Nurse/Licensed Vocational Nurse Workforce, 2008 and 2013. San Francisco, CA: UCSF Health Workforce Research Center on Long-Term Care. [https://healthworkforce.ucsf.edu/sites/healthworkforce.ucsf.edu/files/Report-Profile\\_of\\_the\\_Licensed\\_Practical\\_Nurse\\_Licensed\\_Vocational\\_Nurse\\_Workforce\\_2008\\_and\\_2013.pdf](https://healthworkforce.ucsf.edu/sites/healthworkforce.ucsf.edu/files/Report-Profile_of_the_Licensed_Practical_Nurse_Licensed_Vocational_Nurse_Workforce_2008_and_2013.pdf)

<sup>7</sup> U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. 2017. *National and Regional Supply and Demand Projections of the Nursing Workforce: 2014-2030*. Rockville, Maryland.

responsive to findings and recommendations from a 2016 General Accountability Office report pertaining to the LTSS workforce.<sup>8</sup>

## Model and Results

This analysis utilized the HRSA's Health Workforce Simulation Model (HWSM), a forecasting model developed to estimate and project workforce supply and demand across a wide range of healthcare occupations. The HWSM projected the impact of key factors influencing LTSS demand (not supply) on two specific nursing occupations--RNs and LPNs. These key factors include population growth, population aging, overall economic conditions, expanded health insurance coverage, changes in health care reimbursement, geographic location, and health workforce availability. LTSS settings included nursing homes, residential care facilities, home health, and adult day care. Estimates of current numbers (supply) of RNs and LPNs working in LTSS are also provided, and a discussion of the barriers in estimating current and projecting future supply is included. Workforce numbers are reported as full-time equivalents (FTEs), where an FTE is defined as 40 hours worked per week.

Two demand scenarios are modelled for this report. The first (baseline) scenario reflects the changing demographics from 2015 to 2030 and extrapolates current care utilization and delivery patterns. The second (alternative) scenario further takes into account possible improvements in population health and trends in unpaid care that might impact future demand for paid care.

### Demand: Primary (Baseline) Scenario

Under the baseline scenario, between 2015 and 2030, demand for both RNs and LPNs in LTSS is projected to increase substantially. Demand for RNs will grow by 46%--from 438,600 FTEs in 2015 to 638,800 FTEs in 2030 (an increase of 200,200 FTEs). Similarly, demand for LPNs is projected to drive the workforce to grow by 46%, from 364,200 FTEs in 2015 to 532,900 FTEs in 2030 (an increase of 168,700 FTEs).

Substantial variation is observed in RN demand growth at the regional and state levels (*Exhibit I*). The Western (68%) and Southern (52%) Census regions exhibit the highest projected growth

<sup>8</sup> Accessed at <http://www.gao.gov/assets/680/679169.pdf>

### Exhibit 1: LTSS Demand for Registered Nurses by State, 2015-2030

Region/State	2015	2020	2025	2030	Percent Change
<b>Northeast</b>	<b>92,990</b>	<b>99,550</b>	<b>108,520</b>	<b>122,590</b>	<b>32%</b>
Connecticut	6,230	6,910	7,860	8,970	44%
Maine	2,380	2,550	2,760	3,050	28%
Massachusetts	11,410	12,420	13,600	15,520	36%
New Hampshire	2,390	2,630	3,010	3,660	53%
New Jersey	12,860	14,480	16,130	18,470	44%
New York	30,580	31,570	33,450	36,870	21%
Pennsylvania	23,770	25,550	27,910	31,710	33%
Rhode Island	2,370	2,400	2,620	3,030	28%
Vermont	1,000	1,040	1,180	1,310	31%
<b>Midwest</b>	<b>113,690</b>	<b>122,780</b>	<b>135,560</b>	<b>153,020</b>	<b>35%</b>
Illinois	20,590	22,710	25,680	29,150	42%
Indiana	10,900	11,860	13,100	15,020	38%
Iowa	5,980	6,210	6,700	7,460	25%
Kansas	5,080	5,740	6,480	7,310	44%
Michigan	14,400	15,540	17,170	19,210	33%
Minnesota	8,060	8,850	9,910	11,530	43%
Missouri	11,170	12,210	13,600	15,590	40%
Nebraska	3,630	3,620	3,630	3,770	4%
North Dakota	1,760	1,770	1,990	2,230	27%
Ohio	21,460	22,580	24,130	26,310	23%
South Dakota	1,930	2,200	2,510	2,880	49%
Wisconsin	8,730	9,490	10,660	12,560	44%
<b>South</b>	<b>158,460</b>	<b>181,200</b>	<b>208,970</b>	<b>240,150</b>	<b>52%</b>
Alabama	7,990	9,100	10,160	11,320	42%
Arkansas	5,300	5,860	6,350	6,860	29%
Delaware	1,490	1,680	1,920	2,190	47%
District of Columbia	1,090	1,260	1,420	1,580	45%
Florida	27,620	30,810	35,250	39,400	43%
Georgia	10,670	12,670	14,750	16,800	57%
Kentucky	7,530	8,300	9,220	10,330	37%
Louisiana	7,470	8,210	9,320	10,660	43%
Maryland	7,940	9,220	10,690	12,350	56%
Mississippi	5,320	6,230	7,120	8,050	51%
North Carolina	13,530	15,930	18,560	21,310	58%
Oklahoma	5,610	6,320	7,040	7,830	40%
South Carolina	6,070	6,950	8,010	9,190	51%
Tennessee	9,130	10,600	12,410	14,720	61%
Texas	28,730	33,860	40,630	49,240	71%
Virginia	9,930	10,930	12,570	14,450	46%
West Virginia	3,040	3,270	3,550	3,870	27%
<b>West</b>	<b>73,420</b>	<b>86,410</b>	<b>102,460</b>	<b>123,050</b>	<b>68%</b>
Alaska	750	860	990	1,170	56%
Arizona	5,750	7,040	8,360	9,890	72%
California	37,100	43,710	52,100	63,370	71%
Colorado	5,320	6,360	7,670	9,350	76%
Hawaii	1,370	1,500	1,740	2,070	51%
Idaho	1,810	2,130	2,480	2,860	58%
Montana	1,900	2,050	2,300	2,690	42%
Nevada	2,390	2,880	3,300	3,700	55%
New Mexico	2,040	2,430	2,960	3,500	72%
Oregon	4,260	4,960	5,660	6,380	50%
Utah	2,270	2,740	3,280	3,940	74%
Washington	7,570	8,780	10,520	12,820	69%
Wyoming	890	970	1,100	1,310	47%

Note: Totals may differ from national tables in the report due to rounding.

in demand for RNs in LTSS, and the Northeastern (32%) and Midwestern (35%) regions exhibit a smaller growth in demand. The states with the highest projected demand growth for RNs in LTSS include Colorado (76%) and Utah (74%), while those with the lowest growth include Nebraska (4%) and New York (21%).

Similar patterns are observed in LPN demand growth at the regional and state levels (Exhibit 2). The Western (69%) and Southern (52%) Census regions exhibit the highest projected growth and the Northeastern (32%) and Midwestern (35%) the smallest. The states with the highest growth in projected LPN demand include Colorado (78%) and Utah (75%). As with RNs, Nebraska (4%) and New York (21%) are projected to experience the lowest growth by 2030.

### **Demand: Secondary (Alternative) Scenario**

The results of the first scenario are based on recent national health care utilization and staffing patterns, and assume that within each demographic group, the prevalence of chronic disease and disability remain unchanged over time. However, improvements in population health could contribute to changes in workforce demand by setting. For example, an increased focus on preventive care, medication management and adherence, and evidence-based care protocols may result in improvements in population health. In turn, there may be changes in the level of demand for DCWs across the nation for the provision of LTSS.

An alternative scenario seeks to model the potential long-term health impacts (and subsequent impact on demand for providers) of achieving the following population health goals: 1) sustained a 5 percent reduction in body weight for people who were overweight or obese; 2) improved uncontrolled hypertension, high cholesterol, and high blood glucose levels; and 3) eliminated smoking. Results suggest that improved population health might reduce LTSS demand slightly in the short term, but to the extent that preventive care increases longevity, particularly among older population cohorts, overall demand for LTSS nurses is likely to rise by about 92,900 FTEs (8%) in the long term, compared to the projected demand in the baseline scenario (*Exhibit 3*).



## Exhibit 2: LTSS Demand for Licensed Practical Nurses by State, 2015-2030

Region/State	2015	2020	2025	2030	Percent Change
<b>Northeast</b>	<b>77,820</b>	<b>83,270</b>	<b>90,730</b>	<b>102,840</b>	<b>32%</b>
Connecticut	5,170	5,730	6,530	7,470	44%
Maine	2,010	2,160	2,330	2,590	29%
Massachusetts	9,550	10,390	11,360	13,000	36%
New Hampshire	2,020	2,220	2,540	3,100	53%
New Jersey	10,770	12,130	13,510	15,510	44%
New York	25,230	26,020	27,570	30,490	21%
Pennsylvania	20,190	21,680	23,650	26,970	34%
Rhode Island	2,030	2,060	2,250	2,600	28%
Vermont	850	880	990	1,110	31%
<b>Midwest</b>	<b>95,370</b>	<b>102,990</b>	<b>113,770</b>	<b>128,950</b>	<b>35%</b>
Illinois	17,060	18,820	21,330	24,310	42%
Indiana	9,070	9,870	10,910	12,550	38%
Iowa	4,970	5,170	5,560	6,210	25%
Kansas	4,360	4,930	5,580	6,320	45%
Michigan	11,800	12,730	14,080	15,840	34%
Minnesota	7,000	7,690	8,620	10,070	44%
Missouri	9,330	10,190	11,350	13,040	40%
Nebraska	3,160	3,150	3,150	3,280	4%
North Dakota	1,550	1,560	1,760	1,980	28%
Ohio	17,870	18,790	20,070	21,970	23%
South Dakota	1,680	1,920	2,190	2,510	49%
Wisconsin	7,520	8,170	9,170	10,870	45%
<b>South</b>	<b>129,840</b>	<b>148,460</b>	<b>171,590</b>	<b>197,780</b>	<b>52%</b>
Alabama	6,490	7,410	8,300	9,290	43%
Arkansas	4,290	4,750	5,160	5,590	30%
Delaware	1,250	1,400	1,600	1,830	46%
District of Columbia	920	1,060	1,200	1,330	45%
Florida	22,780	25,330	29,040	32,430	42%
Georgia	8,590	10,220	11,940	13,650	59%
Kentucky	6,110	6,740	7,500	8,440	38%
Louisiana	6,040	6,630	7,540	8,650	43%
Maryland	6,650	7,720	8,990	10,440	57%
Mississippi	4,360	5,130	5,870	6,660	53%
North Carolina	11,060	13,040	15,230	17,560	59%
Oklahoma	4,590	5,180	5,780	6,440	40%
South Carolina	4,900	5,610	6,490	7,470	52%
Tennessee	7,400	8,600	10,090	12,040	63%
Texas	23,660	27,870	33,460	40,680	72%
Virginia	8,310	9,130	10,520	12,130	46%
West Virginia	2,440	2,640	2,880	3,150	29%
<b>West</b>	<b>61,170</b>	<b>72,040</b>	<b>85,540</b>	<b>103,360</b>	<b>69%</b>
Alaska	650	740	860	1,020	57%
Arizona	4,620	5,660	6,730	7,990	73%
California	30,790	36,310	43,300	52,960	72%
Colorado	4,420	5,300	6,400	7,860	78%
Hawaii	1,160	1,260	1,460	1,760	52%
Idaho	1,510	1,780	2,080	2,410	60%
Montana	1,640	1,770	1,980	2,330	42%
Nevada	1,900	2,300	2,640	2,970	56%
New Mexico	1,650	1,970	2,410	2,870	74%
Oregon	3,660	4,280	4,910	5,570	52%
Utah	1,890	2,280	2,740	3,310	75%
Washington	6,530	7,570	9,100	11,200	72%
Wyoming	750	820	930	1,110	48%

Note: Totals may differ from national tables in the report due to rounding.

### Exhibit 3: FTE LTSS Demand: Population Health Scenario, 2030

Occupation	2030 Projected Demand	Population Health Scenario	Percent Change
<b>Nursing Occupations</b>	<b>1,171,700</b>	<b>1,264,600</b>	<b>8%</b>
Licensed Practical Nurses	532,900	576,000	8%
Registered Nurses	638,800	688,600	8%

### Supply

The 2015 American Community Survey is the main source for estimating the LTSS workforce supply in 2015 by occupation, care delivery setting (industry), and state. In 2015, an estimated 434,500 RNs and 361,700 LPNs worked in LTSS settings (*Exhibit 4*).

### Exhibit 4: FTE LTSS Workforce, 2015 American Community Survey

Occupation	Long-Term Services and Supports Settings				All Health Care Settings
	Nursing Facilities	Residential Care	Home Health	Total LTSS	
Registered Nurses	250,500	27,000	157,000	434,500	2,947,200
Licensed Practical/Vocational Nurses	219,400	35,300	107,000	361,700	801,000
Total	469,900	62,300	264,000	796,200	3,748,200

Source: U.S. Census Bureau. 2015 American Community Survey One-Year Estimates. Notes: Estimates of full time equivalents (FTEs) were calculated by dividing each person's reported weekly hours worked by 40 hours.

In addition to the ACS estimates, data from the National Center for Health Statistics' 2014 National Study of Long-Term Care Providers were used to estimate the number of RNs and LPNs working in Adult Day Service Center settings. These estimates (4,100 FTEs for RNs; 2,500 FTEs for LPNs) were included in the 2015 RN and LPN demand estimates shown on Exhibits 1 and 2.

Forecasting the future supply of health workers in a particular employment setting is more difficult than simply projecting the future supply of health workers. Setting-specific supply is dependent on future competitiveness of wages and benefits in that setting, as well as on overall

supply trends. For nursing occupations, a recent HRSA nursing occupation report<sup>9</sup> provides insights on the future adequacy of supply. In terms of RNs, HRSA's 2017 nursing report suggested that, at the national level, the supply of RNs will be adequate to meet demand over the foreseeable future. If the overall future supply of RNs is adequate to meet demand, then within a particular employment sector such as LTSS settings, there is a greater likelihood that supply will also be adequate. For LPNs, HRSA's 2017 nursing report suggests that demand is growing slightly faster than supply, and by 2030, there may be a projected shortfall of 151,500 FTEs.

In summary, RNs constitute just over 13% of the LTSS workforce, and future supply is expected to be adequate to meet demand. LPNs make up 11% of the LTSS workforce, and supply is growing more slowly than demand. As a consequence of these dynamics, the adequacy of future LTSS nursing supplies, especially at regional and state levels, may be determined not only by workforce availability but also by employers' offering competitive wages, benefits, and other incentives to encourage staff recruitment and retention.

## Strengths and Limitations

The primary strengths of this analysis include the use of recent data with sufficient sample size to provide reliable estimates of key model parameters, and the use of state-of-the-art microsimulation workforce projection modeling techniques.

### Modeling Demand

A microsimulation approach was used to project future demand because of the flexibility it provides to simulate potential changes in care delivery patterns. This report presents national, regional and state-level demand projections—where geographic variation in the populations' health risk factors is included. One major modeling limitation is lack of data on how care delivery patterns might change over time with emerging care delivery models, third party payment trends, improvements in technology, and other such developments. The HWSM

<sup>9</sup> U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. 2017. National and Regional Supply and Demand Projections of the Nursing Workforce: 2014-2030. Rockville, Maryland. [https://bhw.hrsa.gov/sites/default/files/bhw/nchwa/projections/NCHWA\\_HRSA\\_Nursing\\_Report.pdf](https://bhw.hrsa.gov/sites/default/files/bhw/nchwa/projections/NCHWA_HRSA_Nursing_Report.pdf)

operates under many assumptions regarding current status and future trends in health care utilization and workforce demand.

This model, like most other health workforce projection models, assumes that the national labor market for the LTSS workforce is currently in balance (i.e., supply and demand in the base year are equal). Current demand is defined by FTE employment in each occupation, which in turn reflects compensation levels of the number of people willing to work in each occupation given market wages.

Thus, the baseline demand projections reported here reflect future changes in the LTSS workforce relative to a balanced 2015 baseline. However, changes in health care service delivery are not incorporated into the baseline model. Ongoing attempts to understand the effects and implications of these changes in care delivery are reflected in the alternative scenario. If the growing population health emphasis on prevention and chronic disease management leads to reduced mortality and therefore a greater need for LTSS workforce, the baseline scenario may underestimate future demand.

### **Modeling Supply**

Modeling the supply of RNs and LPNs in LTSS entails similar challenges to modeling demand. These include predicting how health care delivery may change over time; determining how a greater focus on team-based care may alter staffing levels; and estimating how improvements in technology may change staff loads. Additional challenges specific to modeling LTSS workforce supply relate to deriving setting-specific estimates, recognizing that RNs and LPNs have a choice of workplace opportunities. Setting-specific workforce supplies are likely dependent on a number of factors, including wage competitiveness, employment benefits, workplace environment, and workplace recognition. Estimating the interplay between these various factors over time is beyond the scope of the current HWSM, although future versions of the model may be able to address these elements, and thus estimate health workforce supplies in specific care settings, including LTSS.

In considering the baseline supply estimates of RNs and LPNs in LTSS settings, it must also be noted that the primary data source for these LTSS analyses is the 2015 American Community Survey One-Year estimates. Strengths of these ACS data include the availability of recent, state-level estimates; the availability of occupation codes and industry codes that permit identification of health workers in various LTSS settings; and the availability of detailed labor force participation data. However, some occupation-industry code combinations may be ambiguous. For example, LPNs working for a home health agency owned by a hospital may be characterized as working in a hospital setting, when, in fact, these providers provide LTSS in a home setting. As a result of these coding constraints, certain occupation/industry code combinations may have led to either an underestimate or an overestimate of the current supply of RNs and LPNs working in LTSS. Given the detail available in the ACS occupation and industry codes, it is expected that the overall impact of these potentially ambiguous codes is small.

## Conclusions

This is one in a series of HRSA reports on the health care workforce, in this case intended to provide information on the future demand for RNs and LPNs in LTSS. These occupations are faced with the challenges of a rapidly aging U.S. population, with longer life expectancy and rising burden of disease.

Looking to the future, many factors will continue to affect demand and supply of the LTSS workforce, including demographically driven demand for health services.<sup>10</sup> For example, any potential future changes to the Medicaid program could play a role in determining service use, site of care, and workforce availability.

Policies to improve population health are likely to increase (rather than reduce) demand for nursing occupations in LTSS due to increased longevity, despite slight short-term declines in demand related to improvements in average health.

<sup>10</sup> Institute of Medicine (US). Committee on the Future Health Care Workforce for Older Americans. (2008). *Retooling for an aging America: Building the health care workforce*. National Academies Press.

## About the Model

The results presented in this report come from HRSA's Health Workforce Simulation Model, which is an integrated health professions projection model that estimates the current and future supply of and demand for health care providers.

The supply component of the Model simulates workforce decisions for each provider based on his or her demographics and profession, along with the characteristics of the local or national economy and the labor market. The basic file that underlies the supply analysis contains individual records of the RNs and LPNs in the workforce from the American Community Survey (ACS) and the state licensure data.

Demand projections for health care services in different care settings are produced by applying regression equations for individuals' health care use on the projected population. The current nurse staffing patterns by care setting are then applied to forecast the future demand for nurses. The population database used to estimate demand consists of records of individual characteristics of a representative sample of the entire U.S. population derived from the ACS, National Nursing Home Survey, and the Behavioral Risk Factor Surveillance System. Using the Census Bureau's projected population and the Urban Institute's state-level estimates of the impact of the healthcare reform on insurance coverage,<sup>1,2</sup> the Model simulates future populations with expected demographic, socioeconomic, health status, health risk and insurance status.

This Model makes projections at the state level, which are then aggregated to the national level. A detailed description of the Model can be found in the accompanying technical documentation available at <http://bhw.hrsa.gov/healthworkforce/index.html>.

<sup>1</sup> Holahan, J. & Blumberg, L. (2010 January). *How would states be affected by health reform? Timely analysis of immediate health policy issues*. Retrieved August 2013 from [http://www.urban.org/UploadedPDF/412015\\_affected\\_by\\_health\\_reform.pdf](http://www.urban.org/UploadedPDF/412015_affected_by_health_reform.pdf).

<sup>2</sup> Holahan, J. (2014 March) *The launch of the Affordable Care Act in selected states: coverage expansion and uninsurance*. Retrieved August 2013 from <http://www.urban.org/uploadedPDF/413036-the-launch-of-the-Affordable-Care-Act-in-selected-states-coverage-expansion-and-uninsurance.pdf>. Washington D.C., The Urban Institute.