# Health Care Industry

# Identifying and Addressing Workforce Challenges

**February 2004**

**Prepared by Alexander, Wegner, & Associates and submitted to the U.S. Department of Labor, Employment and Training Administration.**

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1. Health Care Industry's Solutions Matrix – Full
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## Preface

The following is a report prepared by Alexander, Wegner, & Associates for the U.S. Department of Labor, Employment and Training Administration's Business Relations Group. This report details what the U.S. Department of Labor, Employment and Training Administration (DOL ETA) has learned from employers, employees, educators, workforce professionals, and researchers about health care workforce challenges and solutions. It provides the basis for developing strategic partnerships that include industry, education, and the public workforce system.

At the federal level alone the public workforce system invests over $15 billion each year providing employment and training services to people who need them. ETA is always looking for more effective and efficient ways to use these resources. The Initiative, of which this report is a part, is directed toward forging these partnerships and making these improvements.

To address workforce needs in health care and other industries, ETA created the Business Relations Group. Recognizing that workforce development is part of economic development, the Business Relations Group's focus is on the *education*, *employment*, and *economic development* partnerships that are needed to fuel our nation's economy. ETA's goal is to prepare the workforce system to better serve the needs of business, and to connect businesses with the workforce system through targeted initiatives.

Based on ETA's review of major areas of job growth, the health care industry was selected as one of 12 industries for the High Growth Job Training Initiative.

The reality of the situation allows employers the opportunity to reach out and offer jobs in health care that are enticing to potential job seekers. Health care occupations are attractive because they are located across the nation, provide a professional work environment, and are portable. The health care industry needs greater diversity among its workforce, and therefore may be attractive to new labor pools. There is an increased building of career ladders and lattices that are available to workers so they can shape their careers.

Meeting the short-term needs and the projections for the coming decade is only part of the challenge. The long-term care sector alone will see an increase of 5.7 to 6.6 million direct-care workers by the year 2050.[1] Even the most optimistic hopes for increased technological solutions or improvements in the health of Americans will not prevent this increased need for direct care workers.

ETA heard from employers, and others associated with health care, of some of their actions to identify challenges and implement effective workforce strategies. ETA heard of the pressures they experience to do much more, to do it quickly, and to do it in a way that is sustainable over a long period of time. Health care leaders are committed to dealing with major workforce issues.

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[1] U.S. Department of Labor. Bureau of Labor Statistics. July 2002. *Projected Growth Rates by Industry (Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.)*

However, the challenges they face are far too complex for any one institution or sector to solve alone. It has never been more important for ETA to build partnerships between employers, employees, educators, workforce professionals and government.

The Employment and Training Administration and the public workforce system will now move to partner with industry and education institutions to act on solutions from this report that highlight innovative ways that the workforce system can be a catalyst for meeting the health care industry's workforce needs.

To those who gave generously of their time, effort and other resources for this initial work -- thank you for your thoughtful contributions. To those reading about this initiative for the first time -- ETA looks forward to your contributions to building a responsive and sustainable health care workforce system throughout the country.

As ETA heard from different industries, it found several workforce challenges that are common throughout different sectors. ETA will look to partner to address these workforce problems across industries. Solutions will be categorized under the following categories: pipeline, competency models, post-secondary and alternative training, new labor pools, retention, transitioning/declining industries, and small businesses.

## Executive Summary

A top priority for the Department of Labor's (DOL) Employment and Training Administration (ETA) is serving America's workers through effectively meeting the workforce needs of business. The High Growth Job Training Initiative of ETA and its Business Relations Group recognizes that workforce development is not separate from economic development but an integral part of it.

The health care industry was selected as one focus within the High Growth Job Training Initiative. Health Services comprised 5.8 percent ($589.9 billion) of Gross Domestic Product in 2001.[2] In 2002, the total employment in health services was 11,529,000.[3] The Labor Department's Bureau of Labor Statistics projects that the industry will add 3.5 million new jobs, or 16 percent of all wage and salary employment, between 2002 and 2012. Nine out of the twenty fastest growing occupations will be in health care.[4]

Significant workforce supply and demand gaps currently exist across the U.S. that affect acute care, long-term care and primary care health care provider sectors. These gaps are even more significant across all three sectors in rural America.

This report provides the results of *information gathering* from key health care informants regarding workforce issues as reported by the 'demand' side of the workforce. The provider or owner/operator associations employing the greatest numbers of health care workers are the primary employer informants. Parallel to meetings and interviews with employers, relevant workforce reports and information were sought from the DOL Bureau of Labor Statistics, the Department of Health and Human Services Health Resources and Services Administration, health care workforce researchers, reports of provider associations, educators, public and private workforce professionals – including Workforce Investment Boards, and the contacts suggested in interviews with members of these sources.

The initial *analysis* of the information generated concluded with a clustering of the workforce issues or challenges by topic and by sector within the health care industry:

- Pipeline Challenges/Issues: Recruitment and Retention
  - Increasing available labor pool
  - Increasing diversity and seeking workers from non-traditional labor pools
  - Reducing turnover

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[2] U.S. Department of Commerce. Bureau of Economic Analysis. November 2002. *Gross Domestic Product by Industry for 2001.*
[3] U.S. Department of Labor. Bureau of Labor Statistics. February 2004. *Monthly Labor Review.*
[4] Ibid.

- Skill Development Challenge/Issues
  - Entry-level worker preparation
  - Incumbent worker training
  - Need for targeted and specialized areas of skills

- Capacity of Education and Training Providers Challenges/Issues
  - Lack of academic and clinical instructors
  - Lack of facilities and resources
  - Lack of alignment between employer requirements and curricula, and specialized skills areas

- Sustainable Workforce: Leadership, Policy, and Infrastructure Challenges/Issues
  - Need for sustainable and adaptive workforce partnerships at national, state and local levels
  - Opportunities to leverage funding and other resources
  - Planning tools (data, projections, and information systems that are useful in projections of demand at the single facility and local levels)
  - Policy issues including those of regulation

The majority of the workforce issues reported are the same or similar across primary, long-term care and acute care sectors. For example, all types of provider groups report that the current number one problem in occupational vacancies is for registered nurses. There are, however, some identifiable differences among the provider sectors. For example, long-term care providers identify a serious concern regarding the current and projected supply/demand gap of senior managers, while neither acute nor primary care providers share the same degree of concern. The acute care providers' vacancies include a significant number of direct care workers, medical diagnostic and treatment technologists and support workers. The rural health vacancies across a wide spectrum of occupations are of continuing concern and made more problematic with the current vacancy rates nationally.

A second step in *information gathering* and *analysis* was performed prior to and during the course of three Workforce Development Industry Forums held in October 2003. The 126 forum participants were selected from a pool developed through nominations from owner/operator associations, the National Association of State Workforce Agencies, the National Association of Workforce Boards, the American Association of Community Colleges, and other workforce leaders from whom project staff had previously sought information. Some of the participants represented health care workforce projects currently funded by the Employment and Training Administration. Participants were asked to complete a validation tool containing challenges gathered in Phase I and invited to suggest additional issues. In addition, at the forums they were presented with an overview of the challenges and issues and asked for additional input. No changes in the challenges were made.

Participants in the forums were assigned to one of four groups. They clarified challenges or issues, generated 1001 solutions, and ranked the solutions by a voting procedure. For the 83 highest-ranked solutions, small teams worked to develop a matrix that includes the challenge, the

solution, critical attributes for a successful solution, key stakeholders, resources required, policy barriers at the local, state and national or federal level, and any other needed clarifications.

The highest-ranked solutions include recommendations in the following areas:

- Issue: Pipeline: Recruitment and Retention
  - Solution: Creating and expanding youth-focused programs to better inform young people about health care careers and encourage them to consider health care occupations.

- Issue: Pipeline: Recruitment and Retention
  - Solution: Ensuring that public workforce programs provide adequate preparation of entry-level workers in the basic knowledge required to enter many health care occupations, adequate social and financial supports during the training period, opportunities for work placement, and support during the transition to the workplace so these workers can succeed and be retained in the health care industry.

- Issue: Pipeline: Recruitment and Retention
  - Solution: Marketing health care career opportunities to youth, potential worker pools that do not traditionally enter the health care industry, dislocated workers, immigrant communities, older workers, and traditional worker pools.

- Issues: Pipeline: Recruitment and Retention and Skill Development
  - Solution 1: Attracting and retaining workers through significant improvement of the "culture" of the health care workplace by implementing shared governance, incumbent worker training, career ladders, access to education and training opportunities, and other attributes identified by employees, researchers, and from exemplary continuous improvement programs.
  - Solution 2: Providing management training and credentialing in long-term care, consistent with this type of workplace improvement.

- Issue: Skill Development
  - Solution: Designing health care occupation curricula that provide the basic knowledge and skills needed for effective entry to practice in the high-growth areas of employment in primary care, long-term care and acute care sectors. Develop curricula so that there is a fit between programs for advancing the careers of health care workers (often provided through the workplace) and the requirements of the educational institutions.

- Issue: Skill Development
  - Solution: Examining the state credentialing requirements with the goal of expanding less traditional paths to meeting occupational requirements, such as career ladders, apprenticeships and other workforce development strategies. Creating "cross walks" from practice to educational programs and credentialing requirements based on nationally developed measurement of worker skills.

- Issue: Capacity of Education and Training Providers
  - Solution: Addressing the capacity problems (i.e., lack of faculty, resources, etc.) in many community colleges and other post-secondary education and training organizations where barriers to applicants exist and where there are inadequate numbers of qualified applicants for actual or projected demand for some health service occupations. Capacity is affected by lack of faculty and other resources.

- Issue: Sustainability: Leadership, Policy, and Infrastructure
  - Solution: Partnering among a wide range of stakeholders in the health care workforce in order to project changes in workforce demand at the local/regional, state and national levels and to generate long term, efficient, and sustainable approaches to those changes.

- Issue: Sustainability: Leadership, Policy, and Infrastructure
  - Solution: Developing methods for projection of medium-term occupational needs that can be used by a health care entity, such as a hospital or home care agency, as a basis for internal planning and for planning with partners in education, workforce development and other health care workforce stakeholders.

The Department of Labor Employment and Training Administration's Business Relations Group reviewed the solutions generated during the Workforce Development Industry Forums. The purpose of the review was to:

(a) Identify for referral those solutions that are both the responsibility of other entities and not in the domain of the Department of Labor;
(b) Identify solutions that are jointly in the domain of the Department of Labor and another federal department;
(c) Identify solutions where the Department of Labor or the public workforce system already have program commitments; and,
(d) Identify solutions within the Department of Labor's domain that if implemented effectively and widely will have a significant impact on managing the present and future workforce challenges of the health care industry. The latter group of solutions was examined by asking the question: "How can the Employment and Training Administration best use its resources and influence to have a positive impact on the challenges identified by the health care industry?" The solutions selected for initial action are ones that can be adapted to many settings, that are built on partnerships among stakeholders, that provide other opportunities to leverage resources (including funding), and that are relevant to the basic problem of adapting the workforce to changing industry needs.

The solutions anticipated to have the clearest impact include the following program areas:

- ✓ Youth-related programs developed and implemented by partnerships that include schools, health care employers, post-secondary programs for health occupations, and public workforce system entities.

- ✓ Programs focused on non-traditional and traditional pools for health care entry-level workers that both broaden approaches to preparation programs and enhance career mobility in health care and related industries. Competency models for these programs should be developed through a partnership of educators, employers, and workforce professionals.

- ✓ Initiatives that meet the needs for academic and clinical faculty in high-demand health care education programs and that are designed to adapt to changing levels of workforce demand.

- ✓ Programs that deal with the community college and other educational organizations' insufficient capacity through innovative partnerships and other approaches. These capacity issues include the need for appropriate clinical practice opportunities, funding for students, diagnostic and treatment equipment, and laboratory support.

- ✓ Improvement of health care workplaces by interventions such as management training, incumbent worker training, career mobility programs, accessible education and training opportunities, and reducing staff fluctuations through workforce projections.

- ✓ Effective initiatives to build a sustainable national infrastructure with local, state, and national elements tasked with continuous balancing of workforce demand and supply within the health care industry.

The majority of the solutions identified by forum participants are not sector specific. However, many solutions can be adapted to the particular needs of a sector or a community.

*National, State and Local Partnerships for Implementing Workforce Solutions*

Dealing with workforce challenges in the health care industry requires collaboration at the national, state and local levels, and between these levels. Executive and Workforce Development Industry Forum participants recommend a national, systemic approach that aligns the workforce resources available with the challenges facing the health care industry today and well into the future. This direction is consistent with the thinking behind the High Growth Job Training Initiative.

A central role of the Employment and Training Administration is that of identifying and communicating effective workforce solutions that can be replicated to respond to national challenges such as management training or youth-related recruitment programs. A second aspect of that role is the funding of pilot programs, by ETA alone or in partnerships, that are most effective in dealing with some aspect of workforce challenges, and that are replicable by other entities. At the national level, providers and others also identify the need for a national warehouse of sound and effective workforce interventions with a search engine that makes it possible for a local Workforce Investment Board, a human resources manager, or others to identify solutions that have worked elsewhere.

The actions of state governments and state-level entities are pivotal to any national workforce effort. State government decisions direct how some federal funding is used to support some workforce programs. For example, the Workforce Investment Act provides funding to states, and through the states to local Workforce Investment Boards and workforce-related programs. These funds and others, such as Temporary Assistance to Needy Families and Medicaid, are used to provide training, support, and placement for many occupations including those in health care. It is at the state level that policy and funding decisions are made about higher education, licensing and regulation. Medicaid programs that directly affect employment conditions and delivery of care, worker training, collection of information for programs and policy development, and other initiatives that directly influence the implementation, are among many of the solutions recommended in the Executive Forums and Workforce Development Industry Forums. A sustainable, adaptive and effective workforce strategy in health care requires strong public and private partnerships in every state. Without these partnerships ETA cannot respond adequately to current problems or prevent future ones.

Local partnerships, including Workforce Investment Boards, employers, employees, educators and other community members, are needed to implement workforce solutions closest to health care delivery sites, and to potential labor pools. Through such partnerships, both the workforce demand and supply sides can identify the needs in their own communities. Partners can use their state and national networks to find solutions to better manage their particular challenges.

# Introduction

The High Growth Job Training Initiative (HGJTI) is a strategic effort to improve the publicly funded workforce system's responsiveness to the needs of the labor market in order for the workforce system to become more demand-driven. HGJTI is specifically designed to build collaborations among employers, industry leaders, business associations, employees, educators, trainers, community- and technical college systems, and the public workforce system. The purpose of these partnerships is to support models that demonstrate how a demand-driven workforce system can more efficiently serve the workforce needs of business while also effectively helping workers find good jobs at good wages.

In collaboration with private and public sector partners, the High Growth Job Training Initiative seeks to leverage the publicly funded workforce system more effectively to prepare new and incumbent workers with the general and industry-specific knowledge and skills required by employers. HGJTI focuses on high growth industries where specialized skills curricula need to be developed, or upgraded, to ensure that workers have the **right** skills for the **right** jobs at the **right** time.

The identification of high growth industries was accomplished through research and analysis of recognized workforce sources, including the Bureau of Labor Statistics and the Bureau of Economic Analysis. Twelve industries were selected for the initial project focus, based upon high growth industry projections, economic development needs, and micro-enterprise efforts. Health care is one of the industries of focus.

This report represents an assessment of the health care initiative. It is organized into the following sections:

- **Section I –** Presents brief background on the larger context of workforce issues.
- **Section II -** Describes the information gathering and analysis phases of the health care initiative concerning workforce gaps, issues and challenges. Gaps, issues and challenges identified by informants are presented **by sector** – acute, long-term, and primary care – within health care or by those challenges that include more than one sector.
- **Section III -** Describes the information gathering and analysis phases concerning solutions to workforce challenges.
- **Section IV -** Presents the clusters of solutions which are most likely to profit from further Department of Labor and public workforce initiatives.

# I. Background on Workforce Issues

"The crisis facing America's labor market is not widely recognized."[5] This same conclusion is reflected in many recent reports on U.S. economic development that address adjusting worker skills to new technologies in industries, disparities in wages, anticipated needs of an aging population, the funding of Medicare and Social Security, and other issues affected by the labor market. The "crisis" arises from two primary sources: a significant reduction in people with required skills, and the "leveling off" of the number of American-born people available for jobs.

The slowing of educational attainment and its negative, long-term economic impact is reported to be widely ignored in the face of present economic and international concerns. The number of workers with high school completion diplomas grew 121% from 1980-2000. The twenty-year projections are for a rise of only 25 percent, or an additional 20 million workers, with high school diplomas. Moreover, the percentage of the workforce with college degrees is also expected to grow very slowly.[6] The most optimistic scenarios project a marked slowdown in skill growth.

In order to assure a strong economic future, workforce initiatives in the United States must clearly link economic development, employment **and** education. For nearly two decades, the United States has seen a marked increase in both the size and educational level of the labor force, and, as a result, the country has experienced strong economic growth. The depth and breadth of the labor pool has been driven by the large numbers of Baby Boomers entering the workplace, substantial numbers of women entering the workforce and more than a doubling of the number of college-educated workers.

However, the current reality is that such a growth in the numbers of new and educated American-born workers has ended.

> From 1980 to 2000, 26.7 million new, native-born workers age 25-54 provided the workforce needed for our dynamically growing economy. From now until 2021, there will be no additional native-born workers in this prime age group. None.
>
> Therefore, any growth in the labor force will simply have to come from older workers and immigrants.[7]

In addition to older workers and immigrants, labor growth could be realized through the development of workers from our untapped labor pool. The Department of Labor Employment and Training Administration's (ETA) High Growth Job Training Initiative takes this type of a demand-driven approach to workforce issues. During the Executive Forums, ETA asked

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[5] The American Assembly, Columbia University. 2002. *Keeping America in Business. Advancing Workers, Businesses and Economic Growth.* p 12.
[6] DT Ellwood. 2001. "The spluttering Labor Force of the 21st Century. Can social Policy Help?" in A Krueger & R Solow, editors, *The Roaring Nineties: Can Full Employment Be Sustained?* New York: Russell Sage.
[7] The Aspen Institute Domestic Strategy Group. *Grow Faster Together. Or Grow Slowly Apart. How will America Work in the 21st Century.* p 11.

employer organizations to provide their current and anticipated demand for workers, their skill shortages, their views on the capacity and appropriateness of the workforce pipeline, their identification of promising workforce practices, and their knowledge of the existing public workforce system at the local, state and federal levels. This is an important part of a demand-driven approach to workforce issues.

The intended outcomes of the High Growth Job Training Initiative are:

- Targeted investment of workforce development resources and support for private and public sector partnerships to ensure the development of workers' skills in demand occupations based on industry need.

- Improved integration of community and technical college efforts with business and the public workforce system activities to meet the training needs of high growth industries.

- Increased opportunities for employers to use registered apprenticeship training as a skills development method, combining on-the-job and academic training to ensure a pipeline of skilled workers.

- Greater access to career enhancing opportunities in high growth occupations for workers

By expanding the local workforce system's capacity to be market driven, responsive to local economic needs, and contributing to the economic well-being of the community, the Employment and Training Administration is actively promoting workforce quality, enhanced productivity, and economic competitiveness.

The ability to respond to evolving labor market demands will require strong, positive relationships between the private and public sectors. It also requires developing and maintaining a very complex set of workforce perspectives and resources, both demand-side and supply-side. One particularly valuable asset is agreement among key industry stakeholders regarding the major workforce challenges confronting the health care industry. Without agreement on these challenges, there is little or no incentive to construct solutions through national initiatives.

# II. Health Care Workforce Challenges: The View from the Field

The collection and assessment of up-to-date information on the health care industry is an important first step for the High Growth Job Training Initiative. It begins with a Health Care Industry Environmental Scan.

The major settings for health care employment are:

- Private hospitals (39.3% of health services employees. *NOTE: When government hospitals are included, hospitals employ 45% of industry workers*.[8])
- Nursing/personal care facilities and home health care services (24.2% of all employees).
- Physician offices (19.7% of employees).

The major employers are acute care hospital settings, long-term care with facility-based and home care settings, and primary care settings based primarily in large and small physician practices. (NOTE: The terms *acute care, long-term care,* and *primary care* are used in this report to refer to these employment settings.) The boards of the largest employer associations served as the primary source for representatives of the key workforce and industry leaders in health care and were among the attendees for Executive Forums held with Assistant Secretary DeRocco (see below). These Executive Forums allow business and industry an opportunity to share their current and future workforce needs with the workforce system.

The information from the Executive Forums is augmented with the results of guided interviews with key informants from national-level provider, or owner-operator, associations. Parallel to these activities, workforce data and information were obtained from associations, government departments, state-level workforce initiatives and workforce researchers. Since the workforce issues and gaps are perceived differently by workers, educators, and public and private workforce professionals than they are by employers, guided interviews with a small subset of these affected groups were also completed.

## Information Sources

### *Executive Forums*

Assistant Secretary Emily DeRocco of the U. S. Department of Labor Employment and Training Administration met with health care sector industry leaders to gather pertinent information about critical workforce issues and needs, and to hear their recommendations for how to address these issues/needs. In these forums, she had the opportunity to share the Administration's goals and plans to meet the 21st century economy's needs for a skilled workforce, and to elaborate on the current public workforce initiatives. Using this information, ETA, health care providers, and the

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[8] U.S. Department of Labor. Bureau of Labor Statistics. January 2002. *Career Guide to Industries 2002-2003 Edition.* p 184.

public workforce system can identify the workforce gaps; develop training initiatives and strategies to address the needs of business; and foster their alliance so that the publicly funded workforce system can respond to the needs of the labor market and become more of a demand-driven system.

Executive Forums were attended by approximately 200 chief executive officers or senior administrators representing the following:

- The American Hospital Association (AHA) which represents more than 523 facilities, 200,000 employees and 18,000 managed beds.
- The American Health Care Association (AHCA) which has 12,000 members of for-profit and non-profit assisted living, nursing facilities, developmental-disabilities and sub-acute care providers for 1.5 million elderly and disabled Americans. This board has representatives from each state.
- The American Association of Homes and Services for the Aging (AAHSA) which has 5,600 not-for-profit nursing homes, continuing care, retirement communities, assisted living facilities, and home and community-based service providers.
- The National Rural Health Association (NRHA) which has individual and organization members providing care to the 61 million Americans who live in rural areas and who comprise 22% of the nation's Medicare beneficiaries.
- The American Society for Healthcare Human Resources Administration (ASHHRA) which has membership from all three health industry sectors and is an affiliate organization of the AHA.

***Interviews with Health Care Industry Providers, Occupational Representatives, Educators, Workforce Professionals and Researchers***

Relevant input was also gathered through telephone or face-to-face interviews with national health care provider organizations, selected health care occupation representatives, education representatives, workforce professionals, researchers, and health care workforce reports from associations[9] and governmental bodies[10].

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[9]Examples: American Hospital Association Commission on Workforce for Hospitals and Health Systems. April 2002.*In Our Hands: How Hospital Leaders Can Build a Thriving Workforce.* Polisher Research Institute, Jenkintown, PA. February 2001. *A Report to the Pennsylvania Intra-Governmental Council on Long Term Care Pennsylvania's Frontline Workers in Long Term Care: The Provider Organization Perspective.*
[10] Examples: Report to Congress. December 2000. *The Pharmacist Workforce: A Study of the Supply and Demand for Pharmacists.* Department of Health & Human Services, Health Resources and Services Administration, Bureau of Health Professions. Report to Congress. May 14, 2003. *The Future Supply of Long-Term Care Workers in Relation to The Aging Baby Boom Generation* .Department of Labor and Department of Health & Human Services.

## Identified Challenges

The majority of the workforce challenges reported are the same or similar across primary care, long-term care and acute care sectors. For example, all types of provider groups report that the current number one problem in occupational vacancies is for registered nurses. There are, however, some identifiable differences among the provider sectors. For example, long-term care providers identify a serious concern regarding the current and projected supply/demand gap of senior managers, while neither acute care nor primary care providers shared the same degree of concern. The acute care providers' vacancies include not only a significant number of direct care workers, but also medical diagnostic and treatment technologists and support workers. The rural health vacancies across a wide spectrum of occupations are of continuing concern and made more problematic with the current vacancy rates nationally.

The agreement on the health care industry's major issues and gaps is high – regardless of source. Although an allied health professional provides a different emphasis on job scope than a nursing professional, and a community college executive holds a different perspective on entry-level requirements than a workforce professional, we found virtually no disagreement on the issues and gaps.

However, where challenges are identified in only one sector (acute care, primary care or long-term care), those are included in the challenges **only** for that sector. The challenges are phrased primarily as they were reported from the Executive Forums. Interview notes and written reports are yet another source of input on challenges.

The challenges are broken down into four categories:

- *Pipeline: Recruitment and Retention*
- *Skill Development*
- *Capacity of Education and Training Providers*
- *Sustainability: Leadership, Policy and Infrastructure*

***Pipeline: Recruitment and Retention***

The aging of the nursing workforce was raised as an issue in almost all interviews. Workforce forecasters note that the fundamental dilemma is whether the historical rates of the workforce demand side will continue, i.e., whether past projection models will have any validity in the future.

Currently, the average age of both the caregiver population and those receiving care is increasing and is likely to continue to increase for the long-term future.[11] Providers in all health care sectors and workforce-related researchers concur that aging and labor market changes create a human resource demand that current workforce and workplace approaches

[11] U.S. Department of Health and Human Services. Bureau of Health Professionals. bhpr.hrsa.gov.

will not resolve.[12] The increase of the average age of the nursing workforce is expected to lead to increasing stress and pressure for health care workers from home care to large facilities. The median age of direct caregivers with the most physically demanding work, and who are the most difficult to attract and retain, is increasing as well.

### *1.1 Labor Pool*

#### All Sectors

There are many attractive career alternatives for young people other than health care. Increased marketing of health care occupations is a major need. The public's image of careers in the health care field is reported to be less positive than it was a decade ago.

Public workforce professionals, educators and health care employers identify a need for secondary education and experience in a health care sector in order to attract more students into health care occupations.

Labor market changes are reducing traditional sources of health care workers. For example, professional occupations such as rehabilitation therapists and dieticians are comprised primarily of women. Women are increasingly entering male-dominated professions both within and outside of health care.

Community colleges, workforce professionals and some providers note that certain diagnostic and treatment-related occupations, such as respiratory therapy, are finding recruitment of students into existing community college programs to be difficult.

The greatest numbers of current and projected workforce requirements are for registered nurses, nursing assistants, and licensed practical and vocational nurses. This "demand" side assessment concurs with reports such as Bureau of Labor Statistics Occupational Projections, 2000-2010, and *Projected Supply, Demand and Shortages of Registered Nurses:2002-2020* (July 2002, DHHS HRSA, National Center for Health Workforce Analysis). The National Council of State Boards of Nursing reports that U.S.-educated graduates sitting for licensure examinations decreased 31.3% from 1995 to 2002.[13] Service occupations (e.g. food workers) are attracted to non-health care industry employment because of better compensation, working conditions, or both.

### *1.2 Diversity and Non-Traditional Labor Pools*

#### All Sectors

Greater diversity is needed in the health care workforce. Ethnic and cultural diversity amongst workers provides improved care where patients and other health care consumers benefit from insights and understandings that are culturally based. Greater gender diversity

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[12] R Stone with J Wiener. 2001. *Who Will Care For Us?* The Urban Institute and the American Association of Homes and Services for the Aging. pp. 12-18.

[13] National Council of State Boards of Nursing. www.ncsbn.org.

is also needed according to provider associations. Recruitment of men is a priority as the number of women entering traditionally female fields in health care are decreasing.

Former military personnel are a source of recruitment for health care occupations. Recognition of the articulation between military personnel preparation in health care and requirements for various occupations is needed. The Advanced Distributed Learning System of the Department of Defense training via National Guard facilities is a key player for retraining individuals to fill needed occupations, the system may be used for health care training.

There is a need to attract non-traditional workers into health care occupations. However, immigration of foreign-educated health care professionals can partially offset the labor pool decreases. Immigration issues represent a significant challenge. For example, Foreign Language Certification Programs do not seem to work (i.e. assure English language proficiency). Also, there are limitations in the number of professional personnel allowed entry into the U.S., and there are significant time delays and paperwork involved in admitting a foreign health care worker.

### *1.3 Reducing Turnover*

#### All Sectors

Workforce "demand-side" spokespersons note the clear relationship between adequate numbers and retention of employees and safe health care delivery. This concurs with findings reported in *Crossing the Quality Chasm.* [14] There are significant worker retention challenges in the industry. Employers report that the following issues are affecting retention:

- Competitive compensation (e.g. hospital pharmacists are paid less than retail market pharmacists).
- Incumbent worker training (also associated with improved job performance).
- Career progression, especially ladders and 'lattices', for lower income workers.
- Employee support in the workplace (e.g. respectful interactions, problem solving with clinical experts to help with care problems, conflict resolution training, team building, etc.).
- Programs (and technology) that reduce workplace injuries.
- The financial struggles of providers who have limited in-house resources to support training, preceptor programs and clinical rotations.

Recent studies on worker satisfaction and performance and patient safety have placed an emphasis on the need for the redesign of health care jobs, redesign of physical space and development of support systems as highly significant factors.

Hours of work vary among sectors, and since this is a source of dissatisfaction with health care careers, it has a differential impact on hospitals versus home care, in-patient health facilities versus physicians' offices, *et cetera.*

[14] Institute of Medicine. 2001. *Crossing the Quality Chasm.* National Academy Press.

Workers need to be continually updated and trained. However, funding for training is often limited. The impact of diagnostic, treatment and care technologies, such as telemedicine, new medications and medication delivery systems, and new generations of medical equipment and techniques require continual updating of education programs and health care workers. These training needs require substantial human and other resources. During budget cuts, training funds by the employers are often an early target of reductions.

Providers of care, educators and workforce professionals note the need for information technology for incumbent worker training, career development and distance learning opportunities to support attracting, retaining and retraining workers. Employees and employers need more flexibility in selecting the time and place for learning opportunities. Information technology can make training much more accessible and affordable for workers. The health care industry needs cross-disciplinary design teams to develop and expand these approaches.

One participant reported that in a particular health system, twice as much is spent on advertising for position openings than is spent on advertising products and services.

Acute Care Sector

A high labor demand exists for various levels of health care personnel, including nurses (noted above for all sectors), laboratory technicians, rural physicians, pharmacists including aides and technicians, respiratory therapists, radiologic technicians, nuclear technologists, information technicians, laboratory technologists and technicians, service managers and non-professional and technical support staff. State workforce reports include these areas in addition to specific state needs.

The acute care sector in rural areas is experiencing shortages in many occupations and this shortage is worsened by the current overall workforce shortages.

Long-Term Care Sector

Higher worker performance and satisfaction with work are directly and positively correlated with low turnover of facility administrators and chief nursing officers. Vacancies and turnover of staff have been found to be more highly correlated with director of nursing and administrator turnover than any other factors studied.[15] The levels of current turnover and projected gap in these two positions in long-term care present a serious challenge to this sector.

Gaining and retaining nursing home administrators is increasingly difficult because of the environmental constraints such as credentialing and regulation. (NOTE: An example of the

[15] Personal communication with Dr. V. Tellis-Nyak regarding his research on worker satisfaction and performance of nursing homes. April 16, 2003.

nature and extent of this challenge can be found in *The Education and Credentialing of Nursing Home Administrators in New York State*.[16])

Nursing home administrators, and not hospital administrators, are required to have state licensing examinations for licensure. There is growing dissatisfaction with this process.[17]

It is difficult to hire new registered nurse graduates who have the competencies and skills to meet the needs of a very challenging patient population. Graduates have most often received student clinical experience in the acute care sector where there is greater administrative support for care within nursing. For both of these reasons, new graduates are not trained well enough to contribute quickly and successfully in long-term care facilities or community-based care. [This is also a skill development challenge.]

Some long-term care employers are so desperate for staff that they hire new graduates before they are licensed. These new personnel may be asked to be charge nurses, although they are often unprepared to perform in that capacity. [This is also a skill development challenge.]

There is a current and projected shortage of geriatricians in the U.S. In long-term care these physicians and primary care physicians are required as medical directors as well as direct care providers. Disincentives include: reimbursement structures for physicians who must visit nursing homes (i.e. be away from their offices); a lack of knowledge about the field of practice; a need for geriatric advanced nurse practitioners and physician assistants prepared in geriatrics; and other job design factors.

Within the health care industry long-term care providers report they have greater difficulty in attracting and retaining workers compared with the acute care sector. Although there are several reasons proposed by researchers to explain this difference, one is that potential employees do not find work with the elderly to be attractive.

The American Health Care Association reports that approximately 70% of nursing homes are in rural America. The recruitment and retention challenges are greater in rural areas, as noted above.

Primary Care Sector

According to the American Association of Health Plans, large health care plan organizations have "spot" physician shortages. This was not, however, identified as an urgent problem and may be a result of health care provider competition in a particular market area.

Additional challenges, such as the demand for radiographers to meet the increasing need for mammograms, and for cytopathology technicians, were also cited. Likewise, dental care providers have a substantial and growing need for dental hygienists and, in some areas, for

[16] October 2001. *The Education and Credentialing of Nursing Home Administrators in New York State.* University at Albany School of Public Health. chws.albany.edu.
[17] Ibid.

dental technicians. Some smaller medical group practices report the need for medical secretaries and other support staff.

In rural areas the challenge is both to gain – and to retain – the physicians and the necessary laboratory and office staff to support their practices. Primary care shortage areas are reported by the Human Resources and Services Administration for each state and region.[18]

***Skill Development***

All Sectors

The demand for highly skilled incumbent workers and job applicants in the health care industry is high. Overall, the skill development challenges are the same across sectors. Differences occur among those occupations or skills needed by one sector and not reported as needed by another.

Career advancement and entry-level programs that keep pace with changing technology and systems for delivery of safe and accessible health care require continuing skill development. Effective skill development programs must be based on evidence-based interventions within the scope of practice of each occupation. In addition, both incumbent workers and job applicants require basic skills in such areas as basic science, language skills and computer literacy.

Employers, employees and educators reported that testing of skill development through credentialing is a major barrier to skill transfer and to articulation between programs.

*2.1 Entry to Practice*

All Sectors

Employers and educators indicate that there is a barrier for many post-secondary students and incumbent workers seeking to enter health care occupations. The prospective workers need to have better preparation in science, computer literacy, human ethics and language skills.

Specifically, limited proficiency in English is a challenge for many Hispanic employees and trainees as well as other "new" immigrants. The industry needs to help develop additional training in English-as-a-second-language skills because the workplace requires oral (e.g. patient care interactions) and written (e.g. patient care records) English.

Training programs for employment skills such as arranging work schedules, transportation, child care, budgeting, funding (e.g. Temporary Assistance for Needy Families), and other 'soft' skills need to be more available in high-demand locations. Moreover, entry-to-practice educational requirements for a number of professional and technological health care occupations are increasing. A minimum of a baccalaureate degree has been required of all health professions except registered nurses. An increasing number of professions are moving

[18] U.S. Department of Health and Human Services. Bureau of Health Professionals. bhpr.hrsa.gov.

to more advanced degrees for entry-level. [It is not clear whether employers think this is unnecessary or that it is a problem only to the degree it lengthens the time to prepare people for health care occupations.]

Long-Term Care Sector

Nurses often need to use supervisory skills even in beginning registered nurse, and some licensed practical nurse, positions. Few supports are in place, particularly for new graduates, to gain competence in these skills.

Unit charge nurses, a managerial position, often have limited management skills and (from research reports on certified nursing assistants[19]) contribute to the high turnover among nursing assistants.

Many faculty members are not fully equipped to teach long-term care skills and may need continuing education for this. In addition, long-term care employers noted the need for faculty who both practice and teach nursing.

*2.2 Incumbent Worker Training*

Providers and human resource administrators report a need for skill training by distance education and/or computer-assisted learning that is available at times and places convenient to all workers, regardless of work shifts or distance.

Distance learning could assist all sectors in incumbent worker training, particularly in the rural areas.

Competency models and career ladders need to be clearer in order to provide career development opportunities for incumbent workers and potential health care workers.

While most professional and technical programs include medical ethics material, providers also need to provide this content as part of continuing education for employees.

There are significant gaps in employment and training for information systems in health care.

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[19] Example: B Bowers, S Esmond, & N Jacobson (In press). Turnover reinterpreted: CNA's talk about why they leave. *Journal of Gerontological Nursing.*

*2.3 Targeted and Specialized Skills Areas*

Specialized skills programs are needed. For example, nursing assistants who receive training in the care of people with dementias can become highly skilled or specialized within their occupation. For example, long-term care administrators report a need for education and experience that improves patient care and helps retain skilled staff.

Targeted workforce occupations, such as dental hygienists, can build needed skill development on prior experience such as being a dental assistant. This skill building can be facilitated by competency models that can assess prior learning.

### ***Capacity of Education and Training Providers***

Adequate funding is a key challenge for those colleges and universities providing health care programs. Some private organizations, such as providers and foundations, financially contribute to scholarships, joint-appointments for teaching, etc., in return for students agreeing to work/provide care in their organizations or in another health care entity for a period of time following graduation. Some vendors of diagnostic and treatment technology have partnerships with post-secondary programs.

Community colleges report that as the majority of state budgets are reduced, more expensive programs, such as those requiring diagnostic equipment, supervised clinical and laboratory experience, are subject to disproportionate cuts when compared with less costly programs. They also report that some providers are less willing to accept students in clinical areas except under stringent conditions for supervision, or not at all.

Providers say they need to communicate persistently to community colleges that there is a need to deal with waiting lists for health care program applicants.

*3.1 Academic and Clinical Instructors*

Across the country, there are not enough available qualified nursing faculty in the nation's technical schools and community colleges. Community colleges also suffer shortages of qualified academic and clinical faculty to teach other health care-related occupational skills. Currently, the largest gaps are preventing the admission of applicants in nursing. However, as programs are attempting to expand in other health care occupations, the lack of both faculty and equipment is now being widely experienced.[20]

At present, faculty salaries are **not**, in many areas, competitive with those in clinical practice settings. The American Association of Colleges of Nursing reports that graduate nurse programs are experiencing a marked decline in students preparing for teaching careers, although there is an increase in those planning to practice in direct patient care areas.

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[20]Example: LE Berlin & KR Sechrist. "The shortage of doctorally prepared nursing faculty: A dire situation". *Nursing Outlook.* 2002:50-56. And interview with Dr. K Sigler, Provost for Operations, Miami-Dade Community College, Florida.

Accreditation standards for registered nurse education include requirements for faculty to hold graduate degrees in their field. The smaller proportion of graduate students in university nursing programs developing a career in education versus clinical practice preparation is reducing the faculty pipeline to colleges and universities.[21]

### *3.2 Facilities and Resources*

As noted above, higher education administrators report that with declining state resources, the more expensive programs, such as those requiring costly equipment and supervised laboratory and clinical practice, are much more subject to cutbacks. Once closed, programs are almost too expensive, and too difficult, to replace.

Access to clinical practice appears to be a complex, local issue. On the one hand, we hear reports of widespread difficulty in securing clinical placements for students because providers are less willing to take them (the reasons are primarily related to risk management), while on the other hand, we are told that clinical providers want more students but that the educators are not placing them in acute care settings, rural areas and long-term care facilities.

### *3.3 Alignment between Employment Requirements and Program Curricula*

#### All Sectors

There are at least two major issues: the 'intake' end of the pipeline and the 'outflow' end. Flexible 'intake' points for education and training programs are needed for career ladders and 'lattices'. Providers, employees and workforce professionals identify significant barriers at these entry points, such as the requirement for full-time study and traditional academic requirements when the next step on a career ladder is a certificate or degree program, while continuing employment. Students graduating from some curricula (i.e. "outflow") are seen as not well prepared for employer expectations of basic performance in their positions. [The latter is also a Skill Development issue.]

#### Long-Term Care Sector

Assessment skills of the licensed practical/vocational nurses coming through the colleges are often not sufficient to meet the needs of the long-term care profession. For example, long-term care nurses need competency in basic assessment skills to provide safe care because long-term care staff rarely have physicians available 24 hours a day. [This is also a Skill Development issue.]

In a study of alignment between what long-term care administrators are taught, what is tested in certifying examinations, and their actual job requirements, respondents reported that what is taught and examined has little to do, for example, with what state surveyors expect them to do. They spend the most time at work in some areas for which they are the least prepared.[22]

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[21] Ibid.
[22] October 2001. *The Education and Credentialing of Nursing Home Administrators in New York State.* University at Albany School of Public Health. chws.albany.edu

***Sustainability of the Workforce System: Leadership, Policy, and Infrastructure***

(Note: Some of the challenges included here duplicate a few of those listed above. They are repeated because of their relevancy to this particular challenge)

Shifting demographics are creating a long-term demand and supply problem which the health care industry has not previously experienced. The average age of the population receiving care and of caregivers is increasing now and for the foreseeable future.[23] Providers and workforce researchers concur that the aging population and labor market changes create a human resource demand that current workforce and workplace approaches are not likely to resolve. [24]

*4.1 Leadership*

Long-term, systemic change is essential if the U.S. is to have the workforce it requires to provide the quality and quantity of health care it seeks. Leaders in health care owner/operator associations note a lack of national long-term planning for health care workers in this country. One leader observed that there is a lack of vision nationally about the career potential of the health care professions in contrast to that evidenced in the area of information technology. This lack of leadership and direction was also emphasized in other interviews and conversations. The broad consensus among industry leaders was that public and private national workforce agendas need to connect.

*4.2 Policy*

All Sectors

The need for long-term, sustainable national leadership and direction to deal with workforce challenges is great. Limited resources at national, state and local levels require a strategy to allocate and align resources in the best way to meet identified workforce gaps and changes in new and evolving workforce competencies.

Policy challenges are multiple and diverse and include, among other issues, funding, immigration, licensing and regulation.

Community college funding, particularly for capacity building for occupations in health care, is a pervasive challenge. It affects faculty, facilities and the students' clinical experience. State funding is limited and/or is being reduced, the Workforce Investment Act funding for capacity building is likewise limited, and the Carl Perkins vocational/technical funding is primarily directed to secondary schools and not to community colleges. In fact, the Perkins Act is supposed to provide $1.5 billion **annually** to fund vocational training programs, and community colleges are supposed to be the focus of the funding, but this is NOT happening.

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[23] U.S. Department of Health and Human Services. Bureau of Health Professionals. bhpr.hrsa.gov.
[24] For example: R Stone with J Weiner. 2001 *Who Will Care For Us?* The Urban Institute and American Association of Homes and Services for the Aging. pp12-18.

It is imperative that a change be made to the Perkins funding process so that colleges can gain access to these funds.

Training dollars, too, are described as being in short supply for new workers and incumbent worker programs. Providers mentioned the recent funding of the Nurse Training Act as a positive benefit to the workforce support. Workforce Investment Act funds, however, are hard to secure for long-term care "unless members serve on the Workforce Investment Board so they receive funding". Also, rules for the use of employment and training funding from various sources are seen as quite restrictive.

Immigration issues also represent a significant challenge. For example, Foreign Language Certification programs do not seem to work. Also, there are limitations in the number of professional personnel who are allowed entry into the U.S., and there are significant time delays and paperwork involved in getting foreign health care workers, from such locations as the Philippines. Additionally, it appears more difficult to get medical professionals from Mexico than from Canada, for reasons that seem unclear.

There are a number of challenges involving state licensing boards and reciprocity between states. Licensing boards too often have requirements that create barriers for non-traditional learners seeking to further develop their careers, such as faculty credentials and program design. Moreover, the regulations promulgated by state boards of nursing (the licensing bodies), are reported to be barriers to keeping up with the workforce needs faced by providers in many states.

State Boards of Nursing can present obstacles in piloting innovative approaches to having more nursing clinical instructors. (An example is given in Executive Forum with the American Society for Healthcare Human Resources Administration.)

There are a number of challenges involving state licensing boards and reciprocity between states.

Finally, regulatory requirements at the state and federal levels often result in considerable paperwork and excessive time demands on direct caregivers. This regulatory burden needs to be reduced.

Long-Term Care Sector

The lack of sustainable funding for an adequately large workforce was an issue mentioned by long-term care leaders. One interviewee said: "Some argue there is too much money in the system. If that is true then where is it going? There are profitable services: the money shifts there". He recommended the need to consider a utility model for the health care delivery system as opposed to the current market model.

Tort law in many states treats acute and nursing home organizations differently. This has resulted in a plethora of litigation against nursing homes. The results are not only high costs in settlements or court decisions, but also the escalation of premium costs, or complete loss

of insurance coverage, and diversion of scarce resources away from care and management of care into risk management and legal activities.

Medicaid and Medicare regulations and the processes of oversight (e.g. state surveyors who interpret and apply state and federal regulations) are making long term-care less and less of an attractive workplace. These oversight processes are rarely applied in acute care settings.

Criminal background checks required of employees are cumbersome and their effectiveness is questionable. The objection does not concern the necessity of doing criminal background checks but rather the process used. [An alternative suggested by one interviewee is to explore the physician national-tracking system.]

### *4.3 Infrastructure*

Both the workforce demand- and supply-side organizations note the need for more *shared* information about workforce practices that are feasible, effective, and transferable to other settings. A recurrent suggestion was for a national electronic link or website that makes such information available for users.

There are significant gaps for employment and training in the field of information technology systems within health care delivery organizations. Data systems used for funding of care need to be more up-to-date and integrated across federal, state and local platforms.

Health care executives state that, in general, they have limited knowledge and experience in collaborating to anticipate and plan for changes in workforce needs with one another, with public and private workforce professionals, and, to some extent, with educational institutions.

Workforce Investment Boards need to be better known by the health care industry and more engaged in the process of filling health care jobs. They also need to be further engaged in the process of helping to find and implement solutions that will increase the available labor pool for health care occupations.

Workforce intermediaries, a number of whom have effective employee/employer collaborative programs for new and incumbent health care workers, have serious and continuing funding challenges. As a result, much of their time is spent in seeking or managing reporting requirements of funders. Most of the intermediaries' work across industries is directed at recruiting and training lower-income workers, and addressing career progression in the workplace.

Planning for the complex health care occupation curricula in post-secondary education would be considerably more adaptive to workforce needs if health care providers at the single organization or company level could perform medium-term projections of their occupational needs (ETA was provided the name of one acute care health care system that uses such projections in their partnering with a community college). The problem of medium-term projections is rendered greater by unstable funding from public and private health care payers.

***Do Workforce Challenges Differ Between Sectors?***

Most of the workforce challenges reported are the same or similar across primary care, long-term care and acute care sectors. For example, all types of provider groups reported that the current number one problem in occupational vacancies is for registered nurses. There are, however, some identifiable differences among the provider sectors. For example, long-term care providers identify a serious concern regarding the current and projected supply/demand gap of senior managers, while neither acute care nor primary care providers shared the same degree of concern. The acute care providers' vacancies include not only a significant number of direct care workers, but also medical diagnostic and treatment technologists and support workers. The rural health vacancies across a wide spectrum of occupations are of continuing concern and made more problematic with the current vacancy rates nationally.

The agreement on the health care industry's major issues and gaps is high – regardless of source. Though an allied health professional provides a different emphasis on job scope from a nursing professional; a community college executive may provide a different perspective on entry-level requirements from a workforce professional; and the Bureau of Labor Statistics' projection of occupational needs may use different analytic tools than an employers' association.

## Workforce Challenges, Clusters, and Themes

The next steps in the health care industry initiative's data and information collection require validating the clusters of challenges and identifying solutions for the challenges. Since the clusters contain too many different types of issues for decisions to be made by people involved in the next steps, each of the four clusters, drawn from the challenges identified during the Executive Forums and other sources, was **re-analyzed** for sub-issues within the four major areas. The sub-issues are ones that are directly relevant to the health care industry workforce. They provide the classification of challenges and sub-issues within them. This framework is used for information gathering activities to validate the challenges and to generate potential solutions.

- Pipeline Challenges/Issues: Recruitment and Retention
  - Increasing available labor pool
  - Increasing diversity and seeking workers from non- traditional labor pools
  - Reducing turnover

- Skill Development Challenge/Issues
  - Entry-level worker preparation
  - Incumbent worker training
  - Need for targeted and specialized areas of skills

- Capacity of Education and Training Providers Challenges/Issues
  - Lack of academic and clinical instructors
  - Lack of facilities and resources
  - Lack of alignment between employer requirements and curricula, and specialized skills areas

- Sustainable Workforce: Leadership, Policy, and Infrastructure Challenges/Issues
    - Need for sustainable and adaptive workforce partnerships at national, state and local levels
    - Opportunities to leverage funding and other resources
    - Planning tools (data, projections, and information systems that are useful in projections of demand at the single facility and local levels)
    - Policy issues including those of regulation

***External Validation of Workforce Challenges Identified by Key Informants***

The most critical question to be addressed **before** undertaking a major workforce initiative is whether the current shortages and projected demand for health care services occupations seen by employers are consistent with the findings of workforce professionals and researchers. The short answer is, "yes."

There is a high degree of consistency between employer reports, and national and state public workforce reports. The exceptions occur where a particular state labor need, such as phlebotomists, was not reported by national employer associations. Salsberg [25] notes that the major short-term factors contributing to occupational shortages include:

- Competition for workers during a full economy in an industry growing even faster than the rest of the economy. Some program enrollments are now increasing where there is capacity to do so. This increase may also be due to an economic slowdown.
- Educational capacity takes time to build. A program of studies takes time to complete. "Lack of good data and good forecasts of supply and demand contribute to slow responses by the education and training sector."
- Rising demand for health care during the 1990's and rising demand for specialized professionals.
- A decreased interest in health care occupations.

The most widely recognized source for labor data and projections is the Bureau of Labor Statistics. The occupational employment projection from 2002 to 2012 for the health care occupations is 28.8% in contrast to 13.8% for non-health care occupations. New job openings are projected to be 2.9 million. Projected replacements for departed workers are 1.8 million. The largest single number of workers needed is for registered nurse employment.[26]

There is sufficient demographic information about predicted health care needs and labor market projections to support a concentrated workforce effort in health care.

[25] E. Salsberg. 2003. *Making Sense of the System: How States Can Use Health Workforce Policies to Increase Access and Improve Quality of Care.* New York: The Milbank Memorial Fund commissioned report for The Reforming States Group. pp 14-15.
[26] U.S. Department of Labor. Bureau of Labor Statistics. February 2004. *Monthly Labor Review*.

# III. Potential Solutions for Addressing the Health Care Industry Challenges

## The Health Care Industry Responds to Its Workforce Challenges

As ETA gathered information from executives in the health care industry, it learned of exciting and effective workforce initiatives already taking place across the country. The solutions are often directed at improving the quality of health care delivery through improving the workforce. Examples of successful interventions are described in an American Hospital Association document addressing the opportunities to "build a thriving workforce".[27] Programs to increase retention and improve the quality of care in some elder care settings are supported through a growing movement to change the culture of aging in long-term and other care settings.[28] Some state and federal workforce system programs are being directed toward health care issues and gaps.[29] Some interventions are being implemented by post-secondary education institutions in partnerships with employers.[30] Research on workforce interventions is being initiated in a multi-site study.[31]

It is clear that employers, employees, educators, workforce professionals and others in many communities are seeking ways to improve the number and quality of health care workers. However, it is also clear that leaders in the health care industry experience a lack of national workforce leadership and direction. They know that past "crises" in health care have been met by a flurry of initiatives followed by a drying up of support and resources to continue them at the first sign of budget cuts or an economic downturn. Few previous workforce "crisis interventions" survived.[32] During Executive Forums, health care leaders said they had little awareness of the public workforce system, how it could be of use, or how to access the system. They note the need for a much greater knowledge of effective initiatives implemented elsewhere. They welcome the High Growth Job Training Initiative and support going beyond workforce challenges to solutions in a much more systematic and effective way. They are sensitive to many of the complexities of gaining and maintaining an adequate health care workforce system and the support required. Leaders frequently pointed out the need for much broader collaborative efforts to deal effectively with health care workforce challenges.

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[27] American Hospital Association Commission on Workforce for Hospitals and Health Systems. July 2002. *In Our Hands.*
[28] Pioneer Network. www.PioneerNetwork.net.
[29] For an overview of state actions see: bhpr.hrsa.gov.
[30] Source: Colleagues in Caring Project, American Association of Colleges of Nursing with the funding of the Robert Wood Johnson Foundation. www.aacn.nche.edu/CaringProject/index.htm.
[31] Source: Better Jobs, Better Care Project, American Association of Homes and Services for the Aging with the funding of the Robert Wood Johnson Foundation and The Atlantic Philanthropies. www2.aahsa.org.
[32] An example would be the American Nurses Association Magnet Facilities Credentialing Program. www.nursingworld.org/ancc/magnet/facilities.html.

## The High Growth Job Training Initiative: Generating Solutions

The High Growth Job Training Initiative (HGJTI) specifically seeks collaboration with workforce and industry partners to resolve the industry's workforce needs. Partnerships require a shared understanding, not only of the challenges, but also of potential solutions. Thus, the next phase of the HGJTI effort involved participants from four groups: 1) health services employers; 2) health care giver and medical diagnostic and support occupations; 3) educators; and 4) workforce professionals. The goals of these engagements were to provide a process to assure a shared understanding of health care workforce challenges by participants, to generate solutions for these challenges, and to select the higher priority solutions and describe them more fully.

### *Process*

The goals were met by a second step in *information gathering* and *analysis*, performed prior to and during the course of three Workforce Development Forums (WDF) held in October 2003. The 126 forum participants were selected from a pool developed through nominations sought from owner/operator associations, the American Association of Community Colleges, the National Association of State Workforce Agencies, the National Association of Workforce Boards, the Department of Labor, and other workforce leaders from whom project staff had previously sought information. Some of the participants represented health care workforce projects currently funded by the Employment and Training Administration.

Prior to the forums, participants were asked to complete a validation tool containing challenges gathered while collecting information in the earlier part of the initiative, and invited to suggest additional issues. In addition, an overview of the challenges and issues was presented at the forums. Participants were asked for additional discussion, areas of disagreement, and input. Although they made some clarifications, the participants made no changes to the challenges.

Participants in each of the forums were assigned to one of the four challenge clusters (i.e., pipeline, skill development, etc.). Each group was assigned a facilitator trained in the Nominal Group Process.[33] Participants clarified issues on which their group was working and generated a list of solutions and ranked the solutions by a voting procedure.

During the lunch break, participants were invited to visit the other rooms to review the work of the other groups. Each room had a flip chart entitled: "Did you think of this?" which enabled participants to suggest solutions to challenges to which they were not assigned (these solutions are identified in Attachments 3).

In total, 1001 solutions were put forward from the group work (see Attachment 3). A number of solutions are similar to one another in response to a particular issue. The participants were

[33] A.L. Delbecq, A.H. Van de Ven & D.H. Gustafson. 1975. *Group Techniques for Program Planning: A Guide to Nominal Group and Delphi Processes*. Glenview, Illinois: Scott, Foresman & Company.

unaware of solutions generated at other forums. Therefore, some solutions were developed further by more than one group. (See footnote[34])

For the 83 highest-ranked solutions, small teams worked to develop a matrix for each solution (see Attachment 1 and 2). Each matrix is identified by the overall challenge (e.g., Skill Development), the issue (e.g., Targeted/Specialized Skills Areas), and the suggested solution. The teams then identified critical attributes for a successful solution, key stakeholders, resources required, policy barriers at the local, state and national level, and any other needed clarifications.

***Product***

The products of the workgroups can be found in Attachment 1 and 2.[35] The collected and collated group matrices were reviewed to determine the types of solutions identified by participants in response to the workforce challenges. The highest-ranked solutions include recommendations in the following areas:

- Issue: Pipeline: Recruitment and Retention
    - Solution: Creating and expanding youth-focused programs to better inform young people about health care careers and encourage them to consider health care occupations.

- Issue: Pipeline: Recruitment and Retention
    - Solution: Ensuring that public workforce programs provide adequate preparation of entry-level workers in the basic knowledge required to enter many health care occupations, adequate social and financial supports during the training period, opportunities for work placement, and support during the transition to the workplace so that these workers can succeed and be retained in the health care industry.

- Issue: Pipeline: Recruitment and Retention
    - Solution: Marketing health care career opportunities to youth, potential worker pools that do not traditionally enter the health care industry, dislocated workers, immigrant communities, older workers, and traditional worker pools.

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[34] The large number of solutions is useful for readers who have a workforce challenge and who are seeking a range of ideas for solutions. In Attachment 3, a small set of interesting or unusual solutions have been placed in the opening portion of Attachment 3. These solutions were not expanded upon by the Workforce Development Information Forum work groups.

[35] The reader should note that the challenge *Sustainability: Leadership, Policy and Infrastructure* has only three solutions developed by one team in each forum. In Washington, we learned the interventions required participants with knowledge and experience in implementing a solution at the state level. Participants with this background were identified from all three of the groups and asked to form a fourth group to develop a solution. During the Salt Lake City and Chicago forums the teams were selected in advance for their prior work at the national or local level. These two teams were not involved in the generation and ranking of solutions in contrast to all other groups. They focused only on completing the matrix for a national or a local workforce infrastructure.

- Issues: Pipeline: Recruitment and Retention and Skill Development
    - Solution 1: Attracting and retaining workers through significant improvement of the "culture" of the health care workplace by implementing shared governance, incumbent worker training, career ladders, access to education and training opportunities, and other attributes identified by employees, researchers, and from exemplary continuous improvement programs.
    - Solution 2: Providing management training and credentialing in long-term care, consistent with this type of workplace improvement.

- Issue: Skill Development
    - Solution: Designing health care occupation curricula that provide the basic knowledge and skills needed for effective entry to practice in the high growth areas of employment in primary care, long-term care and acute care sectors. Develop curricula so that there is a fit between programs for advancing the careers of health care workers (often provided through the workplace), and the requirements of the educational institutions.

- Issue: Skill Development
    - Solution: Examining the state credentialing requirements with the goal of expanding less traditional paths to meeting occupational requirements, such as career ladders, apprenticeships and other workforce development strategies. Creating "cross walks" from practice to educational programs and credentialing requirements based on nationally developed measurement of worker skills.

- Issue: Capacity of Education and Training Providers
    - Solution: Addressing the capacity problems (i.e., lack of faculty, resources, etc.) in many community colleges and other post-secondary education and training organizations, where barriers to applicants exist and where there are inadequate numbers of qualified applicants for actual or projected demand for some health service occupations. Capacity is affected by lack of faculty and other resources.

- Issue: Sustainability: Leadership, Policy and Infrastructure
    - Solution: Partnering among a wide range of stakeholders in the health care workforce, in order to project changes in workforce demand at the local/regional, state and national levels and to generate long term, efficient, and sustainable approaches to those changes.

- Issue: Sustainability: Leadership, Policy and Infrastructure
    - Solution: Developing methods for projection of medium-term occupational needs that can be used by a health care entity, such as a hospital or home care agency, as a basis for internal planning and for planning with partners in education, workforce development and other health care workforce stakeholders.

### *Review*

The Department of Labor Employment and Training Administration's Business Relations Group reviewed the solutions generated during the Workforce Development Forums. The purpose of the review was to:

(a) Identify for *referral* those solutions that are both the responsibility of other entities and not in the domain of the Department of Labor;
(b) Identify solutions that are *jointly* in the domain of the Department of Labor and another federal department;
(c) Identify solutions where the Department of Labor or the public workforce system *already have program commitments*; and,
(d) Identify solutions *within the Department of Labor's domain* that if implemented effectively and widely will have a significant impact on managing the present and future workforce challenges of the health care industry. The latter group of solutions was examined by asking the question: "How can the Employment and Training Administration best use its resources and influence to have a positive impact on the challenges identified by the health care industry?"

### *Solutions for Initial Action*

The solutions recommended for initial action are ones that can be adapted to many settings, that are built on partnerships among stakeholders that provide other opportunities to leverage resources (including funding), and that are relevant to the basic problem of adapting the workforce to changing industry needs.

The solutions anticipated to have the clearest impact include the following program areas:

- ✓ Youth-related programs developed and implemented by partnerships that include schools, health care employers, post-secondary programs for health occupations, and public workforce system entities.

- ✓ Programs focused on non-traditional and traditional labor pools for health care entry-level workers that both broaden approaches to preparation programs and enhance career mobility in health care and related industries. Competency models for these programs should be developed through a partnership of educators, employers, and workforce professionals.

- ✓ Initiatives that meet the needs for academic and clinical faculty in high-demand health care education programs and that are designed to adapt to changing levels of workforce demand.

- ✓ Programs that deal with the community college and other educational organizations' insufficient capacity through innovative partnerships and other approaches. These capacity issues include the need for appropriate clinical practice opportunities, funding for students, diagnostic and treatment equipment, and laboratory support.

- ✓ Improvement of health care workplaces by interventions such as management training, incumbent worker training, career mobility programs, accessible education and training opportunities, and reducing staff fluctuations through workforce projections.

- ✓ Effective initiatives to build a sustainable national infrastructure with local, state, and national elements tasked with continuous balancing of workforce demand and supply within the health care industry.

- ✓ Creation and maintenance of a national source for accessible information about innovative and effective workforce initiatives for high growth industries, including the health care industry.

The majority of the solutions identified by forum participants are not sector specific. However, many solutions can be adapted to the particular needs of a sector or a community.

***National, State and Local Partnerships for Workforce Solutions***

Dealing with workforce challenges in the health care industry requires collaboration at the national, state and local levels, and between these levels. Executive and Workforce Development Industry Forum participants recommend a national, sustained and systemic approach that aligns the workforce resources available with the challenges facing the health care industry today and well into the future. This direction is consistent with the thinking behind the High Growth Job Training Initiative.

A central role of the Employment and Training Administration is that of identifying and communicating effective workforce solutions that can be replicated to respond to national challenges such as management training or youth-related recruitment programs. A second aspect of that role is the funding of pilot programs, by ETA alone or in partnerships, that are most effective in dealing with some aspect of workforce challenges, and that are replicable by other entities. At the national level, providers and others also identify the need for a national warehouse of sound and effective workforce interventions with a search engine that makes it possible for a local Workforce Investment Board, a human resources manager, or others to identify solutions that have worked elsewhere.

The action of state governments and state-level entities are pivotal to any national workforce effort. State government decisions direct how some federal funding is used to support some workforce programs. For example, the Workforce Investment Act provides funding to states, and through the states to local Workforce Investment Boards and workforce-related programs. These funds and others, such as Temporary Assistance to Needy Families and Medicaid, are used to provide training, support, and placement for many occupations including those in health care. It is at the state level that policy and funding decisions are made about higher education, licensing and regulation. Reanalyzing the Medicaid programs that directly affect employment conditions and delivery of care, worker training, collection of information for programs and policy development, and other initiatives that influence the implementation, was among many of the solutions recommended in the Executive Forums and Workforce Development Forums. A

sustainable[36], adaptive and effective workforce strategy in health care requires strong public and private partnerships in every state. Without these partnerships the health care industry cannot respond adequately to current problems or prevent future ones.

Local partnerships, including Workforce Investment Boards, employers, employees, educators and other community members, are needed to implement workforce solutions closest to health care delivery sites, and to potential labor pools. Through such partnerships, both the workforce demand and supply sides can identify the needs in their own communities. Partners can use their state and national networks to find solutions to better manage their particular challenges.

[36] Note: In a recent survey of states and territories regarding health care workforce activities, 44 of 50 states reported only *temporary* responses. U.S. Department of Health and Human Services. Bureau of Health Professionals. bhpr.hrsa.gov.

# Attachment 1

# Health Care Industry's Solutions Matrix – Full

# Health Care Industry's Solutions Matrix - Full

| Health Care | Critical Attributes | Key Stakeholders | Shared Resources | Policy Barriers | Sector Specific? | Additional Info. |
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| **Issue/Challenge: Recruitment and Retention** | | | | | | |
| Issue: Ensuring the Skills of Entry-Level Workers<br><br>Solution 1 from Washington DC<br><br>To develop a competency-based instructional and assessment system that covers all para-professional employees that leads to national standardized certifications and requirements.<br><br>**Overall Solution 1** | ▪ Applied research component that links competencies with quality of jobs and quality of patient care.<br>▪ Skills are anticipated.<br>▪ People acquire skills that enable them to provide superior patient care.<br>▪ The instructional system is broken into modules that do not require a set sequence. There are many modules common to many jobs.<br>▪ Allows people to progress within that job and/or other related jobs.<br>▪ Credentials are portable to other settings and across states.<br>▪ Assessment supports individualized learning and provides information to support hiring, promotion, and further education.<br>▪ Uses technology for assessment and instruction where appropriate.<br>▪ Builds upon best practices in other industries (ETS, | ▪ DOL<br>▪ DHHS: Health, Welfare<br>▪ Department of Education<br>▪ DOD<br>▪ Organized Labor<br>▪ Consumer Organizations<br>▪ Health Employees<br>▪ Community colleges and other educational providers<br>▪ Nursing organizations<br>▪ Associations: AHA, AHSHRA<br>▪ Licensing Boards<br>▪ WIBs and State WIBs | ▪ Dedicated funding stream for development and implementation<br>▪ Association summit and agreements so that they might advocate with their members<br>▪ System of skilled trainers to manage and deliver<br>▪ Experts who have developed similar systems<br>▪ Communication systems – website, newsletter<br>▪ Labor market analysis | ▪ WIA (Senate) restricting to community colleges should be broadened to include others<br>▪ Workfirst philosophy should be refocused to emphasize training<br>▪ Revenue decline of workforce training dollars<br>▪ Support legislation that support training allied health moving the Nurse Reinvestment Act<br>▪ Promote integration of HHS, DOL, & DOE systems and resource at the national and state levels<br>▪ Promote integration of the various healthcare employment and | ▪ All | ▪ Seeks venture capital. |

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| | Manpower) for both instructional method and assessment – National demonstration of integrating health care, workforce and education systems. | | | association. | | |
| Issue: Ensuring the Skills of Entry-Level Workers<br><br>Solution 2 from Washington DC<br><br>The DOL will exercise leadership in identifying the needs and finding ways to implement and institutionalize skills training for entry-level health care workers at the national, state, and local level.<br><br>**Overall Solution 2** | ▪ DOL provides political and administrative leadership on the healthcare initiative.<br>▪ Help White House, as well as other federal partners, and state and local operations take this as a priority.<br>▪ DOL will establish goals and analyze at least on an annual basis and publish health care industry report card on the workforce a quarter of end of the fiscal year.<br>▪ DOL will establish discretionary Grant Healthcare Initiative. | ▪ DOL:<br>▪ National<br>▪ State<br>▪ Local/WIB<br>▪ White House | ▪ DOL Funding<br>▪ Leadership<br>▪ Data<br>▪ Convener<br>▪ Communication Channels:<br>▪ Political Administrative System<br>▪ Agenda | ▪ Interagency coordination/<br>▪ Communication among DOL, DHHS … (to prevent "warfare")<br>▪ Staffing at federal level | ▪ All | ▪ BLS needs to have data for Healthcare Initiative<br>▪ Have other agencies look into Healthcare Initiative (such as GAO) |
| Issue: Employment & Working Conditions<br><br>Solution 3 from Washington DC<br><br>To enhance the public image and awareness of employment opportunities in the health care profession<br><br>**Overall Solution 3** | ▪ Coordinated nationwide marketing effort publicizing full range of health care opportunities.<br>▪ Buy-in by key professional organizations and associations.<br>▪ High quality national marketing/advertising organization.<br>▪ Ensure outreach to a diverse non-traditional audience.<br>▪ Designed programming for long-term effort. | ▪ DOL<br>▪ HHS<br>▪ Elected Officials<br>▪ Professional organizations and associations<br>▪ Providers<br>▪ State and local workforce boards | ▪ Funding<br>▪ Donated resources<br>▪ Informational resources to prepare advertising tracking methodology to determine impact/intake and diversity<br>▪ Stakeholder forums for support of the effort<br>▪ Funnel inquiries through One-Stop centers | ▪ None | ▪ All but audiences may differ | ▪ Impact measures and publication<br>▪ Ensure program continuation over the long term (Three or more years.) |

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| Issue: Employment & Working Conditions<br><br>Solution 4 from Washington DC<br><br>Continuous problem solving involving all levels to improve the working environment in order to increase retention.<br><br>**Overall Solution 4** | ▪ Buy-in by all levels<br>▪ Adequate preparation and training at all levels: Communication, problem solving<br>▪ Incentive system to support participation<br>▪ Open, honest discussion without fear of retaliation<br>▪ Method to validate change in environment | ▪ CEO to entry-level workers<br>▪ Trainers | ▪ Time to train people<br>▪ Time to carry out problem solving<br>▪ Development of training materials<br>▪ Guidelines/parameters<br>▪ Staff person to ensure accountability of the process | ▪ Union contacts<br>▪ Medicaid funding<br>▪ Internal organization and rules and roles<br>▪ State laws regarding licensure and certification | ▪ All | ▪ Impact measures showing increased retention and reduced recruitme nt costs |
| Issue: Employment & Working Conditions<br><br>Solution 5 from Washington DC<br><br>Identify successful cultural change initiatives to provide "models" to institutions that are struggling with how to improve their working environment.<br><br>**Overall Solution 5** | ▪ Criteria to identify successful models (best practices)<br>▪ Method to catalog existing change initiatives<br>▪ Distribution channel to communicate "models"<br>▪ Determine a methodology to set a reasonable turnover rate for health care jobs | ▪ Public and private funders and providers<br>▪ Experts in change modeling to direct the efforts | ▪ Train-the-trainer<br>▪ Funding to identify successful models and catalogue<br>▪ Resources to develop turnover goals | ▪ Could be policy barriers identified in certain programs<br>▪ Potential liability issues | ▪ All | ▪ Must keep up with the times and change as required |
| Recognizing that the current supply of workers will not be adequate to meet future health care demands, we need to identify solutions to recruit non-traditional workers (such as, but not limited to: men, older adults, and | ▪ Market research to determine what messages will interest diverse populations in nursing and allied health careers.<br>▪ Marketing research on how to project an image that will appeal to non-traditional workers to enter the industry. | ▪ Social marketing people<br>▪ Leaders in nursing and allied health to support the effort and validate the information. | ▪ Money (grant) to do the research.<br>▪ Pilot the program<br>▪ Media advertising | ▪ None | ▪ All | ▪ Ensuring existing recruitme nt efforts by education al institution s to reflect the lessons |

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| individuals from culturally and linguistically diverse communities.)<br><br>Solution 6 from Washington DC<br><br>Design of a national marketing campaign to sell nursing and allied health careers and give information on career entry.<br><br>**Overall Solution 6** | | | | | | learned on effective messaging and imaging.<br>▪<br>▪ |
| Issue: Recognizing that the current supply of workers will not be adequate to meet future health care demands, we need to identify solutions to recruit non-traditional workers (such as, but not limited to: men, older adults, and individuals from culturally and linguistically diverse communities.)<br><br>Solution 7 from Washington DC<br><br>To expose people, beginning in elementary school thru post-secondary.<br><br>**Overall Solution 7** | ▪ Development of a tested tool kit on how to recruit non-traditional workers (young workers and older workers) into nursing and allied health.<br>▪ Identification of champions and ambassadors with a sustainable commitment to health care careers … exposure and career opportunities, and retaining of the workforce. | ▪ National clubs and organizations<br>▪ Public and private school systems<br>▪ Associations<br>▪ Industry partners<br>▪ Private employers<br>▪ School systems (vocational counselors and teachers)<br>▪ Department of Education, federal and state<br>▪ Department of Labor, federal and state<br>▪ Chambers of Commerce | ▪ Community colleges (nursing programs and allied health programs)<br>▪ Federal "train-the-trainer and implementation grants<br>▪ Support form key decision makers in local communities<br>▪ Bilingual and bi-cultural resources | ▪ Lack of local funding<br>▪ Overcoming security issues with getting students out into health care environments | ▪ All | ▪ Organized paid and unpaid work opportunit ies in all of these healthcare organizati ons<br>▪ Continued support and funding for champion s |
| Issue: Recognizing that the current | ▪ Identification and replication of what works | ▪ Targeted and/or board coalitions of CB & Faith- | ▪ Social marketers<br>▪ Coordination w/state, local | ▪ Support for non-traditional | ▪ All | ▪ Continued funding |

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| supply of workers will not be adequate to meet future health care demands, we need to identify solutions to recruit non-traditional workers (such as, but not limited to: men, older adults, and individuals from culturally and linguistically divers communities.)<br><br>Solution 8 from Washington DC<br><br>To develop targeted recruitment and retention strategies with community-based organizations (EMS Volunteer services programs, e.g., fire department, area aging agencies) nursing and allied health workers and faith based organizations. *ONLY EXAMPLES.*<br><br>**Overall Solution 8** | ▪ Developmental grants to identify community leaders who can help a coalition of key players to the table as program participants<br>▪ Trained individuals who represent the communities that are in or they are going to … to motivate individuals | based organizations | funding<br>▪ Targeted resources, training and counselors for non-traditional workers | workers to make the choice (e.g., wage, transportation, training resources tailored to that non-traditional worker) | | for the champion s with CBOs and FBOs. |
| Issue: Incumbent worker training<br><br>Solution 1 from Salt Lake City<br><br>Solution: Increased flexibility of educational program provider offerings | ▪ Identify and secure public and private providers<br>▪ Staffing availability/ flexibility<br>▪ Multiple delivery program delivery systems (web, satellite, traditional classrooms, etc.) | ▪ Employers<br>▪ Vendors<br>▪ Academic institutions<br>▪ Faculty/staff<br>▪ Faculty<br>▪ Employers<br>▪ Employees | ▪ Instructional/training staff program/administration money<br>▪ Money for staffing<br>▪ Distance learning program offerings from vendors<br>▪ Educational institutions<br>▪ Trade associations | ▪ Public/private, e.g., boards of regents<br>▪ Accrediting bodies | ▪ All | |

| **Overall Solution 9** | | | | | | |
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| Issue: Incumbent worker training<br><br>Solution 2 from Salt Lake City<br><br>**Solution: Create a learning culture that provides time, access, and compensation for learning**<br><br>**Overall Solution 10** | ▪ Employer provided flexible scheduling and/or educational leave<br>▪ Reasonable workloads to allow for access for training<br>▪ Provision of adequate learning space, equipment and learning materials<br>▪ Active employer promotion of programs<br>▪ Making career counseling available to employees at not cost regarding growth opportunities within the institution/organization<br>▪ Maintain payment of salaries while attending learning activities<br>▪ Create flexible and creative plans to provide elective and temporary growth and development opportunities (based on personal circumstances)<br>▪<br>▪ | ▪ Employers<br>▪ Department managers<br>▪ Employees | ▪ PRN staff and money to pay<br>▪ Technical – technological equipment to support efficient work processes<br>▪ Money, equipment, printed materials<br>▪ Professional/skilled career counselor and money to pay<br>▪ Money | | ▪ All | ▪ Tradition |
| Issue: Incumbent worker training<br><br>Solution 3 from Salt Lake City<br><br>Solution: Incentives for employee growth, development and continuing education<br><br>**Overall Solution 11** | ▪ Needs assessment system (for employee)<br>▪ Improved parity of wage and salary program among professions with equivalent education and training<br>▪ Employee commitment to assisting/contributing to employees continuing education costs<br>▪ Employer providing interim staffing when | ▪ Representatives of employee groups, HR/Staff development coordinators<br>▪ Individual practitioner groups<br>▪ Management/managers/admin istration.<br>▪ Human resources<br>▪ Employer (finance division)<br>▪ Employees<br>▪ Employees and department managers<br>▪ Academic institutions<br>▪ Employers | ▪ Data analysis consultant or expertise<br>▪ Market surveys: national/regional wage and salary info<br>▪ Information on wage requirements<br>▪ Need dollars<br>▪ Implementation plan<br>▪ PRN (as needed) staff and dollars to pay<br>▪ Degree granting institutions | ▪ Internal assumptions<br>▪ Accrediting bodies | ▪ All, but most critical in long-term care (includ es home care) based on nationa | ▪ Assumpti ons about employee needs, goals, etc.<br>▪ Tradition as potential barrier |

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| | employee is absent for learning purposes<br>▪ Recognize and accept experiential learning as credit toward degree completions<br>▪ Employer publication and marketing of program offerings<br>▪ Employer providing employee opportunity to assume additional responsibilities (e.g., project management, training, etc.) | ▪ Employees<br>▪ | ▪ (No special demands on resources except for cost of credit review by Academic Institution)<br>▪ PRN (as needed) staff and dollars to pay | | l average compen sation for these worker s | |
| Issue: Targeted specialized skills areas: How to help retain/orient new hires<br><br>Solution 4 from Salt Lake City<br><br>Solution: Create mentoring opportunities to acculturate new staff to the department or company<br><br>**Overall Solution 12** | ▪ Adopt apprenticeship model of using industry mentors to help orient new hires to promote retention. | | | | ▪ All | |
| Issue: Targeted specialized skills areas: Filling specialty jobs<br><br>Solution 5 from Salt Lake City<br><br>Solution: Develop system to identify, project and match/map | ▪ Take experience into account: give credit toward academic degrees/certificates<br>▪ Collaboration across disciplines to identify competencies and build training (educators, managers, recruiters, workforce planners, labor) | ▪ Frontline managers<br>▪ Educators (industry and academic settings)<br>▪ Recruiters<br>▪ Workforce boards<br>▪ Healthcare administrators<br>▪ Labor<br>▪ Students | ▪ Assessment tools<br>▪ Funding to conduct competencies and gap analysis<br>▪ Incentives for industry to consider training non-traditional students<br>▪ Innovative solutions (build on what's out there) | ▪ Educational institutions not recognizing or providing credit for experiential learning | ▪ All | ▪ Process Steps:<br>▪ Access the skills/com petencies required for jobs across healthcare and other |

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| competencies for roles within health care and across industries to identify matches and skill gaps. Create training to bridge the gap.<br><br>**Overall Solution 13** | ▪ Use assessment tools (e.g., work keys) individuals' skill level in confidential setting<br>▪ Educational institutions willing to approve innovative or pilot training programs | | | | | industries<br>▪ Match jobs by competencies development paths, ladders, links<br>▪ Develop training programs as needs arise<br>▪ Evaluate<br>▪<br>▪ This process can be done on very local level for a particular job or could be used for retraining |
| Issue: Targeted specialized skills areas: Staff skills necessary to develop into management and supervisory roles<br><br>Solution 6 from Salt Lake City<br><br>Solution: Develop management certificate program<br><br>**Overall Solution 14** | ▪ Support groups of class participants for regular follow-up to reinforce learning<br>▪ Courses offered on flexible schedule (on paid time, distance learning/online)<br>▪ Mandatory for those going into supervisory roles<br>▪ Evaluation process | ▪ Administrators<br>▪ Healthcare professionals<br>▪ Pre-management staff<br>▪ Staff of new manager<br>▪<br>▪ Partners to help develop programs:<br>▪ educators<br>▪ managers<br>▪ apprenticeship programs | ▪ Trainers<br>▪ Tracking system<br>▪ Funding to develop, offer and sustain training<br>▪ Funding to backfill staff while in training and follow-up<br>▪ Training materials | ▪ Industry leadership buy in to offer it and make it mandatory-make it happen<br>▪<br>▪ Examples of training skills components:<br>▪ listening<br>▪ communication<br>▪ budget/ accounting finance | ▪<br>▪<br>▪ Of use to all sectors but is essential in nursing homes according to informants | ▪ Consider a 'capstone' class or mini-project to tie all the learning together<br>▪ Classes could be cross-disciplinary or not<br>▪ Programs |

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| | | | | ▪ understanding the business (competition, regulation, strategy, vision)<br>▪ how to give performance reviews<br>▪ delegation<br>▪ HR: regulations and labor law<br>▪ Workers comp process<br>▪ OASH and other regulators | | could be multi-employer<br>▪ Can use this process for supervisor training an well as managem ent training |
| Issue: Entry-level worker preparation<br><br>Solution 7 from Washington DC<br><br>Solution: Provide English as a second language programs to develop language skills and meet minimum job requirements<br><br>**Overall Solution 15** | ▪ Identify training facilities and develop program partnerships<br>▪ Locate appropriate populations<br>▪ Identify areas of employment where bilingual employees are preferred or desirable<br>▪ Guarantee employment if program is completed successfully through sponsor or placement services | ▪ Appropriate basic skills instructors – GED, EDS, etc.<br>▪<br>▪ For marketing efforts<br>▪ Partnership with local media outlets<br>▪ Partner with local churches<br>▪ Community champion – major or other official | ▪ Qualified instructors<br>▪ Program sponsor for financial needs- hospital<br>▪ Human resources coordinator for oversight of program and for placement | ▪ Citizenship status for employment<br>▪ Background checks | ▪ All | ▪ Provide remediati on and GED prep training<br>▪ Spanish for health profession al |
| Issue: Entry-level worker preparation<br><br>Solution 8 from Salt Lake City<br><br>Solution: Increase exposure of students to health care workforce environment in junior high and high schools | ▪ Partnerships between health care institutions and middle and high school to establish mentors for a health care career<br>▪ Utilize a 'big brother/big sister' program for health care professionals to 'adopt' children<br>▪ Introduce applied science | ▪ Interested health care professionals<br>▪ Interested school officials<br>▪ Interested students<br>▪ Interested faculty<br>▪ Business, health care facilities to host field trips<br>▪ Location for speakers bureau | ▪ Committed individuals in schools, health care and industry to promote program | ▪ Local educational barriers, re., prescribed curriculum in K-12<br>▪ Limitations on K-12 students field trips<br>▪ Limitations on institutional and | ▪ All | ▪ Evaluatio n and establish ment of appropriat e protocols for introducti on of the health |

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| **Overall Solution 16** | lesson plans into elementary and middle school curriculum targeting health care science applications, field trips, speakers bureaus, demonstration, and science career days<br>▪ Local champion to act as cheerleader | | | health care facility permission to spend time on the task | | care workforce environm ent |
| Issue: Entry-level worker preparation<br><br>Solution 9 from Salt Lake City<br><br>Solution: Develop and sustain partnerships between local educational institutions and the health care industry<br><br>**Overall Solution 17** | ▪ Willingness to participate in initiative<br>▪ Sites for training – clinical and classroom<br>▪ Sites for employment<br>▪ Champion for partnership<br>▪ Communicate/market program to public and potential students<br>▪ Sensitivity to customized training needs (flexible and diverse to accommodate community needs<br>▪ Identify students who are in the appropriate maturity/interest level to complete training | ▪ All secondary schools<br>▪ All higher ed institutions<br>▪ All health care provider<br>▪ Local government support<br>▪ Local chamber of commerce, other community leaders | ▪ Clinical staff<br>▪ Lecture staff<br>▪ Overall coordinator<br>▪ Champion – important financial and community supporters<br>▪ Clinical sites | ▪ Liability insurance<br>▪ Funding<br>▪ Health insurance for students<br>▪ Restrictions in certain areas<br>▪ HIPAA – age appropriateness for certain patient info | ▪ All | ▪ Provide customize d training<br>▪ Establish health academies as part of partnershi p<br>▪ Provide remediati on and GED prep training |
| Career Ladder / Lattice<br><br>Solution 1 from Chicago<br><br>Develop career paths to accommodate vertical and horizontal moves within the health care field | ▪ To develop national models for unique career ladder issues.<br>▪ Career development planning<br>▪ Senior management champion | ▪ National organization professionals<br>▪ Educational partners at all levels<br>▪ Employees<br>▪ Management<br>▪ Patients | ▪ Existing models<br>▪ Staff to implement<br>▪ Apprenticeship models | ▪ Instructor shortage | ▪ All | |

| **Overall Solution 18** | | | | | | |
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| Issue: Through Development of a Health Corps to Increase the Available Labor Pool<br><br>Solution 2 from Chicago forum<br><br>Develop a Health Corps, based on the Peace Corps or Teachers Corps model<br><br>**Overall Solution 19** | ▪ Jointly funded/supported by federal government and private industry<br>▪ Requires partnerships with education<br>▪ Cover all aspects of health care in every market<br>▪ Clear understanding of outcomes<br>▪ Develop specific criteria for participation<br>▪ Oversight group or agency<br>▪ Cost effective/cost savings<br>▪ Need a snappy uniform to wear | ▪ Health care agencies<br>▪ Private industry<br>▪ Education | ▪ Funding<br>▪ Sponsorship<br>▪ Qualified applicants<br>▪ Oversight agency<br>▪ Legislative support | ▪ Lack of choices<br>▪ Interdepartmenta l cooperation<br>▪ Funding<br>▪ No funding for career changing<br>▪ Buy-in<br>▪ Competition from other sources | ▪ All | |
| Issue: Pipeline: Recruitment and Retention Through a Media Campaign to Increase Available Labor Pool<br><br>Solution 3 from Chicago forum<br><br>Build A Positive and Effective Media Campaign to increase health care workers<br><br>**Overall Solution 20** | ▪ Multi-media<br>▪ Multi-market<br>▪ Multi-lingual<br>▪ Image makeover<br>▪ Multi-cultural<br>▪ Coordinated effort<br>▪ Balanced amongst all careers<br>▪ Number of multiple contracts in different recruitment strategies | ▪ Educational institutions<br>▪ Health care institutions<br>▪ Job seekers<br>▪ One Stop/Career Centers<br>▪ Private Industry<br>▪ Government | ▪ One Stops/Career Centers<br>▪ Marketing Strategies | ▪ Time<br>▪ Money<br>▪ Leadership<br>▪ Responsibilities<br>▪ Completion | ▪ All, but needs to be adapted for a range of settings | ▪ (Overall solutions # 3 & # 6) |
| Issue: Pipeline: Recruitment and Retention Through Funding to Increase the Available Labor Pool<br><br>Solution 4 from | ▪ Uniform approach<br>▪ Students and faculty<br>▪ Sufficient equipment<br>▪ Availability to qualified applicants<br>▪ Streamlined process<br>▪ Must be carefully | ▪ Private industry, government, education and health care organizations<br>▪ Job seekers/student | ▪ Money<br>▪ Federal, state and private industry<br>▪ Financial Aide Officers<br>▪ Educators mentors<br>▪ Legal<br>▪ Support from legislature | ▪ Not enough sources<br>▪ Competition from other priorities<br>▪ Determine qualifications of | ▪ All | |

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| Chicago<br><br>To develop individual and system financial/funding models that promote student enrollment, faculty development and program growth<br><br>**Overall Solution 21** | monitored<br>▪ Innovative approaches<br>▪ Shared accountability at each level | | | students<br>▪ People defect from program | | |
| Issue: Pipeline: Recruitment and Retention Through Increased Partnerships to Increase the Available Labor Pool<br><br>Solution 5 from Chicago<br><br>Develop a partnership model between industry, government and education<br><br>**Overall Solution 22** | ▪ Identify effective partners (right people)<br>▪ Build "sustainability" – win-win solutions<br>▪ National, state and local level<br>▪ Tailored to the occupation and needs<br>▪ A model for working together with role clarity, timelines<br>▪ Outcome –based, with evaluations<br>▪ Cost effective | ▪ Industry<br>▪ Education<br>▪ Health care institutions<br>▪ Government<br>▪ Specific Employers<br>▪ Each partner | ▪ Dedicated liaisons from each stakeholder<br>▪ Professional, education, community and health care organizations<br>▪ Legal associations<br>▪ Training<br>▪ Skilled facilitators<br>▪ Support from leadership | ▪ Competitive markets<br>▪ Differences between the partners<br>▪ Socio-economics<br>▪ Political, geographical differences | ▪ All | ▪ (#81, #82, #83 #60, #68). |
| Issue: Pipeline: Recruitment & Retention: Turnover – Changing Culture<br><br>Solution 6 from Chicago<br><br>Develop strategies and incentives to move to shared governance and continuous, quality improvement | ▪ Top management support<br>▪ Senior management champions<br>▪ Clearly defined benefits and buy-in at each level<br>▪ Experts trained in quality improvement<br>▪ Communication, training and strategies to institutionalize<br>▪ Open, honest legitimate communication leading to trust | ▪ Management<br>▪ Employees<br>▪ Unions<br>▪ Community<br>▪ Various schools | ▪ Time to meet for governance activities<br>▪ Consultants to start quality projects up<br>▪ Training of project leaders<br>▪ Time to do this in a 24/7 environment<br>▪ Other sites that are doing this – St. Mary's Health System for this<br>▪ Federal funding, foundations, state quality awards | ▪ Staffing level requirements<br>▪ Union contracts<br>▪ FLSA laws | ▪ All | |

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| environment<br><br>**Overall Solution 23** | ▪ Means to continuously measure successful communication to all levels | | ▪ Information systems needed to track | | | |
| Issue: Pipeline: Recruitment & Retention: Turnover -- Incentives<br><br>Solution 7 from Chicago<br><br>Solution: Develop a comprehensive range of employee incentives to remain in the health care field<br><br>**Overall Solution 24** | ▪ Include both monetary and non-monetary incentives<br>▪ Entire spectrum of occupations in health care<br>▪ Top management support and creative thinking<br>▪ Communicate incentives to all levels of organization<br>▪ Reward managers for developing and retaining their staff | ▪ Management<br>▪ Employees<br>▪ Unions<br>▪ Other health care organizations and educational institutions | ▪ Funding for programs<br>▪ Creative scheduling<br>▪ Continuing education<br>▪ Tuition reimbursement<br>▪ Pension plans<br>▪ Sabbatical<br>▪ Work at home<br>▪ Housing subsidy<br>▪ Transit subsidy<br>▪ Onsite day care<br>▪ Sharing resources across organizations to preserve benefits | ▪ Across organizational issues<br>▪ Traditional thinking on employment | ▪ All | |
| Issue: Pipeline – (A): Recruitment and Retention – Diversity / Non-traditional Labor Pool<br><br>Solution 8 from Chicago<br><br>A system wide commitment to provide consistent access, opportunity and support for recruiting and retaining underrepresented culturally diverse populations in the health care workforce<br><br>**Overall Solution 25** | ▪ Identification of best practices currently being used<br>▪ Educational materials that are culturally sensitive<br>▪ Committed employers with resources to support workforce diversity<br>▪ On-going programmatic focus on the work site | ▪ Workers<br>▪ Employers<br>▪ Educators<br>▪ Community groups<br>▪ Governmental agencies | ▪ Foundations (health care related)<br>▪ Diversity trainers<br>▪ Special interest groups (Hispanics in H.R., minority engineers, women in sciences, Black Nurses Association, etc.) | ▪ Conflicts among groups for funding<br>▪ Union agreements with employers<br>▪ Political expediency | ▪ All | |

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| Issue: Pipeline – (B) Recruitment and Retention – Diversity / Non-traditional Labor Pools<br><br>Solution 9 from Chicago<br><br>Reduce barriers to entry level jobs and increase retention through financial or in-kind subsidies to targeted populations<br><br>**Overall Solution 26** | ▪ Partners to provide subsidies<br>▪ Data to assess appropriate subsidies<br>▪ Development of post-hiring information to measure success of a particular subsidy<br>▪ Demographic data | ▪ State and local agencies<br>▪ Federal agencies<br>▪ Trainers from education<br>▪ Employers<br>▪ Recruits | ▪ Social services<br>▪ Transportation providers<br>▪ State legislators<br>▪ Local officials<br>▪ Community groups<br>▪ Unions | ▪ Union agreements with employers<br>▪ State and local appropriations for funding<br>▪ Political experience | ▪ All | |
| Issue: Pipeline – (C) Recruitment and Retention – Diversity / Non-traditional Labor Pools<br><br>Solution 10 from Chicago<br><br>To Improve Retention by Creating Flexible Work Options within health care to Appeal to Non-Conventional Workers<br><br>**Overall Solution 27** | ▪ Redefinition of job functions to allow flexibility<br>▪ Review prerequisites to permit flexible training<br>▪ Flexible scheduling | ▪ Unions<br>▪ Employers<br>▪ Accreditation Associations<br>▪ Profess-ional Associations<br>▪ Recruits | ▪ Workforce<br>▪ Accrediting Agencies<br>▪ Professional Associations<br>▪ Workflow Consultants | ▪ H.R. Policies<br>▪ Union Agreements<br>▪ Accrediting Agency unresponsivenes s<br>▪ Scope of Practice | ▪ All parts of the industr y but especia lly where there are shifts | |
| **Issue/Challenge: System Capacity** | | | | | | |
| Capacity of Workforce-related Organizations<br><br>Solution 1 from Washington DC | ▪ Accurate assessment of occupational and related educational needs initially and ongoing (assess skill levels of participants).<br>▪ Agreement of | ▪ Employers<br>▪ Training Providers<br>▪ Student/worker<br>▪ One-stop Career Centers<br>▪ Community –based | ▪ Curricula<br>▪ Tuition<br>▪ Federal training grants<br>▪ Loan repayment programs<br>▪ Foundations | ▪ Educational barrier with teacher credentialing<br>▪ Liability | ▪ All | |

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| Partnering with Employers (Hospitals, LTC) and training providers (community colleges, universities, other) on a regional basis.<br><br>**Overall Solution 28** | programmatic detail with flexibility on both sides (employer and educational provider.<br>▪ Division of training, scheduling.<br>▪ Agreement of who pays for what.<br>▪ Ongoing monitoring, assessment and evaluation of goals and outcomes.<br>▪ Identification of additional support needed to allow the student/worker to attend class – i.e. childcare, transportation, etc.<br>▪ Address prerequisites for needed occupation – adult basic education (math, literacy, ESOL) | organizations<br>▪ WIB<br>▪ Community | ▪ State funding<br>▪ Data resources (HHS, DOL)<br>▪ Community involvement for meeting students needs, e.g. transportation, childcare, studying needs, mentoring. | ▪ Student loans not available to part-time workers<br>▪ Approval of distance learning related to university setting politics of possibly losing students | | |
| Issue: Capacity of Workforce-related Organizations<br><br>Solution 2 from Washington DC<br><br>Solution: Training for practicing providers to provide adult learning competence and cultural competence. Training clinicians to teach adults will help more of them become academic and clinical faculty. (Given because many clinicians do not | ▪ Standard tool set for adult learning theory<br>▪ Effective training modules for cultural competency (best practices)<br>▪ "Train the trainer" method of extending learning<br>▪ Buy-in from stakeholders<br>▪ Needs assessment of educators and students | ▪ Educators<br>▪ Employers<br>▪ Workers<br>▪ Residents/Patients<br>▪ WIBs<br>▪ Diverse ethnic populations | ▪ Federal funding for expansion of current training – Workforce Investment Act funds<br>▪ Foundation and state funding for expansion of current training<br>▪ Accurate data supporting improved outcomes and educational methods – might help with employer buy-in | ▪ Potential limits in terms of $ and timeframe for education/trainin g. | ▪ All. | |

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| think they are able to teach adults.) Training in cultural competencies will help clinicians understand the different cultural aspects of their patients/students.<br><br>**Overall Solution 29** | | | | | | |
| Issue: Capacity of Workforce-related Organizations<br><br>Solution 3 from Washington DC<br><br>Solution: Faculty loan repayment<br><br>**Overall Solution 30** | ▪ Funding for graduate education<br>▪ Stipends for living expenses<br>▪ If online, technology for distance learning<br>▪ Duration – Need acceleration while maintaining standards of education and practice<br>▪ Special priority for diverse populations | ▪ Employers<br>▪ Education providers<br>▪ Faculty members<br>▪ Students<br>▪ Diverse populations | ▪ Foundation, federal or state monies<br>▪ State Boards of Nursing<br>▪ Colleges/Universities | ▪ State Boards of Nursing<br>▪ Requirements specific – the Masters of Nursing or other degree in nursing that cannot teach if degree is not as required by the Higher Education Council<br>▪ Too few PhD programs to require doctoral faculty for BSN training | ▪ All | |
| Issue: Capacity of Workforce-related Organizations<br><br>Solution 4 from Washington DC<br><br>Solution: Prioritize training and occupations so that budget cuts do not affect key occupation training | ▪ Assessment of occupational needs.<br>▪ Communication of those needs to state and educational providers.<br>▪ Buy-in of educational providers.<br>▪ Reassess true need of degree level to keep costs controlled. | ▪ Employers<br>▪ Mayors<br>▪ Chambers of Commerce<br>▪ Community colleges<br>▪ State ONE and Deans and Directors<br>▪ Public policymakers<br>▪ Department of Public Health (HHS – HRSA)<br>▪ Community advocates and stakeholders | ▪ Would almost require policymaker mandate.<br>▪ Legislation<br>▪ Accurate data regarding projected occupational needs | ▪ Competitive sectoral interests<br>▪ Board of Nursing | ▪ All but it would have to be implem ented on a sectoral basis. | |

| **Overall Solution 31** | | | | | | |
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| Issue: Mid-term Projections<br><br>Solution 5 from Washington DC<br><br>Input from Consumers | ▪ Consumer ongoing feedback on future health care needs.<br>▪ Ongoing by demography and race/ethnicity. | ▪ Consumers and Policymakers | ▪ Actual process to have consumer input nationwide.<br>▪ Financial and technological resources necessary. | ▪ Privacy policies/regulations | ▪ All | |
| **Overall Solution 32** | | | | | | |
| Issue: Midterm Projections<br><br>Solution 6 from Washington DC<br><br>Solution: Agreed upon assumptions. In order to have a process the industry and statisticians saw as valid, certain uniform assumptions and results are required. | ▪ Standardize data collection.<br>▪ Includes employment growth and reduction (demand) and replacement needs (supply). | ▪ Policy-makers<br>▪ Employers<br>▪ Training institutions<br>▪ State and local governments<br>▪ Suppliers/Manufacturers | ▪ Ability to share projections and develop/share action plans<br>▪ Minimal level of resources available in each state.<br>▪ Federal/national management and integration.<br>▪ Ongoing funding. | | ▪ All | ▪ See also #58 |
| **Overall Solution 33** | | | | | | |
| Issue: Midterm Projections<br><br>Solution 7 from Washington DC<br><br>Solution: Database of different occupation and state analyses | ▪ Timely<br>▪ Reliable<br>▪ Comprehensive<br>▪ Accessible<br>▪ State/Regional-based national database<br>▪ Ongoing<br>▪ Sustainable | ▪ Employers<br>▪ Prospective employees<br>▪ Current employees<br>▪ Policymakers<br>▪ Training institutions<br>▪ Health care profession suppliers<br>▪ State and local governments | ▪ Minimal level of resources available for each state.<br>▪ Federal or national management with systems support.<br>▪ Ongoing funding. | ▪ Isolation of data elements and capabilities | ▪ All | ▪ See also #33,32 |
| **Overall Solution 34** | | | | | | |
| Issue: Building Partnerships and Healthcare Information | ▪ Critical Attributes for Implementing:<br>▪ Share information among all stakeholders. | ▪ Education system<br>▪ Licensing board<br>▪ Coordinating agencies<br>▪ Health care providers | ▪ Resources for Planning:<br>▪ Must be adequately funded<br>▪ Adequately staffed | ▪ Overcoming competitiveness of partnerships<br>▪ Competing policies and | ▪ All | ▪ See also #83 |

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| Solution 8 from Washington DC<br><br>Regional Healthcare Workforce Council<br><br>**Overall Solution 35** | ▪ Must have reliable workforce data.<br>▪ Everyone's perspective is valued equally and have a sense of ownership.<br>▪ Solutions-oriented<br>▪ Needs to filter up and down from local to regional.<br>▪ Willingness to share and help others in partnership.<br>▪<br>▪ Critical Attributes for Implementing:<br>▪ Consortium of stakeholders that will be labor pool.<br>▪ Ownership and investment – everyone's role well defined.<br>▪ Communication and trust.<br>▪ Willingness to share and help each other. | ▪ Unions<br>▪ WIBs – regional, state, local<br>▪ Think tanks<br>▪ Other public agencies<br>▪ Chambers of Commerce<br>▪ Area economic development agencies<br>▪ Same stakeholders with planning | ▪ Intellectual resources<br>▪ Repository of best practices and successful strategies<br>▪<br>▪ Resources for Implementing:<br>▪ Funding<br>▪ Demo funding<br>▪ Funding for management of partnership<br>▪ Repository of best practices and successful strategies | priorities of various jurisdictions | | |
| Issue: Occupational Gaps<br><br>Solution 9 from Washington DC<br><br>Solution: Develop recruitment and retention strategies<br><br>**Overall Solution 36** | ▪ Flexibility<br>▪ Making professions attractive<br>▪ Being grounded in workforce trends<br>▪ Good pay/benefits<br>▪ Support for employees<br>▪ Supportive work culture<br>▪ "Grow your own" or recruit/train local people who live in area<br>▪ Use multiple strategies<br>▪ Web sites<br>▪ Improve staff morale<br>▪ Employer recognition of employee contributions<br>▪ Students are aware of | ▪ Health care providers<br>▪ Education systems<br>▪ Media<br>▪ Workforce system<br>▪ Unions<br>▪ Patients<br>▪ Foundation<br>▪ Economic development organizations<br>▪ Chambers of Commerce | ▪ Provide housing subsidies<br>▪ Advertising funds<br>▪ Strong communication networks between health care providers, educational systems, etc.<br>▪ Staffing resources for recruitment | ▪ Competition<br>▪ between health<br>▪ care organizations | ▪ All | |

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| | health careers<br>▪ | | | | | |
| Issue: Occupational Gaps<br><br>Solution 10 from Washington DC<br><br>Solution: Expand career lattices within the industry<br><br>**Overall Solution 37** | ▪ Flexible minds<br>▪ Ability of entry-level person to go from one job to another.<br>▪ Education and training to fill gaps between steps.<br>▪ Understand the career ladder and lattice steps to take; make them transparent by mapping them.<br>▪ Accessible training for employees.<br>▪ Funding for advancements.<br>▪ Support: Support of employer; support of employee; child care support.<br>▪ Mentoring and counseling and coaching.<br>▪ Tutoring<br>▪ Cohort of trainees.<br>▪ Get the core competencies in place with training – ESOL, literacy, science<br>▪ Buy-in from management (middle and senior)<br>▪ Supervision buy-in on training. | ▪ Education system – community colleges, high schools, universities, vocational technical schools.<br>▪ Licensing boards<br>▪ Credentialing agencies<br>▪ Health care providers – Hospitals, nursing homes, long-term care, acute, chronic, clinics, area agency on aging, community health centers, employees, supervisors, managers, top management<br>▪ Unions<br>▪ Health care associations<br>▪ WIBs<br>▪ Think tanks<br>▪ Other public agencies, agency of community health | ▪ Funding for training programs (individual as an organization)<br>▪ Time<br>▪ Flexible schedules<br>▪ Up-front payment of tuition<br>▪ Tuition forgiveness<br>▪ Funding for child care, coaching, counseling, mentoring<br>▪ Living stipend, benefits<br>▪ Equipment – distance learning computers, labs (ultimate resource – laptop for each!)<br>▪ Other technical training equipment<br>▪ Time of H.R., training departments, supervisors, managers<br>▪ Grants (federal, foundation)<br>▪ Transportation | ▪ Licensing and credentialing<br>▪ Lack of consistent release time policy; lack of ability to release; need for release time at same time!<br>▪ Classroom space<br>▪ Union agreements??<br>▪ Medicaid/Medicare reimburse-ment rates limit; release time; resources for workforce<br>▪ Lack of flexibility regarding discipline/job boundaries | ▪ All | |
| Issue: Occupational Gaps<br><br>Solution 11 from Washington DC<br><br>Solution: Distance Learning for Staff | ▪ Reliable/effective technology (e.g. T1 lines)<br>▪ Informed and effective trainers and educators<br>▪ Curricula that is effective and appropriate<br>▪ Experience with computer technology | ▪ Employers<br>▪ Employees<br>▪ Patients<br>▪ Trainers/educators<br>▪ | ▪ Technology<br>▪ Educators<br>▪ Curricula and materials<br>▪ Computers at home<br>▪ Funds<br>▪ Release time<br>▪ | | ▪ All. This is particularly relevant to small provide | |

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| **Overall Solution 38** | among learners<br>▪ Support structure for technical or other problems | | | | r groups, special needs groups (e.g. single parents ) and rural areas. | |
| Issue: Lack of facilities and resources<br><br>Solution 1 from Salt Lake City<br><br>Solution: Healthcare – Expand Training Programs – Allied Health Professions<br><br>**Overall Solution 39** | ▪ Partnership between educational institution and health care provider<br>▪ To supplement current curriculum with needed classes such as management skills<br>▪ Life skills training<br>▪ Cross disciplinary education<br>▪ CNAs seen as entry to career ladder program (recognize through college credits or advanced placement) | ▪ Training institution<br>▪ Healthcare employers<br>▪ State accreditation and licensure boards<br>▪ National accreditation and licensure boards | ▪ Faculty funding<br>▪ Curriculum development for revision<br>▪ Facilities funding<br>▪ Skills labs – learning resource centers | ▪ Accreditation and licensure regulations<br>▪ Allocation of resources into allied healthcare programs<br>▪ Recognizing mentoring, med tech programs, CNAs college credits | ▪ All | ▪ Availabili ty of clinical resource space (clinical practice) |
| Issue: Lack of facilities and resources<br><br>Solution 2 from Salt Lake City<br><br>Solution: Distance and education learning<br><br>**Overall Solution 40** | ▪ E-learning classroom<br>▪ E-learning staff person<br>▪ Instructors with technology knowledge<br>▪ Partnerships for e-learning to provide clinical partnerships<br>▪ Hybrid education (mixed modalities)<br>▪ Student with baseline technology knowledge<br>▪ On-site tutor to assist with technology | ▪ Faculty/Academic institutions<br>▪ Employers<br>▪ Technical centers<br>▪ One Stop Centers<br>▪ Technical support staff<br>▪ Community leaders<br>▪ Libraries<br>▪ Funding resources<br>▪ Healthcare providers<br>▪ Accreditation and licensing agencies | ▪ Equipment<br>▪ Space<br>▪ Technical Support<br>▪ Staff (e-learning) to support students<br>▪ Time to develop online curriculum<br>▪ Department of Labor<br>▪ Private funding<br>▪ Phone companies<br>▪ Power companies | ▪ Credibility of distance learning<br>▪ Approval by each participating state for licensure/accredi tation<br>▪ Collective bargaining agreements<br>▪ Cost effectiveness<br>▪ State reimbursement guidelines | ▪ All. More importa nt to those who need access because of time, distanc e from educati onal opportu nities, | ▪ Pieces of RN program online<br>▪ Continuin g education of current employee s |

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| | | | | ▪ Wage and hour regulations<br>▪ Company internet policies/procedures<br>▪ HIPAA laws | family constraints. | |
| Issue: Lack of academic and clinical instructors<br><br>Solution 3 from Salt Lake City<br><br>Solution: Provide paid time off and flexible work schedules for those that wish to advance their education to teach or want to serve as part-time instructors (both academic and clinical)<br><br>**Overall Solution 41** | ▪ Staff to cover<br>▪ Funding<br>▪ Students<br>▪ Instructors<br>▪ Paid time off<br>▪ Flexible employers | ▪ Health care industry<br>▪ Schools scheduling | ▪ Staff to cover<br>▪ Funding<br>▪ Funding (HC industry)<br>▪ Tax incentives<br>▪ Grants<br>▪ Technology | ▪ Personnel/policies of industry | ▪ All | |
| Issue: Lack of academic and clinical instructors<br><br>Solution 4 from Salt Lake City<br><br>Solution: Subsidize (from industry) BSN and MSN students and professionals to continue their education to become instructors<br><br>**Overall Solution 42** | ▪ Increased funding<br>▪ Recognize need for participation by private industry<br>▪ Students who want to further their education | ▪ Industry<br>▪ Students<br>▪ Education<br>▪ Government agencies<br>▪ Workforce services<br>▪ Chambers<br>▪ NIH<br>▪ DOL<br>▪ DOE<br>▪ Sate and local workforce boards<br>▪ State boards of Nursing<br>▪ AHCA<br>▪ NLN | ▪ Colleges<br>▪ Universities<br>▪ Proprietary schools<br>▪ Health Care Industry<br>▪ Scholarships<br>▪ Grants<br>▪ Salaries while they are in school<br>▪ H1B Grant<br>▪ Web-based training | ▪ Individual agency policies which prohibit employees from going to school (i.e., benefits, wages) | ▪ All | ▪ Student issues<br>▪ Childcare<br>▪ Transportation<br>▪ Benefits<br>▪ Funds<br>▪ Supportive family |

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| | | ▪ DOPL<br>▪ NEA<br>▪ AACC<br>▪ LADONNA<br>▪ Nurses who don't practice or are retires<br>▪ ANA | | | | |
| Issue: Lack of academic and clinical instructors<br><br>Solution 5 from Salt Lake City<br><br>Solution: Increase faculty salaries so they are competitive with clinical practice salaries<br><br>**Overall Solution 43** | ▪ Available funding<br>▪ Private<br>▪ Institutional<br>▪ Educational preparation<br>▪ Pay according to educational levels | ▪ Industry, education, government, students<br>▪ Chambers<br>▪ HAS, NIH, DOL<br>▪ State and local workforce boards<br>▪ Associations<br>▪ Licensing boards<br>▪ AACCE | ▪ Grants, endowments, stipends, incentives<br>▪ Qualified applicants<br>▪ Private foundations | ▪ State and accrediting agency regulations<br>▪ Legislative funding | ▪ All | ▪ Allow some flexibility in the instructio n of certain skills<br>▪ Could reduce cost of training |
| Issue: Lack of alignment between requirements and curriculum<br><br>Solution 6 from Salt Lake City<br><br>Solution: Provide flexible entry points<br><br>**Overall Solution 44** | ▪ Some core beginning for post-high school preparing<br>▪ Choose a health care path but you can move between the 'silos'<br>▪ Pathways are visible to students<br>▪ Adults (dislocated workers) need to find their way to a new career, i.e., steel workers to nursing<br>▪ Acknowledgement of prior skills/knowledge<br>▪ Transferable credits or advanced placement in programs<br>▪ All year 'round<br>▪ Online learning is the | ▪ Accrediting bodies<br>▪ Certifying and licensing bodies<br>▪ Public consumer of health care<br>▪ Health care industry in setting the standards<br>▪ Proprietors of the distance learning technology | ▪ Funding for 12 month programs – open entry, open exit, self-pacing in program to extent possible<br>▪ More access to lab (experience) in non-traditional times/ways<br>▪ Move volume of the core, cross-functional courses | ▪ Accreditation<br>▪ Standardization of competencies across states | ▪ All | |

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| | model<br>▪ Benchmark points of competency<br>▪ Learning modules?<br>▪ Applying science to problem – larger that that | | | | | |
| Issue: Lack of alignment between requirements and curriculum<br><br>Solution 7 from Salt Lake City<br><br>Solution: Industry-led curriculum development committee<br><br>**Overall Solution 45** | ▪ Ability for education to respond to industry needs<br>▪ Retrofit to respond to technology<br>▪ Initially industry takes responsibility for equipment, training, but then moved to earliest education opportunity possible<br>▪ All stakeholders are part of the industry specific team<br>▪ | ▪ Education<br>▪ Teachers<br>▪ Administrators<br>▪ Health Care industry<br>▪ Practitioners<br>▪ Administrators<br>▪ Pharmaceutical<br>▪ Industry<br>▪ Equipment<br>▪ Workforce investment boards, one stops<br>▪ Students<br>▪ | ▪ Time for collaboration, curriculum development<br>▪ HC industry must allow release time for participation | ▪ Education curriculum change is not quick<br>▪ Licensing board need to be more flexible, i.e., multi-state licenses | ▪ All | |
| Issue: Lack of alignment<br><br>Solution 8 from Salt Lake City<br><br>Solution: Academic faculty required to have contact clinical experience<br><br>**Overall Solution 46** | ▪ Instructors would have up to date knowledge of industry trends<br>▪ Students would be prepared to enter workforce day one<br>▪ Partnerships between industry, education and science<br>▪ Diffusion, communications needs to flow among stakeholders<br>▪ Joint training for the academics/clinicians<br>▪ Rotations should allow for clinicians/academics to be involved along the way | ▪ Instructors<br>▪ Clinical setting for the industry<br>▪ Students | ▪ Shared in-services for knowledge exchange<br>▪ Ability to stay ahead of the knowledge, clinical practice trends<br>▪ Time for academic persona to go to the clinical setting and job shadow<br>▪ Minimum threshold of training (people and technological) | ▪ HIPAA require merits limit<br>▪ Students exposure<br>▪ State scope of practice<br>▪ Not all clinicians can teach and not all teachers are clinically able | ▪ All | |
| Issue: Lack of facilities and | ▪ Negotiated agreements between educational institutions and facilities | ▪ Colleges<br>▪ Universities<br>▪ Health care agencies/providers | ▪ Academic administrators must be in agreement<br>▪ Federal and state funds | ▪ State laws governing licensing and | ▪ All | ▪ Capacity to monitor |

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| resources<br><br>Solution 9 from Salt Lake City<br><br>Solution: Use of available facilities<br><br>**Overall Solution 47** | ▪ Facilities must be evaluated for proper equipment<br>▪ Reciprocity across state lines<br>▪ Partnerships that would facilitate joint use educational programs<br>▪ Funding to create community clinical laboratory sites | ▪ Public school districts<br>▪ State licensing/credentialing entities<br>▪ One Stop Centers<br>▪ WIB<br>▪ Governor's office<br>▪ State Agencies<br>▪ Vocational Schools | ▪ Private funds<br>▪ Local healthcare council<br>▪ Trade Association<br>▪ Federal and state funding resources | certification<br>▪ Collective bargaining agreements<br>▪ State boards for licensing and certification<br>▪ State practice acts<br>▪ Liability issues<br>▪ OSHA issues<br>▪ Capacity | | teacher performan ce |
| Issue: Lack of facilities and resources<br><br>Solution 1 from Chicago<br><br>Solution: Partnership among providers, training and education of public officials to use facilities<br><br>**Overall Solution 48** | ▪ Available facilities<br>▪ Access to current technology<br>▪ Sufficient infrastructure funding<br>▪ Lab, classroom, technology on a continuous basis | ▪ Hospitals<br>▪ Clinics<br>▪ Churches<br>▪ Schools (k-12-universities)<br>▪ Chamber of commerce<br>▪ Economic development entities<br>▪ Municipality (local)<br>▪ State, federal<br>▪ Students<br>▪ Community-at-large<br>▪ Governmental agencies | ▪ Funds<br>▪ Furniture<br>▪ Space consultants<br>▪ Designers<br>▪ Architects<br>▪ Land<br>▪ Technologies (medical, technical) | ▪ Union agreements<br>▪ Sharing of cost<br>▪ Use of taxpayer money<br>▪ OSHA<br>▪ Policies (state)<br>▪ Statues<br>▪ Political party | ▪ All | |
| Issue: Lack of facilities and resources<br><br>Solution 2 from Chicago<br><br>Solution: Clearing house (portal) of resources (space, finding, equipment) Models, exports, programs | ▪ National database<br>▪ Coordination among key funding sources<br>▪ Visible information<br>▪ Instructions for how to use | ▪ Education facilities<br>▪ Accrediting bodies<br>▪ Industry<br>▪ Health Resources and Services Administration.<br>▪ All government agencies<br>▪ Foundations<br>▪ Philanthropic organizations<br>▪ National, state and local workforce systems | ▪ Technology<br>▪ Funds to pull it together<br>▪ Maintenance<br>▪ "Home" need to select a host this solution<br>▪ Communication<br>▪ Strong links to all stakeholders | ▪ Turf<br>▪ Confidentiality<br>▪ Keeping the data current | ▪ All | ▪ Uses for providers, industry, workforce , etc. |

| **Overall Solution 49** | | | | | | |
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| Issue: Lack of alignment between requirements and curriculum<br><br>Solution 3 from Chicago<br><br>Solution: Curriculum for new models of care<br><br>**Overall Solution 50** | ▪ Up to date and forward thinking<br>▪ Vision of new models of care – including changing technology, job definitions, changing professions, cultural diversity, redesign of workplaces<br>▪ Setting priorities<br>▪ Understanding of changing demographics<br>▪ Understanding of values of different generations | ▪ Same as previous 2<br>▪ Manufacturers of medical equipment and technology<br>▪ Futurists<br>▪ 3rd party payers<br>▪ Pharmaceutical companies | ▪ Scenarios, projections, forecasts<br>▪ Data! Good understanding of current data and how it will change<br>▪ In addition to previous 2 | ▪ Bricks and mortar<br>▪ Unknown future<br>▪ Resistance to change | ▪ All | |
| Issue: Lack of alignment between requirements and curriculum<br><br>Solution 4 from Chicago<br><br>Solution: Partnerships between industry and accrediting agencies and certification bodies for a realistic alignment between practice requirements and curricular design and implementation<br><br>**Overall Solution 51** | ▪ Shortening of time between identification (needs assessment) and implementation<br>▪ Using technology to lessen time gap<br>▪ Academic accrediting agencies must connect with business and industry<br>▪ Synchronization of processes and stakeholders , i.e., certification process and accreditation process not connected and both operate independently of technology | ▪ Accreditation agencies<br>▪ Certification agencies<br>▪ HC industry<br>▪ Education providers<br>▪ Department of Education<br>▪ (same list as #1)<br>▪ Manufacturers of medical equipment and technology<br>▪ Pharmaceutical companies | ▪ Incentive to bring two groups together<br>▪ Convener<br>▪ Industry associations | ▪ Disconnect between industry standards and what is on certification exams<br>▪ No incentive for those two groups to come together<br>▪ No clear leader<br>▪ Education organizations – 'turf' | ▪ All | ▪ CMS and other 3rd party payers drive practice and this is a disconnect from accreditations |

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| Issue: Lack of alignment between requirements and curriculum<br><br>Solution 5 from Chicago<br><br>Solution: HC industry driven curriculum<br><br>**Overall Solution 52** | ▪ Common vision among the HC industry<br>▪ Convening and communication among key stakeholders<br>▪ Identification of core competencies and standards of care<br>▪ Reduce curriculum/accreditation cycle time<br>▪ Identification of a national core curriculum by and across occupations that is tied to accreditation<br>▪ Breakdown barriers between education and industry<br>▪ Realignment of resources<br>▪ Increased exposure to world of work for students – build into curriculum | ▪ Faculty and or curriculum – champions at each level<br>▪ Education and training providers<br>▪ Accreditation institutions – both regional and specialized umbrella<br>▪ HC Associations<br>▪ Labor Associations<br>▪ Department of Labor<br>▪ Department of Education<br>▪ Department of HHS<br>▪ Licensing entities<br>▪ Workforce Boards<br>▪ JCAHO, etc.<br>▪ Manufacturers of Medical equipment and technology<br>▪ Pharmaceutical companies | ▪ Identification of champions and vision leaders – evangelicals<br>▪ Web-based technology to support communication effort<br>▪ Centralized 'home'- owner<br>▪ Demonstration models<br>▪ Funding<br>▪ Good data and good information – historical, current and future<br>▪ Subject matter expertise within professions willing to build toward national vision | ▪ State by state structure<br>▪ Institutional culture<br>▪ Competing accreditation organizations<br>▪ State by state licensing issues<br>▪ Turf wars between local/ state/national<br>▪ Old technology obsolete<br>▪ Turf issues within industry<br>▪ Segmentation of resources<br>▪ University requirements conflicting with professional curriculum<br>▪ Disconnect between k-12 education and careers | ▪ All | ▪ National licensing?<br>▪ European model 2+2, 3+1, etc. Alternativ e curriculu m models<br>▪ CMS and other 3rd party payers drive practice and this is a disconnec t from ed programs<br>▪<br>▪ Related to solution # 51. |
| Issue: Train practitioners as instructors by partnering with industry<br><br>Solution 6 from Chicago<br><br>Solution: Develop an educational program to teach practitioners to be effective clinical instructors<br><br>**Overall Solution 53** | ▪ Cooperation of all stakeholders (particularly employers)<br>▪ Right type of education model (curriculum)<br>▪ Support system – scheduling<br>▪ Buy-in at all employee levels<br>▪ Cultural change in the worth of gaining education<br>▪ Reward mechanism/place a value | ▪ Educational health care programs<br>▪ Health care employees<br>▪ Patients<br>▪ Payers for health care<br>▪ Students<br>▪ General public<br>▪ Regulatory agencies for education and quality health care<br>▪ Industry (health care products, IT)<br>▪ Physicians | ▪ Funding<br>▪ Forgivable notes<br>▪ Grants/scholarships<br>▪ Employers<br>▪ Willing and qualified staff<br>▪ Instructors/staff development<br>▪ Clinical facilities<br>▪ Partnership with appropriate (GE, Microsoft, etc.) industry to fund fellowships<br>▪ Childcare | ▪ Union agreements<br>▪ Scheduling<br>▪ Compensation while off duty. | ▪ All | |

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| Issue: Enhance academic instructors' compensation so it is competitive with practitioners<br><br>Solution 7 from Chicago<br><br>Solution: Development of alternative funding mechanisms for education<br><br>**Overall Solution 54** | ▪ The will or ability to make a cultural change regarding the value placed on the teaching profession<br>▪ Recognition of the value of practical work/clinical experience | ▪ Colleges and universities<br>▪ State government<br>▪ Hospitals<br>▪ Industry Partners<br>▪ | ▪ Funding<br>▪ Students/instructors | ▪ Value placed on practical experience<br>▪ Value placed on teaching profession<br>▪ State mandates for salaries<br>▪ Salary compression – possibility<br>▪ Union agreements | ▪ All | |
| Issue: Lack of academic and clinical instructors<br><br>Solution 8 from Chicago<br><br>Solution: Distance education<br><br>**Overall Solution 55** | ▪ Access to technology – technical barriers eliminated<br>▪ Increase the value of distance education<br>▪ Updates available quickly | ▪ Students – self directed<br>▪ Qualified faculty<br>▪ Qualified clinical sites<br>▪ Preceptors<br>▪ Support of academic leadership<br>▪ Accreditation | ▪ Faculty<br>▪ Clinical Training sites<br>▪ IT Support<br>▪ Competent Preceptors | ▪ Access to technology<br>▪ Faculty<br>▪ Accreditation of distance learning | ▪ All | ▪ Solutions #57 (as a resource) and #73 also focus on distance learning |
| Issue: Lack of facilities and resources<br><br>Solution 9 from Chicago<br><br>Solution: Donate/lease equipment to stay current<br><br>**Overall Solution 56** | ▪ Current equipment | ▪ Suppliers, manufacturers<br>▪ College foundations<br>▪ Hospitals<br>▪ School<br>▪ Faculty/ students<br>▪ Donors<br>▪ Financial officers | ▪ Donors (public, private)<br>▪ Financial officer<br>▪ Transportation | ▪ Transportation<br>▪ Voltage<br>▪ Temperature<br>▪ Acceptance of gift policy<br>▪ Training of personnel<br>▪ Training on donated equipment<br>▪ What are the restrictions on donated equipment | ▪ All | |

| **Issue/ Challenge: Demographic Shifts and Labor Market Trends** | | | | | | |
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| The Need for Resources to Remove the "Bottleneck" of Potential Workers into the System<br><br>Solution 1 from Washington DC<br><br>Solution: Remove the "Bottleneck" of potential workers into the system by becoming more flexible and creative in identifying and applying resources.<br><br>**Overall Solution 57** | ▪ Funding to pay and train faculty (nursing professors)<br>▪ Access to clinical sites: The need for more "bricks and mortar," distance learning, and flexibility among employers to allow people time to be trained.<br>▪ A study to determine the "real costs" of training a health care professional; i.e. total costs of a program including salaries and equipment<br>▪ Universal professional accreditation to allow for increased flexibility for people who relocate or work in multiple jurisdictions | ▪ Employers<br>▪ Students<br>▪ Federal and state legislators<br>▪ Current Faculty<br>▪ Insurance Companies<br>▪ Accrediting bodies (academic, professions and industrial) | ▪ On-site training programs with "in-kind" teachers and facilities<br>▪ Resources for non-traditional students – such as transportation, child care and insurance.<br>▪ Dollars to build infrastructure<br>▪ U.S. Military defense contracts.<br>▪ Incentives for private sector to contribute<br>▪ Distance Learning Improvements<br>▪ Scholarships | ▪ State Licensing Requirements | ▪ All | ▪ Flexibility and creativity in identifying financial resources<br>▪ Apply programs to people in the "pipeline" as well as to newcomers<br>▪ See also # 13, 18, |
| The Need for Better Data Analysis, Forecasting, and Dissemination<br><br>Solution 2 from Washington DC<br><br>Solution: Establish better data analysis, forecasting, and dissemination by focusing on most appropriate information and increasing processing efficiency. | ▪ Done at the local levels to identify specific needs<br>▪ Identify proper topics for collection<br>▪ Better sources (look to cases management)<br>▪ Federal should share its collected data in a form that will assist the local level.<br>▪ Cross pollination of collected data among federal agencies<br>▪ Standardization of what data is collected and when | ▪ Labor market information professionals<br>▪ Workforce Professionals | ▪ Coordination among federal agencies<br>▪ Direction<br>▪ Planning<br>▪ Evaluation of "the big picture" | ▪ HIPPA regulations<br>▪ Difficulty in getting government agencies to cooperate | ▪ All | ▪ Forward thinking approach<br>▪ Evaluation of meaningful and ongoing trends<br>▪ Industry participation determining what info to collect |

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| **Overall Solution 58** | ▪ Collection should be "forward thinking" not reflective (more like business market research) | | | | | ▪ Discussion and recommendations see #33, 34, and 83. |
| **Skills Development** | | | | | | |
| Issue: Public perception<br><br>Solution 1 from Salt Lake City<br><br>Solution: To develop programs for branding to enhance the perception of healthcare jobs<br><br>**Overall Solution 59** | ▪ Big name endorsement/ sponsor<br>▪ Corporate<br>▪ Individual<br>▪<br>▪ Media time donations<br>▪ TV<br>▪ Radio<br>▪ Internet<br>▪ Magazine<br>▪<br>▪ Construct common, positive message<br>▪ Co-branding<br>▪ Unveil media blitz – on-going | ▪ Employers<br>▪ Employees<br>▪ Community<br>▪ COL/HHS<br>▪<br>▪ Big Names:<br>▪ Michael Jordan<br>▪ Bill Cosby<br>▪ Michael Vic<br>▪ American IDU<br>▪ Microsoft | ▪ COL<br>▪ HHS<br>▪ Big Names<br>▪ Private funding<br>▪ Health care associations | | ▪ All | ▪ Related to other marketing solutions #3,6,20, |
| Issue: Think outside the bowl<br><br>Solution 2 from Salt Lake City<br><br>Solution: To develop an understanding of local or regional constraint points and develop a strategies to relieve that constraint in health care<br><br>**Overall Solution 60** | ▪ Local/regional community partnerships<br>▪ Gap analysis<br>▪ Sharing information and resources<br>▪ Co-operative solutions<br>▪ Building trust<br>▪ Develop common measure of success<br>▪ Create real outcomes for all partners | ▪ CEOs – leaders in health care industry<br>▪ Local elected officials<br>▪ Agency heads<br>▪ Community college and university decision makers<br>▪ Community based organizations<br>▪ Workforce development leaders (local/regional/state) | ▪ Funding for planning analysis<br>▪ Leaders in industry, communities who care make commitment to process/project (all stakeholders) | ▪ Internal organizational barriers? | ▪ All | ▪ This solution is related to solution # 83 |

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| Issue: Increasing available labor pool<br><br>Solution 3 from Salt Lake City<br><br>Solution: To modify and improve the health care delivery system by making it more operationally efficient and more patient focused<br><br>**Overall Solution 61** | ▪ Leverage technology cost reductions<br>▪ Public changes – their mindset about how health care is delivered<br>▪ Care givers change their mind set about how health care is delivered<br>▪ Identify opportunities to eliminate waste in the current delivery system | ▪ Health care providers<br>▪ Patients<br>▪ Insurance companies<br>▪ Unions<br>▪ Professional workers<br>▪ Professional organizations (AMA, ANA, etc.)<br>▪ Federal and state governments | ▪ Research studies for re-engineering the health care delivery system<br>▪ DOL<br>▪ Funding<br>▪ State and federal funding<br>▪ Industry support for service delivery projects | ▪ Tort reform<br>▪ State and federal laws<br>▪ Union contracts | ▪ All | |
| Issue: Increasing available labor pool<br><br>Solution 4 from Salt Lake City<br><br>Solution: To maximize the available options for access and training opportunities for the emerging transition and current workforce<br><br>**Overall Solution 62** | ▪ Standardized pre-requisites<br>▪ Dual/concurrent enrollment in courses<br>▪ 2+2+2 agreements between high school community colleges and universities<br>▪ Increased availability online, distance-learning, experiential learning<br>▪ Increased awareness of industry certification programs<br>▪ Enhanced school-to-work job placement possibilities<br>▪ Increased training and employment opportunities for out-of-school youth<br>▪ Increased outreach programs for minority and other populations with barriers | ▪ Colleges<br>▪ Universities<br>▪ Public schools<br>▪ Private schools<br>▪ Employers<br>▪ City and state governments<br>▪ Health professionals<br>▪ Skilled workers | ▪ Department of Labor<br>▪ State, city governments<br>▪ Employers<br>▪ Publicly funded workforce development funds leveraged with private sector funds | ▪ Maximize current WIA statues<br>▪ Educational standards<br>▪ Job placement policies<br>▪ Articulation agreements | ▪ All | ▪ See also #51,52 |
| Issue: Turnover | ▪ Money – public/private<br>▪ Matching funds for | ▪ Employers<br>▪ Staff | ▪ Private funding<br>▪ Grants- demonstration | | ▪ All | ▪ See also #5,9,12,2 |

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| Solution 5 from Salt Lake City<br><br>Solution: To redesign the health care work environment creating an atmosphere of on-going professional growth and mutual respect and appreciation<br><br>**Overall Solution 63** | additional education<br>▪ Better hours/flex schedule<br>▪ Improved supervisory training<br>▪ Family friendly<br>▪ Fringe benefits<br>▪ Opportunity for professional development<br>▪ Educate staff on respect<br>▪ Incentive for senior staff | ▪ Customers | projects – DOL, HHS<br>▪ Community college – scholarships | | | 3,18,26,27,29,36,37,38,38,40,55 |
| Issue: Turnover<br><br>Solution 6 from Salt Lake City<br><br>Solution: To develop an innovative incentive program to increase retention and support performance excellence<br><br>**Overall Solution 64** | ▪ Design a model/template<br>▪ Criteria for when incentives are earned<br>▪ Trading system<br>▪ Regionalized approach<br>▪ Additional money<br>▪ Incentive for advancement not just recruitment – loyalty incentive program – stay for pay | ▪ Employers<br>▪ Employees<br>▪ Where a union is involved, they play a part | ▪ Community college (training)<br>▪ Public transportation<br>▪ Facility daycare<br>▪ Community resources/leaders | | ▪ All | ▪ See also # 63 with other solutions |
| Issue: Turnover<br><br>Solution 7 from Salt Lake City<br><br>Solution: To develop an innovative program to provide realistic views of all levels of health care professionals<br><br>**Overall Solution 6** | ▪ Design a model<br>▪ Establish demonstration sites<br>▪ Establish communication mechanisms<br>▪ speed of certification<br>▪ e-mails<br>▪ healthcare association buy-in<br>▪ Job shadowing<br>▪ High school work programs/ Internships | ▪ Technical school teachers<br>▪ High school teachers/can contact the public workforce system<br>▪ Interviews – with current and future healthcare workers<br>▪ Labor source | ▪ Not given | | ▪ All | ▪ Carrot? – respect<br><br>▪ See also # 7,16,19 |

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| Issue: Increasing available labor pool<br><br>Solution 8 from Salt Lake City<br><br>Solution: To increase the overall wage of entry-level health care workers<br><br>**Overall Solution 66** | ▪ Larger labor pool<br>▪ More stable entry-level work force<br>▪ Enhance retention<br>▪ First choice career decisions<br>▪ Increased involvement of out-of-school youth | ▪ Employers<br>▪ Workers<br>▪ Unions<br>▪ Training providers<br>▪ Professional associations<br>▪ Local workforce boards<br>▪ City and country/parish governments | ▪ Insurance companies<br>▪ Federal government<br>▪ State governments<br>▪ Patients and family members<br>▪ Employers<br>▪ Training providers | ▪ Union agreements<br>▪ Existing service contracts<br>▪ Insurance coverage | ▪ All | |
| Issue: Increasing available labor pool<br><br>Solution 9 from Salt Lake City<br><br>Solution: To leverage youth programs to provide awareness, exploration and training for the emerging workforce in health care careers<br><br>**Overall Solution 67** | ▪ Increased enrollment in health science and health technology programs in high school<br>▪ Increased job placement of high school graduates in health care fields<br>▪ Increased number of students enrolled and completing professional./state certificate programs<br>▪ Marketing, brochures, job shadows, mentoring, career camps, career days<br>▪ Appropriate hands-on activities<br>▪ Capacity building instructional techniques for education | ▪ Employers – health care<br>▪ Training providers<br>▪ Public schools<br>▪ Private schools<br>▪ Vocational schools<br>▪ Youth:<br>▪ A – minority<br>▪ B – disadvantaged<br>▪ C – disabled<br>▪ Existing health care workers | ▪ National health care skill standards<br>▪ DOL demonstration projects<br>▪ Employer funded activities<br>▪ Redirection of Carl Perkins funds<br>▪ Redirection of local and state funds<br>▪ Education and technical support from health care professionals (AMA, NA, HOSA, etc.) | ▪ Affiliation agreements between business and education<br>▪ Union agreements<br>▪ State and federal funding policies | ▪ All | ▪ See also #65 |
| Issue: Diversity/non-traditional labor pools<br><br>Solution 10 from Salt Lake City<br><br>Solution: To develop s system to encourage/ that | ▪ Access to labor pool<br>▪ Community events<br>▪ Trusted, meaningful community organizations<br>▪ Health care partners involved in developing the system | ▪ Community organizations<br>▪ Health care employers<br>▪ One-stop/public workforce partners<br>▪ Health care employees<br>▪ Training providers | ▪ Funding to develop system<br>▪ Human resources – community based organizations, mentors, etc.<br>▪ Outcome monitoring funding | ▪ Flexibility of public workforce dollars<br>▪ Prescriptive grant constraints | ▪ All | ▪ Should be linked to solution #83, 60 |

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| encourages community involvement in health care training and workforce systems<br><br>**Overall Solution 68** | | | | | | |
| Issue: Diversity/non-traditional labor pools<br><br>Solution 11 from Salt Lake City<br><br>Solution: To develop a system that rewards community partnerships / a diverse array of stakeholders<br><br>**Overall Solution 69** | ▪ Leveraging resources of a variety of stakeholders in the community (i.e., matching funds)<br>▪ All key partners must be at the table<br>▪ Must be sustained over time (several/many years) | ▪ Health care employers<br>▪ Community organizations<br>▪ Public workforce system<br>▪ Labor/apprenticeship programs<br>▪ Training providers<br>▪ Community colleges | ▪ Multi-year funding<br>▪ Federal and non-federal sources<br>▪ Monitoring to ensure that outcomes are achieved | ▪ Internal/organiza tions barriers | ▪ All | ▪ Same as for solution # 68. |
| Issue: Diversity/non-traditional labor pools<br><br>Solution 12 from Salt Lake City<br><br>Solution: To achieve basic skills competency and health care prerequisites in non-traditional labor pools<br><br>**Overall Solution 70** | ▪ Access to training at convenient times/locations for students<br>▪ System flexibility<br>▪ Reduced training time<br>▪ Access to training supports (i.e., childcare, transportation) | ▪ Training providers – adult education/vocational schools<br>▪ Community organizations<br>▪ Health care employers<br>▪ Other technical industry employers<br>▪ Workforce system<br>▪ Local government (economic development, school districts, etc.) | ▪ Adult education funding<br>▪ Distance learning access points | ▪ Incumbent workers process? | ▪ All | ▪ The solution is also a componen t of #68, #69, # 83 and is referred to in *Starting and Managing Health Care Initiatives*<br><br>▪ See also #6,7,8,15, 25,26,37, 38,40,44, 55,57,70 for other |

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| | | | | | | solution related to non-traditional labor pools and entry-level training |
| Issue: Loss of patient care-givers<br><br>Solution 1 from Chicago<br><br>Solution: Develop career paths/educational opportunities to retain patient care-givers<br><br>**Overall Solution 71** | ▪ Opportunities in work environment must be perceived as valuable<br>▪ Employer buy-in<br>▪ Support of health professions<br>▪ Developmental programs for incumbent workers<br>▪ Collaboration between employers/education | ▪ Employees<br>▪ Employers<br>▪ Educational system and faculty | ▪ Funding to employers<br>▪ Funding to education system<br>▪ Assessment of skill demand need<br>▪ Need 'demand' data | ▪ Access to funding<br>▪ Existing labor contracts | ▪ All | ▪ See also related solutions in #64 |
| Issue: Inconsistent recognition of credentials (state)<br><br>Solution 2 from Chicago<br><br>Solution: National standards for licensing/credentialin g all technical/clinical HC roles<br><br>**Overall Solution 72** | ▪ Establish knowledge, skills, and ability requirements for each role<br>▪ Adopted and consensus by all stakeholders<br>▪ States comply (mandatory)<br>▪ National practitioner database (professional discipline/malpractice) | ▪ Educational systems (secondary and post-secondary systems)<br>▪ Professional Association credentialing entities<br>▪ Employees<br>▪ Employers<br>▪ State governments<br>▪ Federal governments<br>▪ Lawyers (?)<br>▪ Unions<br>▪ Patients<br>▪ Regulatory boards | ▪ Professional (professions, organizations and credentialing agencies) expertise willing to commit to development of standards<br>▪ IT resources<br>▪ Federal funding<br>▪ Needs champion (DOL?)<br>▪ Non-professional organization (other stakeholder input, ex: facilitated regional forums) | ▪ Federalism (state laws)<br>▪ Professional organization turf wars (tithing and between professions)<br>▪ Education system<br>▪ Existing labor contracts | ▪ All | ▪ See also #51,52,62 ,80 for solutions related to curricula, licensing and practice issues |

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| Issue: Training is not readily accessible to large group of population<br><br>Solution 3 from Chicago<br><br>Solution: Distance learning can dramatically and rapidly expand access<br><br>**Overall Solution 73** | ▪ Must be well designed<br>▪ Easily accessible<br>▪ Interactive<br>▪ Educationally sound<br>▪ Must address<br>▪ ESL<br>▪ Computer skills<br>▪ Math, reading, etc.<br>▪ Linked to real work exposure and career ladder<br>▪ Cultural competency<br>▪ Employer supports in place | ▪ Trainers<br>▪ Learners<br>▪ Employers<br>▪ Workforce boards<br>▪ Community leaders | ▪ Distance learning businesses<br>▪ Community colleges-program design<br>▪ Employers (chief HR, chief learning officer)<br>▪ State Hospital Association<br>▪ Local foundations and business<br>▪ W.I.U. S<br>▪ Training grants<br>▪ Research to validate distance learning effectiveness<br>▪ Web software<br>▪ IT experts | ▪ Distance learning centralization, but budgeting decentralized<br>▪ Willingness of colleges to accept credits and credentials<br>▪ Distance learning image | ▪ All see notes on distanc e learnin g access above | ▪ See solution # 55. Distance learning is also a componen t of other solutions such as # 57. |
| Issue: Immigrant workers with health care skills (potential labor pool) not working in the health care field.<br><br>Solution 4 from Chicago<br><br>Solution: Develop bridging programs<br><br>**Overall Solution 74** | ▪ Assess educational and work skills<br>▪ Individual focus of program (flexible)<br>▪ Assess language/communication skills | ▪ INS credentialing organizations<br>▪ Advocacy groups<br>▪ Professional organizations<br>▪ Employers<br>▪ Co-workers<br>▪ Educational resources (system/employer) | ▪ Funding for employers<br>▪ Educators familiar with cultural barriers both as program developers and teachers<br>▪ Tool kits<br>▪ Language programs | ▪ Lack of internal standards<br>▪ Immigration laws | ▪ All | ▪ Resistanc e from US profession al organizati ons<br><br>▪ Peer mistrust of skill equivalen cy |
| Issue: People are not choosing health professions<br><br>Solution 5 from Chicago<br><br>Solution: Incorporate health care in K-12 education | ▪ Link science and math to health<br>▪ School system support<br>▪ Exposure to real work careers and people<br>▪ 2-way street between healthcare system and school system<br>▪ Creative teaching tools<br>▪ Partnerships | ▪ School systems<br>▪ Healthcare<br>▪ Organizations<br>▪ Students<br>▪ Teachers | ▪ Counselors<br>▪ People to design and market programs<br>▪ Local financial support<br>▪ Foundations, associations<br>▪ hospitals<br>▪ businesses | ▪ Channel/satellite distribution<br>▪ Role models for underrepresente d groups<br>▪ Computers, etc.<br>▪ Financial support for kids | ▪ All | ▪ Schools are strapped<br>▪ Create an adopt-a-school program<br>▪ Bring back candy |

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| **Overall Solution 75** | | | | | | strip shadow program<br><br>▪ See youth-related solutions in #65 |
| Issue: People are not choosing health professions<br><br>Solution 6 from Chicago<br><br>Solution: Develop training to enhance entry-level workers' basic skills sets<br><br>**Overall Solution 76** | ▪ Contextual learning<br>▪ Pervasive, easy access<br>▪ Cultural competency<br>▪ Creating an accepting environment<br>▪ Appropriate marketing<br>▪ Integration of soft skills<br>▪ Computer literacy | ▪ State adult ed departments<br>▪ Community college remediation programs<br>▪ Employers<br>▪ Participants<br>▪ Immigration rights associations | ▪ Assessments<br>▪ Workforce boards and one stops<br>▪ Existing job training programs<br>▪ Funding<br>▪ Computer access libraries<br>▪ Churches<br>▪ Community organizations<br>▪ Family literacy centers | ▪ Access to funding support<br>▪ No employer tax credits for worker education at this level | ▪ All | ▪ 21st century 'GED' for those who have high school diploma, but lack basic reading, writing, etc.<br>▪ Needs to be portable |
| Issue: Employers need education on how to provide on-the-job training<br><br>Solution 7 from Chicago<br><br>Solution: Standardized template for creating program<br><br>**Overall Solution 77** | ▪ Understanding of steps in the process<br>▪ Identification of core competencies<br>▪ Principles of adult education<br>▪ Cultural competence<br>▪ Ease of Implementation<br>▪ Positive ROI – retention of employees<br>▪ Sharing best practices across institutions | ▪ Academic institutions<br>▪ Health care employers<br>▪ Employees<br>▪ Teachers<br>▪ In-house training departments | ▪ Human:<br>▪ trainers<br>▪ content experts<br>▪ instructional designers<br>▪ child care providers<br>▪ HR professionals<br>▪ assessment of outcome<br><br>▪ Financial:<br>▪ ROI<br>▪ Funding for courses – train-the-trainer<br>▪ courseware and materials<br><br>▪ Technical:<br>▪ existing research | ▪ Employers not recognizing the need<br>▪ Financial<br>▪ Union contracts | ▪ All | ▪ Need a marketing campaign to roll it out |

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| | | | ▪ Web and media designers | | | |
| Issue: Targeted/Specialized Skills<br><br>Solution 8 from Chicago<br><br>Solution: Encourage seasoned health care workers to move within the systems and explore opportunities<br><br>**Overall Solution 78** | ▪ Supportive Employer<br>▪ Allow flexibility<br>▪ Not threatened by employee exploring<br>▪ See the big picture<br>▪ Motivated employers<br>▪ Rewards for exploring and advancing<br>▪ Quality system for initial exploration that is quick and inexpensive<br>▪ 'Job info-mercials' for the employee<br>▪ Informational interviews<br>▪ Time allotment or career development beyond initial exploration<br>▪ Cost benefit for the hospital –vs.- cost of training/exploration<br>▪ Maintain Benefits, seniority, vacation, etc. while training and transferring | ▪ Employers/Supervisors<br>▪ Employees<br>▪ Hospice administrations<br>▪ Union<br>▪ Education institution | ▪ Life long learning tax credit<br>▪ College tuition break beyond a certain age<br>▪ Involved Departments<br>▪ Hospital Tuition reimbursements<br>▪ Need increased employee pool to cover employee who is exploring<br>▪ Computer access and training sessions<br>▪ Time constraints of employee to get training<br>▪ On-line learning | ▪ Employment and training programs have been cut to nothing<br>▪ Union agreements with employees<br>▪ Transferability of benefits problems | ▪ All | ▪ See related solutions in #64 |
| Issue: Targeted/Specialized Skills<br><br>Solution 9 from Chicago<br><br>Solution: Develop models to share faculty with educational institutions<br><br>**Overall Solution 79** | ▪ Increase pools for faculty and direct care while also keeping skills current for faculty<br>▪ Promotes life long learning<br>▪ Ability to train more workers<br>▪ Training curriculum will be more up-to-date<br>▪ Educational instruction for new faculty will be needed<br>▪ Attention to difference | ▪ Faculty – current<br>▪ Educational institutions<br>▪ Health care workers to work part-time shifts when faculty/worker is performing faculty duties<br>▪ Educational trainers for faculty training | ▪ Current faculty<br>▪ Funding for training and to cover shift not covered<br>▪ Computer skills for new faculty<br>▪ TIME constraints for the employee to get training, etc.<br>▪ Online learning | ▪ Requirements to becoming 'faculty'<br>▪ Differences in wage and benefits programs between patient care and faculty positions<br>▪ Requirements to maintain position in each<br>▪ Who is your boss? | ▪ All | ▪ See also # 21,30,42, 46,53,54, |

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| | working/learning styles<br>▪ Allow 'overworked' employee to take a break from manual labor | | | ▪ Academia is rigid and not conducive to part-time learning – non-traditional learner | | |
| Issue: Targeted/Specialized Skills<br><br>Solution 10 from Chicago<br><br>Solution: Map out skill sets and credentials that are transferable<br><br>**Overall Solution 80** | ▪ Identify credentials for each specialty<br>▪ Identify skills and coursework needed for each credential<br>▪ Identify skills and courses that are transferable<br>▪ Determine which skills are required but not identified as transferable | ▪ All providers/professions and students<br>▪ All credentialing bodies/entities<br>▪ All educators and deans of educational programs<br>▪ Accrediting agencies and standards developers for educational programs<br>▪ Credentialing review agencies for foreign workers<br>▪ Government oversight (DOL. DOE, DHHS/HRSA)<br>▪ Health care organizations | ▪ Oversight body – probably governmental federal/state/local system<br>▪ Financial (gift in kind from hospitals, educators, etc.) support given to oversight body – maybe federally funded or funded by individual professions<br>▪ Need extensive database of all health care careers and skills; education requirement needed for each program<br>▪ Ex: ONET (DOL NCHSTE<br>▪ Use professional organizations as data resources | ▪ Turf Wars<br>▪ Educational system that does not allow transferable credits<br>▪ Licensing requirements for each profession<br>▪ Legal implications of oversight body. Can providers do quality work | ▪ All | ▪ Identify credentials for each specialty<br>▪ Identify skills and coursework needed for each credential<br>▪ Identify skills and courses that are transferable<br>▪ Determine which skills are required but not identified as transferable<br><br>▪ See also # 72 for DOL role with regard to this |

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| | | | | | | solution and other related solutions |
| **Sustainability** | | | | | | |
| Issue: Long Term Demographic Changes and Labor Market Trends<br><br>Washington DC SWAT Team<br><br>To Develop a State-Level Workforce System that is Sustainable Across Years and Adaptable to Increases and Decreases in Workforce Challenges.<br><br>**Overall Solution 81** | ▪ Requires authority to act such as a mandate from the Governor (e.g. MD), certificate of need (e.g. VT).<br>▪ A state center, either actual or virtual, which is focused on HC workforce with monitoring, policy advising and related mandates from State.<br>▪ Implements the correct scale of all critical attributes such as 'fit' to the size of the State, user demographics (e.g. age of population), worker/potential worker pool demographics, resources available, degree of local /regional coordination would be more complex in larger states.<br>▪ The secretariat and governance structure requires core funding.<br>▪ Authority or legitimization to require of stakeholders the alignment of resources when there are actual or projected variations in workforce needs.<br>▪ Function of coordination of support for planning and action on workforce issues is carried out by a | ▪ Primarily at the State level<br>▪ Legislative and Executive bodies<br>▪ Employers<br>▪ Community colleges, universities and other educational entities who prepare people for HC occupations<br>▪ Public and private workforce entities (e.g. workforce boards)<br>▪ HC occupation licensing bodies<br>▪ Professional associations<br>▪ Consumer groups | ▪ Intersectoral partnerships because they can save money (e.g. English-as-a-second language programs; science and math skills; 'soft skills' needed for work; resources for workforce lattices such as former military personnel), steps in workforce plans and interventions, time, greater capacity, financial underpinnings, data sharing, definition of State workforce needs<br>▪ Monitoring for finding knowledge of transferable ideas from other industries or idea sources<br>▪ A taxonomy of HC occupations that is functional for a period of years so statistics and projections are more useful<br>▪ Current list of all State HC providers, educators, relevant workforce intermediaries, employee groups aggregated at the local, regional (if needed), state levels<br>▪ States need national/federal assistance for links for dissemination of information (e.g. of ideas such as the | ▪ State/federal/insurance funding entities for health care<br>▪ Scope of practice regulations<br>▪ Need increased flexibility in the use of funds for dealing with adapting to changes in workforce challenges | ▪ All | ▪ See related solutions # 22,35,49, 60,68,69, 81, 82 and 83<br><br>▪ Solutions #81, #82 and #83 are each a component of an adaptive workforce system. |

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| | coordinator, office for coordination or similar entity.<br>▪ Has measurable outcomes that determine system effectiveness and provide a basis for correcting the course of workforce responses through interventions.<br>▪ Competence in the diversification of funding resources for workforce pipeline (e.g. State, foundations, 'sweat equity, employers, employees) targeted to specific needs and outcomes sought.<br>▪ Information system capacity adequate for sectoral analysis, projections of workforce requirements, linkages to other workforce sites, research and studies about workforce issues, workforce-related data and informed studies, *et cetera.*<br>▪ Collaboration skills of everyone who 'uses' or is part of the workforce pipeline.<br>▪ Robust agendas of quality of performance, diversity of workforce, distribution of workforce, *et cetera.*<br>▪ Alignment of policy direction by key agencies (e.g. Maryland approach) including political policy affecting HC workforce | | marketing concept of Lancaster, PA workforce investment board); "we have jobs but we don't connect jobs with people who need them". | | | |

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| | at state, regional and local levels.<br>▪ Seeks communication, collaborative opportunities among stakeholders.<br>▪ Maintains information linkages with other workforce entities such as DOL, WIB's, HC employer and employee associations, labor organizations, education associations, consumer associations, *et cetera* that can inform and enhance the carrying out of the state coordination entity.<br>▪ Skill in serving as one catalyst for aligning resources for career ladders/lattices and other recruitment and retention strategies. | | | | | |
| Issue: Sustainability: Infrastructure, Leadership, and Policy<br><br>Salt Lake City Swat Team<br><br>Solution: National Model for a Sustainable Workforce in Health Care<br><br>**Overall Solution 82** | ▪ Business-friendly – can do vs can't do attitude<br>▪ Ability to Change Policy<br>▪ Research and models to project the needs accurately<br>▪ Must have the authority to act; institutionalized<br>▪ "Failure is not an option" attitude<br>▪ Quiet deliberation and negotiation tactics to "gel" partnerships<br>▪ Use of incentives—Infrastructure (e.g. fiscal policy - gas tax) for local/state planning. | ▪ DOL as Lead (broader perspective)<br>▪ DHHS<br>▪ DOJ<br>▪ DoEd<br>▪ ANA, AMA (other worker associations)<br>▪ Accreditation Organizations<br>▪ Allied Health<br>▪ AFL-CIO; SEIU; (labor Unions)<br>▪ Insurers<br>▪ NGA<br>▪ EDA<br>▪ Industry-driven (Labor & Management) | ▪ Independent Lead/Convening organization that is neutral<br>▪ Fiscal Policy<br>▪ AACC; other educational organizations and entities<br>▪ Demonstration Money<br>▪ Foundations<br>▪ Regulatory Boards<br>▪ Vendors<br><br>▪ Minority Voice<br><br>▪ BLS | ▪ Need to define the imperative through Legislation that is accountable to the consumer.<br>▪ Possibly take on another piece of legislation that speaks to this. | ▪ All | ▪ See related solutions with #81 |

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| | Incentives must be data driven vs politically driven<br>▪ ROI – value added; cost benefit<br>▪ Broad understanding of health care from the perspective of those needing care (patient-centered). | | | | | |
| Need For Sustainable Infrastructure, Leadership and Policy<br><br>Chicago SWAT Team<br><br>To Identify, Address and Adapt to Local Workforce Supply and Demand Changes<br><br>**Overall Solution 83** | ▪ Has the mandate or other leverage to engage and convene the appropriate stakeholders to address supply and demand issues. Suggested a local board management structure such as that used by Rush medical center because of its size, complexity yet functional nature.<br>▪ Has community and workforce demographic information including projections. Can determine short/medium-term needs in the context of longer-term workforce projections with decisions based on the same data, common agreement on meaning, done at certain regular dates. Planning tools and data needed.<br>▪ Local workforce systems need integration of some sort with education entities to increase or decrease the number and type of HC occupations for the community and to assist with resolving | ▪ Local entities relevant to HC workforce issues." a community of common interest groups".<br>▪ Physicians, nurses, allied health professionals<br>▪ Labor organizations<br>▪ Employers<br>▪ Educational institutions from K through post-secondary<br>▪ Community sources of potential workers such as religious organizations, YM/YWCA | ▪ The DOL ETA "Primer" when available as it describes the process for the developing and working of a local HC workforce group suggested in this solution<br>▪ Communications specialist or media assistance<br>▪ Skill in calculating the economic impact of HC workforce to the community ( see Aspen Institute current research on return on investment in HC workforce), in preventing losses to the community, in attracting business to the community, in costing out local, State and Federal decisions such as "add this regulation".<br>▪ Contacts among regulators, accrediting bodies, research sources, media, technology resources (e.g. helping provide care or training to work "smarter").<br>▪ Key informants for HC workforce issues at the local government and | ▪ Articulation of programs so that career ladders can be implemented (e.g. State of Oregon consensus approach by educators)<br>▪ If there are Federal or State mandates (e.g. HIPPA, small pox regs, staffing requirements) then there must be adequate public funding to carry out these mandates.<br>▪ State and Federal workforce and health care funding. Workforce policies that are intended to support the worker training steps and are too | ▪ All | ▪ See related solutions #81 |

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| | capacity issues requiring partnerships.<br>▪ The workforce entity is characterized by continuous quality improvement process in its work management.<br>▪ Strong, accurate and transparent communications internally and externally when appropriate. .. need for high levels of trust within the group, "sunshine law" on all deliberations, characterized by inclusiveness and accountability.<br>▪ The capacity or authority (the group was not sure about the latter) to align workforce resources and to rethink how to best do this.<br>▪ Need to have/create a workforce infrastructure that is consistent with career ladders/lattices and must be aligned with State and Federal support (group noted, however, that the levels of government have funding directives that are antithetical to sound workforce development).<br>▪ Core activities for the local area HC workforce team: identify local gaps and barriers related to HC workforce; know where money is being spent | | State levels.<br>▪ Diversity groups (e.g. disabled workers)<br>▪ Ability to be a support and catalyst for developing workforce environments that attract, retain and support patients/residents and employees (e.g. see American Hospital Association commission report; see Eden centers).<br>▪ Creativity and flexibility in workforce solutions while assuring high quality of care (e.g. apprenticeship approaches to workforce development, career ladders, Magnet Hospitals recognition). | often not aligned with current needs (e.g. incumbent worker funding for taking a whole program when the person needs funding for small steps in their career ladder activities). Our group did not know the solution but the fragmentation and lack of alignment of current funding with sustainable and adaptable workforce development at the local level is problematic.<br>▪ Licensure reciprocity between States<br>▪ The problem with the process required for criminal background checks | | |

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| | now, how much and its sources both by employers and by workforce pipelines; best practices that are applicable in the local area; set priorities about what issues should be addressed<br>▪ The skill and processes in place to overcome "turf battles" (e.g. competition for staff within the local area; competing labor organizations). Serves as an "honest broker" in the community and with levels of government.<br>▪ Ability to do multitasking. That is, the group can keep multiple workforce agendas moving ahead even when there is a short-term crisis | | | | | |

# Attachment 2

# Health Care Industry's Solutions Matrix – Condensed

# Health Care Industry's Solutions Matrix - Condensed

| Overarching Issue/Challenge | Specific Issue/Challenge | Potential Solution | Solution Number |
|---|---|---|---|
| **Recruitment and Retention** | Ensuring the Skills of Entry-Level Workers | To develop a competency-based instructional and assessment system that covers all Para-professional employees that leads to national standardized certifications and requirements. | *Solution 1 from Washington, DC*<br><br>**Overall Solution 1** |
| **Recruitment and Retention** | Ensuring the Skills of Entry-Level Workers | The DOL will exercise leadership in identifying the needs and finding ways to implement and institutionalize skills training for entry-level healthcare workers at the national, state, and local level. | *Solution 2 from Washington DC*<br><br>**Overall Solution 2** |
| **Recruitment and Retention** | Employment & Working Conditions | To enhance the public image and awareness of employment opportunities in the healthcare profession | *Solution 3 from Washington DC*<br><br>**Overall Solution 3** |
| **Recruitment and Retention** | Employment & Working Conditions | Continuous problem solving involving all levels to improve the working environment in order to increase retention. | *Solution 4 from Washington DC*<br><br>**Overall Solution 4** |
| **Recruitment and Retention** | Employment & Working Conditions | Identify successful cultural change initiatives to provide "models" to institutions that are struggling with how to improve their working environment. | *Solution 5 from Washington DC*<br><br>**Overall Solution 5** |
| **Recruitment and Retention** | Recognizing that the current supply of workers will not be adequate to meet future health care demands, we need to identify solutions to recruit non-traditional workers (such as, but not limited to: men, older adults, and individuals from culturally and linguistically diverse communities.) | Design of a national marketing campaign to sell nursing and allied health careers and give information on career entry. | *Solution 6 from Washington DC*<br><br>**Overall Solution 6** |
| **Recruitment and Retention** | Recognizing that the current supply of workers will not be adequate to meet future health care demands, we need to identify solutions to recruit non-traditional workers (such as, but not limited to: men, older adults, and individuals from culturally and linguistically diverse communities.) | To expose people, beginning in elementary school thru post-secondary. | *Solution 7 from Washington DC*<br><br>**Overall Solution 7** |

| Overarching Issue/Challenge | Specific Issue/Challenge | Potential Solution | Solution Number |
|---|---|---|---|
| **Recruitment and Retention** | Issue: Recognizing that the current supply of workers will not be adequate to meet future health care demands, we need to identify solutions to recruit non-traditional workers (such as, but not limited to: men, older adults, and individuals from culturally and linguistically divers communities.) | To develop targeted recruitment and retention strategies with community-based organizations (EMS Volunteer services programs, e.g., fire department, area aging agencies) nursing and allied health workers and faith based organizations. *ONLY EXAMPLES.* | *Solution 8 from Washington DC*<br><br>**Overall Solution 8** |
| **Recruitment and Retention** | Incumbent worker training | Increased flexibility of educational program provider offerings | *Solution 1 from Salt Lake City*<br><br>**Overall Solution 9** |
| **Recruitment and Retention** | Incumbent worker training | Create a learning culture that provides time, access, and compensation for learning | *Solution 2 from Salt Lake City*<br><br>**Overall Solution 10** |
| **Recruitment and Retention** | Incumbent worker training | Incentives for employee growth, development and continuing education | *Solution 3 from Salt Lake City*<br><br>**Overall Solution 11** |
| **Recruitment and Retention** | Targeted specialized skills areas: How to help retain/orient new hires | Create mentoring opportunities to acculturate new staff to the department or company | *Solution 4 from Salt Lake City*<br><br>**Overall Solution 12** |
| **Recruitment and Retention** | Targeted specialized skills areas: Filling specialty jobs | Develop system to identify, project and match/map competencies for roles within health care and across industries to identify matches and skill gaps. Create training to bridge the gap. | *Solution 5 from Salt Lake City*<br><br>**Overall Solution 13** |
| **Recruitment and Retention** | Targeted specialized skills areas: Staff skills necessary to develop into management and supervisory roles | Develop management certificate program | *Solution 6 from Salt Lake City*<br><br>**Overall Solution 14** |
| **Recruitment and Retention** | Entry-level worker preparation | Provide English as a second language programs to develop language skills and meet minimum job requirements | *Solution 7 from Washington DC*<br><br>**Overall Solution 15** |
| **Recruitment and Retention** | Entry-level worker preparation | Increase exposure of students to health care workforce environment in junior high and high schools | *Solution 8 from Salt Lake City*<br><br>**Overall Solution 16** |

| Overarching Issue/Challenge | Specific Issue/Challenge | Potential Solution | Solution Number |
|---|---|---|---|
| **Recruitment and Retention** | Entry-level worker preparation | Develop and sustain partnerships between local educational institutions and the healthcare industry | *Solution 9 from Salt Lake City*<br>**Overall Solution 17** |
| **Recruitment and Retention** | Career Ladder / Lattice | Develop career paths to accommodate vertical and horizontal moves within the healthcare field | *Solution 1 from Chicago*<br>**Overall Solution 18** |
| **Recruitment and Retention** | Through Development of a Health Corps to Increase the Available Labor Pool | Develop a Health Corps, based on the Peace Corps or Teachers Corps model | *Solution 2 from Chicago*<br>**Overall Solution 19** |
| **Recruitment and Retention** | Pipeline: Recruitment and Retention Through a Media Campaign to Increase Available Labor Pool | Build A Positive and Effective Media Campaign to increase healthcare workers | *Solution 3 from Chicago*<br>**Overall Solution 20** |
| **Recruitment and Retention** | Pipeline: Recruitment and Retention Through Funding to Increase the Available Labor Pool | To develop individual and system financial/funding models that promote student enrollment, faculty development and program growth | *Solution 4 from Chicago*<br>**Overall Solution 21** |
| **Recruitment and Retention** | Pipeline: Recruitment and Retention Through Increased Partnerships to Increase the Available Labor Pool | Develop a partnership model between industry, government and education | *Solution 5 from Chicago*<br>**Overall Solution 22** |
| **Recruitment and Retention** | Pipeline: Recruitment & Retention: Turnover – Changing Culture | Develop strategies and incentives to move to shared governance and continuous, quality improvement environment | *Solution 6 from Chicago*<br>**Overall Solution 23** |
| **Recruitment and Retention** | Pipeline: Recruitment & Retention: Turnover -- Incentives | Develop a comprehensive range of employee incentives to remain in the healthcare field | *Solution 7 from Chicago*<br>**Overall Solution 24** |

| Overarching Issue/Challenge | Specific Issue/Challenge | Potential Solution | Solution Number |
|---|---|---|---|
| **Recruitment and Retention** | Pipeline – (A): Recruitment and Retention – Diversity / Non-traditional Labor Pool | A system wide commitment to provide consistent access, opportunity and support for recruiting and retaining underrepresented culturally diverse populations in the healthcare workforce | *Solution 8 from Chicago* **Overall Solution 25** |
| **Recruitment and Retention** | Pipeline – (B) Recruitment and Retention – Diversity / Non-traditional Labor Pools | Reduce barriers to entry level jobs and increase retention through financial or in-kind subsidies to targeted populations | *Solution 9 from Chicago* **Overall Solution 26** |
| **Recruitment and Retention** | Pipeline – (C) Recruitment and Retention – Diversity / Non-traditional Labor Pools | To Improve Retention by Creating Flexible Work Options within healthcare to Appeal to Non-Conventional Workers | *Solution 10 from Chicago* **Overall Solution 27** |
| **System Capacity** | Capacity of Workforce-related Organizations | Partnering with Employers (Hospitals, LTC) and training providers (community colleges, universities, other) on a regional basis. | *Solution 1 from Washington DC* **Overall Solution 28** |
| **System Capacity** | Capacity of Workforce-related Organizations | Training for practicing providers to provide adult learning competence and cultural competence. Training clinicians to teach adults will help more of them become academic and clinical faculty. (Given because many clinicians do not think they are able to teach adults.) Training in cultural competencies will help clinicians understand the different cultural aspects of their patients/students. | *Solution 2 from Washington DC* **Overall Solution 29** |
| **System Capacity** | Capacity of Workforce-related Organizations | Faculty loan repayment | *Solution 3 from Washington DC* **Overall Solution 30** |
| **System Capacity** | Capacity of Workforce-related Organizations | Prioritize training and occupations so that budget cuts do not affect key occupation training | *Solution 4 from Washington DC* **Overall Solution 31** |
| **System Capacity** | Midterm Projections | Input from Consumers | *Solution 5 from Washington DC* **Overall Solution 32** |
| **System Capacity** | Midterm Projections | Agreed upon assumptions. In order to have a process the industry and statisticians saw as valid, certain uniform assumptions and results are required. | *Solution 6 from Washington DC* **Overall Solution 33** |

| Overarching Issue/Challenge | Specific Issue/Challenge | Potential Solution | Solution Number |
|---|---|---|---|
| **System Capacity** | Midterm Projections | Database of different occupation and state analyses | *Solution 7 from Washington DC*<br>**Overall Solution 34** |
| **System Capacity** | Building Partnerships and Healthcare Information | Regional Healthcare Workforce Council | *Solution 8 from Washington DC*<br>**Overall Solution 35** |
| **System Capacity** | Occupational Gaps | Develop recruitment and retention strategies | *Solution 9 from Washington DC*<br>**Overall Solution 36** |
| **System Capacity** | Occupational Gaps | Expand career lattices within the industry | *Solution 10 from Washington DC*<br>**Overall Solution 37** |
| **System Capacity** | Occupational Gaps | Distance Learning for Staff | *Solution 11 from Washington DC*<br>**Overall Solution 38** |
| **System Capacity** | Lack of facilities and resources | Healthcare – Expand Training Programs – Allied Health Professions | *Solution 1 from Salt Lake City*<br>**Overall Solution 39** |
| **System Capacity** | Lack of facilities and resources | Distance and education learning | *Solution 2 from Salt Lake City*<br>**Overall Solution 40** |
| **System Capacity** | Lack of academic and clinical instructors | Provide paid time off and flexible work schedules for those that wish to advance their education to teach or want to serve as part-time instructors (both academic and clinical) | *Solution 3 from Salt Lake City*<br>**Overall Solution 41** |
| **System Capacity** | Lack of academic and clinical instructors | Subsidize (from industry) BSN and MSN students and professionals to continue their education to become instructors | *Solution 4 from Salt Lake City*<br>**Overall Solution 42** |
| **System Capacity** | Lack of academic and clinical instructors | Increase faculty salaries so they are competitive with clinical practice salaries | *Solution 5 from Salt Lake City*<br>**Overall Solution 43** |

| Overarching Issue/Challenge | Specific Issue/Challenge | Potential Solution | Solution Number |
|---|---|---|---|
| **System Capacity** | Lack of alignment between requirements and curriculum | Provide flexible entry points | *Solution 6 from Salt Lake City*<br>**Overall Solution 44** |
| **System Capacity** | Lack of alignment between requirements and curriculum | Industry-led curriculum development committee | *Solution 7 from Salt Lake City*<br>**Overall Solution 45** |
| **System Capacity** | Lack of alignment | Academic faculty required to have contact clinical experience | *Solution 8 from Salt Lake City*<br>**Overall Solution 46** |
| **System Capacity** | Lack of facilities and resources | Use of available facilities | *Solution 9 from Salt Lake City*<br>**Overall Solution 47** |
| **System Capacity** | Lack of facilities and resources | Partnership among providers, training and education of public officials to use facilities | *Solution 1 from Chicago*<br>**Overall Solution 48** |
| **System Capacity** | Lack of facilities and resources | Clearing house (portal) of resources (space, finding, equipment) Models, exports, programs | *Solution 2 from Chicago*<br>**Overall Solution 49** |
| **System Capacity** | Lack of alignment between requirements and curriculum | Curriculum for new models of care | *Solution 3 from Chicago*<br>**Overall Solution 50** |
| **System Capacity** | Lack of alignment between requirements and curriculum | Partnerships between industry and accrediting agencies and certification bodies for a realistic alignment between practice requirements and curricular design and implementation | *Solution 4 from Chicago*<br>**Overall Solution 51** |

| Overarching Issue/Challenge | Specific Issue/Challenge | Potential Solution | Solution Number |
|---|---|---|---|
| **System Capacity** | Lack of alignment between requirements and curriculum | HC industry driven curriculum | *Solution 5 from Chicago*<br><br>**Overall Solution 52** |
| **System Capacity** | Train practitioners as instructors by partnering with industry | Develop an educational program to teach practitioners to be effective clinical instructors | *Solution 6 from Chicago*<br><br>**Overall Solution 53** |
| **System Capacity** | Enhance academic instructors compensation so it is competitive with practitioners | Development of alternative funding mechanisms for education | *Solution 7 from Chicago*<br><br>**Overall Solution 54** |
| **System Capacity** | Lack of academic and clinical instructors | Distance education | *Solution 8 from Chicago*<br><br>**Overall Solution 55** |
| **System Capacity** | Lack of facilities and resources | Donate/lease equipment to stay current | Solution 9 from Chicago<br><br>**Overall Solution 56** |
| **Demographic Shifts and Labor Market Trends** | The Need for Resources to Remove the "Bottleneck" of Potential Workers into the System | Remove the "Bottleneck" of potential workers into the system by becoming more flexible and creative in identifying and applying resources. | *Solution 1 from Washington DC*<br><br>**Overall Solution 57** |
| **Demographic Shifts and Labor Market Trends** | The Need for Better Data Analysis, Forecasting, and Dissemination | Establish better data analysis, forecasting, and dissemination by focusing on most appropriate information and increasing processing efficiency. | *Solution 2 from Washington DC*<br><br>**Overall Solution 58** |
| **Skill Development** | Public perception | To develop programs for branding to enhance the perception of healthcare jobs | *Solution 1 from Salt Lake City*<br><br>**Overall Solution 59** |

| Overarching Issue/Challenge | Specific Issue/Challenge | Potential Solution | Solution Number |
|---|---|---|---|
| **Skill Development** | Think outside the bowl | To develop an understanding of local or regional constraint points and develop a strategies to relieve that constraint in healthcare | *Solution 2 from Salt Lake City* **Overall Solution 60** |
| **Skill Development** | Increasing available labor pool | To modify and improve the healthcare delivery system by making it more operationally efficient and more patient focused | *Solution 3 from Salt Lake City* **Overall Solution 61** |
| **Skill Development** | Increasing available labor pool | To maximize the available options for access and training opportunities for the emerging transition and current workforce | *Solution 4 from Salt Lake City* **Overall Solution 62** |
| **Skill Development** | Turnover | To redesign the healthcare work environment creating an atmosphere of on-going professional growth and mutual respect and appreciation | *Solution 5 from Salt Lake City* **Overall Solution 63** |
| **Skill Development** | Turnover | To develop an innovative incentive program to increase retention and support performance excellence | *Solution 6 from Salt Lake City* **Overall Solution 64** |
| **Skill Development** | Turnover | To develop an innovative program to provide realistic views of all levels of healthcare professionals | *Solution 7 from Salt Lake City* **Overall Solution 65** |
| **Skill Development** | Increasing available labor pool | To increase the overall wage of entry level healthcare workers | *Solution 8 from Salt Lake City* **Overall Solution 66** |
| **Skill Development** | Increasing available labor pool | To leverage youth programs to provide awareness, exploration and training for the emerging workforce in healthcare careers | *Solution 9 from Salt Lake City* **Overall Solution 67** |
| **Skill Development** | Diversity/non-traditional labor pools | To develop a system that encourages community involvement in healthcare training and workforce systems | *Solution 10 from Salt Lake City* **Overall Solution 68** |
| **Skill Development** | Diversity/non-traditional labor pools | To develop a system that rewards community partnerships / a diverse array of stakeholders | *Solution 11 from Salt Lake City* **Overall Solution 69** |

| Overarching Issue/Challenge | Specific Issue/Challenge | Potential Solution | Solution Number |
|---|---|---|---|
| **Skill Development** | Diversity/non-traditional labor pools | To achieve basic skills competency and healthcare prerequisites in non-traditional labor pools | *Solution 12 from Salt Lake City*<br><br>**Overall Solution 70** |
| **Skill Development** | Loss of patient care-givers | Develop career paths/educational opportunities to retain patient care-givers | *Solution 1 from Chicago*<br><br>**Overall Solution 71** |
| **Skill Development** | Inconsistent recognition of credentials (state) | National standards for licensing/credentialing all technical/clinical HC roles | *Solution 2 from Chicago*<br><br>**Overall Solution 72** |
| **Skill Development** | Training is not readily accessible to large group of population | Distance learning can dramatically and rapidly expand access | *Solution 3 from Chicago*<br><br>**Overall Solution 73** |
| **Skill Development** | Immigrant workers with healthcare skills (potential labor pool) not working in the health care field. | Develop bridging programs | *Solution 4 from Chicago*<br><br>**Overall Solution 74** |
| **Skill Development** | People are not choosing health professions | Incorporate healthcare in K-12 education | *Solution 5 from Chicago*<br><br>**Overall Solution 75** |
| **Skill Development** | People are not choosing health professions | Develop training to enhance entry-level workers' basic skills sets | *Solution 6 from Chicago*<br><br>**Overall Solution 76** |
| **Skill Development** | Employers need education on how to provide on-the-job training | Standardized template for creating program | *Solution 7 from Chicago*<br><br>**Overall Solution 77** |
| **Skill Development** | Targeted/Specialized Skills | Encourage seasoned health care workers to move within the systems and explore opportunities | *Solution 8 from Chicago*<br><br>**Overall Solution 78** |

| Overarching Issue/Challenge | Specific Issue/Challenge | Potential Solution | Solution Number |
|---|---|---|---|
| **Skill Development** | Targeted/Specialized Skills | Develop models to share faculty with educational institutions | *Solution 9 from Chicago*<br><br>**Overall Solution 79** |
| **Skill Development** | Targeted/Specialized Skills | Map out skill sets and credentials that are transferable | *Solution 10 from Chicago*<br><br>**Overall Solution 80** |
| **Sustainability** | Long Term Demographic Changes and Labor Market Trends | To Develop a State-Level Workforce System that is Sustainable Across Years and Adaptable to Increases and Decreases in Workforce Challenges. | *Washington DC SWAT Team*<br><br>**Overall Solution 81** |
| **Sustainability** | Sustainability: Infrastructure, Leadership, and Policy | National Model for a Sustainable Workforce in Health Care | *Salt Lake City Swat Team*<br><br>**Overall Solution 82** |
| **SWAT Teams on Sustainability** | Need for Sustainable Infrastructure, Leadership and Policy | To Identify, Address and Adapt to Local Workforce Supply and Demand Changes | *Chicago SWAT Team*<br><br>**Overall Solution 83** |

# Attachment 3

# 1001 Solutions Generated at the Health Care Industry Workforce Development Forums

## 1001 Solutions Generated at the Health Care Industry Workforce Development Forums

Total number of solutions generated at forums: 1001

The large number of solutions is useful for readers who have a workforce challenge and who are seeking a range of ideas for solutions. In this document, a small set of 16 interesting or unusual solutions has been placed below. These solutions were not expanded upon by the Workforce Development Information Forum work groups.

- Assistive technology/job redesign
- To redesign jobs to allow older workforce to continue to work (i.e. six months per year contracts). Work from home when possible.
- To create more flexible part-time, work-at-home jobs for individuals with children or older workers.
- To market healthcare career opportunities in sports media, TV, radio, magazines normally used by men.
- Develop career ladders for workers in the health care industry that link compensation to new skill development (pay for knowledge)
- Promote regional collaboration to minimize effect of labor cannibalizing.
- To improve workplace culture, support incentives to become a magnet hospital.
- To discourage hospitals/employers from cannibalizing each other's employees by developing city-wide/regional agreements on hiring bonuses/salary, etc.
- To develop/expand health service corps that exchanges tuition support for work in shortage areas.
- To develop a Health Corp modeled after the Peace Corp.
- National/state advertising of healthcare jobs sponsored on every major sporting event on T.V.
- Tap into and develop links to distance learning programs to bring educational sessions (1 instructor) to teach multiple students over many states.
- To develop older RNs into instructors – help keep them in healthcare. Reach out to retirees to come back to work as instructors; must make it easy or them to be licensed instructors (e.g., Georgia model)
- Stretch faculty further using retired to teach online courses or serve as part-time faculty.
- Licensing requirements reevaluated.
- National rather than state licensing.

The following is a complete list of the solutions generated at the Workforce Development Forums:

# Pipeline: Recruitment and Retention

### *Diversity/Non-Traditional Labor Pools*

**Washington, DC Solutions**

1. National marketing effort to sell the industry and where to go for help (image – multi-ethnic)
2. Identify barriers for entry
3. Offer immediate employment to older works and train on-the-job
4. Preparation for different workplace issues
5. Assistive technology/job redesign
6. Introduction in elementary/middle schools of healthcare careers
7. Healthcare clubs – role model, speaker bureaus
8. Partnering with CBOs and FBOs – develop needs for specific communities
9. Recruit and test in multiple languages and train – training resources for the multi-ethnic/multi-language
10. Guide for career changers

**Washington, DC "Did You Think of This"**

11. Difficulty of immigrants meeting admission standards of community college without transcripts
12. No translation of immigrant skills into U.S. medical occupations (licensing board examination)
13. Cultural competency training needed for supervisors = people leaving jobs if they don't feel respected

**Salt Lake City, UT Solutions**

14. Community Outreach
15. Community Partnerships
16. Basic Skills
17. Develop vocational ESL curriculum for health care careers training.
18. Seek out the alternative Labor Pool.
19. Develop an immigrant strategy to attract non traditional workers.
20. Introduce local minority mentorship programs to attract individuals from targeted populations.
21. Recruit workers, especially in home health care, from the families and communities of patients.
22. Promote the hiring of local residents through funding support targeted at reducing dependence on foreign labor.
23. Develop a targeted marketing campaign to large pools of non-traditional health care labor pools
24. Eligible post criminal offenders
25. Disabled

26. Other types of service workers
27. Men
28. International
29. Engage national, state and local civic groups with regularly scheduled presentations, workshops, or linking to a sponsored community health care event like a "good eating" event
30. Provide diverse/non-traditional students with funding supports to enable them to gain needed skills.
31. Provide tax credits to males and other minority groups to enter the health care industry
32. Have inclusiveness training for existing staff
33. Make the health care profession attractive again to those that left the field.
34. Develop a media campaign promoting health care as an industry of choice for nontraditional health care labor pools
35. Develop a more diversified educated pool of future healthcare workers and increase the availability of programs to youth
36. Example: Academic Enrichment Math and Language Arts
37. Mentors/Tutors
38. Combine existing resources in community to leverage opportunity
39. Develop and leverage training programs with historically black universities and Hispanic populations.
40. Offer special public transportation from targeted neighborhoods to training opportunities.
41. Work with the industry and community to create "paths" for the older/2nd career worker.
42. Reassess the potential for ex-offenders to participate in certain healthcare professions.
43. Develop an importation strategy of skilled workers for the health care industry from the labor force of other countries.
44. Reach out with multiple partners to minority communities
45. Develop a support system by which non-traditional students with family responsibilities can simultaneously meet family needs and gain skills and competencies for health care professions.
46. Develop partnerships with other service-related industries in order to get them to understand the urgency of health care needs and assist in developing solutions.

## Chicago, IL Solutions

47. To provide loan forgiveness
48. To provide child care assistance, support for underrepresented workers in healthcare.
49. To provide county tax rebates for those willing to relocate to serve in healthcare fields for up to two years or more.
50. To establish funds/scholarships targeted to populations.
51. To provide transportation assistance to healthcare jobs for underrepresented groups (e.g. older workers, workers with English as a second language)

52. To provide subsidized prescription drug funding for older workers, second career workers.
53. To subsidize home ownership/housing and offer stipends for students including loan forgiveness education.
54. To remove non-essential physical skill requirements from occupational requirements.
55. To redesign jobs to allow older workforce to continue to work (i.e. six months per year contracts). Work from home when possible.
56. To provide flexible work schedules for non-traditional workers.
57. To expand scheduling options i.e., 2 - 4 - 6 hour shifts/seasonal
58. To create more flexible part-time, work-at-home jobs for individuals with children or older workers.
59. To loosen state/fed licensing regulation burdens to encourage retired practitioners to do more part-time/volunteer work in healthcare.
60. To provide role models for diverse student populations.
61. To develop “back-to-school” programs with practitioners from underrepresented populations making presentations/mentoring in inner city or rural schools.
62. To include cultural diversity and sensitivity in healthcare education programs.
63. To increase cultural competence/cultural sensitivity of all practitioners so that potential applicants feel this is a viable option for them.
64. To use minorities in health care industry as community role models to encourage careers in healthcare.
65. To increase English immersion availability.
66. To develop recruitment tools in a variety of languages and formats.
67. To recruit using non-English speaking media outlets.
68. To provide special education incentive funding for ESL, community college students to join healthcare fields.
69. To bring in healthcare workers that are non-English speakers, to develop Spanish speaking teams of healthcare providers to serve Spanish speaking clients while also learning English.
70. To recruit bilingual healthcare providers i.e., doctors, nurses, etc.
71. To market healthcare career opportunities in sports media, TV, radio, magazines normally used by men.
72. To change image/message to increase males
73. To attract more men into nursing, change the name to reflect technology and management skills needed.
74. To target lesbian, gay, bi-sexual, transgendered individuals
75. To identify and attract retired workers back to healthcare
76. To have community healthcare agencies provide grassroots outreach to their local communities.
77. To expand beyond traditional healthcare occupations to include electronic technicians/instrument mechanics, building maintenance, lab techs, ambulance drivers, computer techs.
78. To have employers work with workforce development projects

79. To partner with educational institutions to support programs focusing on these groups.
80. To target new immigrants who are healthcare providers with alternative prep strategies to enter U.S. workforce.
81. To offer non-citizen groups a quicker ticket to citizenship by entering the healthcare field.
82. To recruit workers from overseas by loosening visa requirements and expand use of overseas workers in certain fields (information management, reading x-rays) by outsourcing to them.
83. To promote healthcare programs to displaced workers
84. To re-employ workers from declining manufacturing positions
85. To work with transitioning Military personnel back into public employment (healthcare technical skills)
86. To partner with Job Service to reach out to displaced workers

### *Career Ladders/Retention*

### Salt Lake City, UT Solutions

87. Structure training and career ladders to allow for career advancement at a more rapid pace.
88. Develop career ladders for workers in the health care industry that link compensation to new skill development (pay for knowledge)
89. Increase supports needed for people to train and stay in health care jobs.
90. Develop a process to engage those already in health care to stay in the profession.
91. Provide coursework to aid the academic preparedness of individuals demonstrating interest but lacking necessary competencies
92. Make training available and affordable for low-wage workers, the unemployed and entry level incumbent workers.
93. Increase the number of students allowed in clinical settings or increase wages for instructors so the job is more than or as appealing as the hospital setting so more instructors could be hired/retain their employment.
94. Conquer the stigma of males as health care providers by promoting the work stability and living wages of the profession.
95. Provide more career counseling to current workers so they view health care as a career and don't feel they need to leave to have a change.
96. Provide/help worker access supports to entry level or low-wage workers
    a. Transportation
    b. Child Care
97. Develop incentive programs for individuals based on seniority
98. To decrease patient/health care stress, worker ratios, the feeling of being unprepared by giving workers opportunities for bonuses, leave, training, child care as incentives to stay on board and perform at a higher rate of excellence.
99. Develop formalized post licensure training with colleges to ensure that workers are adequately prepared for job learning curves (continued competency).
100. Promote regional collaboration to minimize effect of labor cannibalizing.

101. Long Term Care – regulation/guidance awareness for families could mean higher wages for entry level employees and lower turnover
102. Improve the lines of communication and reduce disputes between front-line worker and management (unions) through the joint creation of community visions and strategic work plans.
103. Develop a compensation plan that produces a living wage for all levels of workers.
104. Develop more flexible delivery of didactic work to meet student demand.
105. To decrease turnover, assist health profession programs to provide realistic views of careers (e.g. require clinical training for all shifts).
106. Introduce students to basic nursing skills, responsibilities and demands before entering a nursing program.
107. Look at job demands, not money.
108. Make the work "reality" experienced more in the educational process (RN Residency).

## Chicago, IL Solutions

109. To improve workplace culture, support incentives to become a magnet hospital.
110. To develop easily interactive communication links between employee and employer, i.e., regular focus groups, teams-shared governance, continue ways of improvement.
111. To create a culture of R-E-S-P-E-C-T
112. To improve employee satisfaction with leaders/supervisors – highly prepared leaders
113. To develop quick responding process improvement procedures (interactive) so that things can change in a timely fashion.
114. To develop a culture of continuous learning by rewarding those who participate.
115. To increase awareness and understanding of and respect for the roles of nurses//allied health professionals among physicians and hospital management (allied health professions week – Nov 2-8, 2003)
116. To change culture of M.D.—R.N. dynamic, create innovative med school and nursing school partnerships to foster team approach.
117. To focus management education on coaching career development and other areas which support employees.
118. To increase tuition reimbursement benefit.
119. To provide incentives for extended stay within a healthcare organization beyond wages and hours, such as additional 'comp' time or free community college classes.
120. Ability to get time off.
121. To provide for sabbatical – time out – job rejuvenation.
122. To reward managers for developing and retaining their staff.
123. To create more flexible part-time, work-at-home special benefits.
124. To end the pay/benefit battle between facilities

125. To offer pension programs or other longevity incentives for long term service in the industry.
126. To adopt flexible scheduling, create shared assignments, etc., to promote retention.
127. To provide more attractive total rewards (compensation, benefits, etc.)
128. To stop the mandatory overtime argument between employees vs. employer.
129. To provide career ladders for healthcare workers.
130. To develop career ladders across competing healthcare systems
131. Utilize tools such as mentoring, career counseling, career ladders, and career lattices to provide productive alternatives for exiting the field.
132. To keep two-thirds R.N's in the field, streamline ability to get BSN that will increase options.
133. To redesign workload to accommodate the older worker (physical and mental)
134. To discourage hospitals/employers from cannibalizing each other's employees by developing city-wide/regional agreements on hiring bonuses/salary, etc.
135. To bridge the gap between long term care and acute care
136. To realize that turnover will happen no matter what, so build into the organization's plan.
137. To develop a study that identifies causes of turnover and provides strategies for minimizing turnover problems.
138. To evaluate through a comprehensive national study, causes of turnover with attention to local issues, ages, sex, nationality, personal needs, to foster models to reduce turnover, step outs and unproductive migration.
139. To institute "better" orientations for new healthcare providers, to job and culture
140. To implement mentoring programs in each facility with employee buy-in.
141. To target time of most turnovers (first two years) to nurture people through.
142. To support mentorships with additional incentives for veteran workers so they better accept new employees thereby improving culture.

***Increasing the availability of the labor pool***

## Salt Lake City, UT Solutions

143. Youth programs
144. Living wages
145. Access to training
146. Develop increased interest in health careers by providing motivating activities to introduce youth to health careers.
    a. Summer camps
    b. A day with health professionals
    c. Dissections
147. Develop a pipeline of new entry level workers to the health care industry by marketing health care careers to middle school and high school students
148. Develop a formalized process by which high school students can earn college credit in the health care field.
149. Develop a media campaign focused on increasing the reputability and respect level for entry level health care jobs

150. Develop a more dedicated work pool to assist health profession organizations to improve the image of their profession
151. Engage community partners to bring increased awareness to various health care professions/needs.

### *Improving the Work Environment*

152. Improve the quality of the work environment
    a. Better hours
    b. Flexible hours
    c. Improved supervisory training
153. Work environment to have the industry training more family/work life friendly.
154. Work more with physicians as to their impact on t/o
155. Foster a working environment that supports long term employment (i.e. work hours, fringe benefits, career ladders, etc)
156. Competitive work place
157. Provide more opportunities for professional growth and development
158. Develop programs to constantly reiterate respect and appreciation for staff working in health care jobs. Programs at all levels: National, Regional, Local and Organizational.

## Chicago, IL Solutions

159. To increase awareness of non-physician/nursing careers (i.e., allied health) in K12-PSAs on MTV, Nick, etc., internet banner ads, viral e-mail campaigns, etc.
160. To promote allied health professions to the public to increase the number of applicants to ed programs
161. To recruit all schools, not just public schools. Remember private and parochial schools, Remember they frequently have a “mission” philosophy
162. To develop a positive media image through targeted strategies; i.e. right message, right population, right number of contacts
163. To market the plus side or advantages of a health care career including variety, flexibility, transportability, job security, etc.
164. To lure high school students in healthcare related fields by making the different fields more appealing, more sexy
165. To get healthcare corporate sponsors to donate technical and lab equipment to high schools and community colleges so healthcare subjects are more appealing to students.
166. To form partnerships with healthcare corporate providers to develop joint training and receiving programs
167. To increase collaboration between service and education to provide faculty and programs.
168. To improve communications between high school and community colleges for better preparation for probable labor pool.

169. To partner with organizations training in future shortage areas to introduce healthcare opportunities to them.
170. To develop effective targeted partnerships, e.g. accelerated BSN requires partnering with four year institutions not necessarily with high schools
171. To finance student tuition (at time of admission) so students can depend on it.
172. To provide tax incentives for people to move to rural areas.
173. To develop/expand health service corps that exchanges tuition support for work in shortage areas.
174. To encourage continued state/fed funding to hospitals, Title VII funding
175. Go to the community service organizations, churches, places where people wait (driver's license or clinics) with recruitment materials.
176. To encourage new citizens to better understand health care in the US by including info with citizenship training.
177. To recruit former healthcare workers. Provide training and support transition back into healthcare.
178. To work with high school career counselors to increase their awareness of health careers.
179. To support our welfare reform / low income population for success in a healthcare career.
180. To assess ability of non-traditional worker (older workers, part-time workers) to supplement labor pool, targeting limited ability workers to areas of limited need. And develop career ladders to provide for fallback opportunities.
181. To use your current labor pool for a grass roots effort (i.e., role modeling, education)
182. To hire students studying in areas with labor shortages for summer intern jobs at hospitals, summer camps, (4-12).
183. To recruit displaced workers
184. To provide reciprocity for qualified foreign-trained healthcare workers to increase available labor pool
185. To rehabilitate the formerly incarcerated to join the healthcare profession (reduces recidivism)
186. To work creatively with four-year and community colleges to relieve bottle-necks in waiting lists.
187. To develop on-line training opportunities to attract working people interested in changing jobs.
188. To increase quality of K-12 math/science education—magnet high schools for health careers, job shadowing.
189. To tutor adult students in math, English, and science.
190. To develop a Health Corp modeled after the Peace Corp.
191. To manage job listings for healthcare organizations to better generalize their info for possible labor pool.
192. To get employers to actually list healthcare skills needed when writing up job orders, not overlooking or minimizing the obvious skills and experience levels.
193. To analyze current processes to reduce reliance on high shortage occupations

194. To establish pools of workers for shared employment across regions, employers share costs for employee benefits
195. To transition our economy from low-skilled manufacturing to "business" services, reframe healthcare service into a "business" service model vs. caretaking model.
196. To review and implement a generalist apprentice program for the healthcare industry
197. To provide high school students exposure to healthcare through school-to-work programs or healthcare youth apprenticeship
198. To use job shadowing for persons to explore healthcare careers.
199. To provide career info and counseling to all existing employees.
200. To streamline access into healthcare fields, develop entry/access based on skills vs. degree achievement. "Career ladder" in the workplace.
201. To redefine the prerequisites for healthcare jobs so that people are more likely to view themselves as likely candidates (cuts time)

### *Employment and Working Conditions*

## Washington, DC Solutions

(Eliminated in Salt Lake City, UT and Chicago, IL)

*Employment and Working Conditions Defined:*

- Physical Facility
- Unpleasant Job Attributes
- Management Issues
- Increasing Worker Perspectives about Employment Opportunities
- Job Design
- Supervisory/Employee Relationships
- Access to Workplace
- Support Services
- Union/Non-Union Relationships
- Respect for the Job Performed (by the public and private sectors)

202. Supervisory/management training
203. All levels involved in decision making
204. Open communication between all levels
205. Good new employee orientation – management and department heads
206. Schedule flexibility
207. Articulated career path with a fast track to promotion – state-wide
208. Case management approach to employee support
209. Competency-based management – clearly define essential functions and understanding of the evaluation process
210. Respect from the top down – team morale building
211. Workable staffing ratio guidelines
212. Identification of successful cultural change initiative and national grant program

213. Appropriate assignments based on education and training
214. Continuous problem solving involving all levels
215. Have fun and let each other know that you care – meet with employees, monthly activities, good communication with a positive attitude – TEAM
216. Work/family balance – accommodating
217. Regular learning opportunities
218. Increased reimbursement rates tied to wage and benefit packages, linked to retention – key to reward, competitive employment packages
219. On-the-spot recognition programs
220. Safety input from frontline workers
221. Examine "sun-set" rules – licensure, credentialing and certification
222. Job enrichment – teachers, nurses, and allied health professionals
223. Federal regulations from pre-employment and continuing education to decrease turnover
224. Clear policies regarding rewards and consequences
225. Reduce paperwork
226. Support collaborative and cooperative union relationships
227. Employee-based training models that integrate healthcare and workforce resources
228. Intelligent use of technology advances, better use of digital technology and handheld software solutions
229. More use of paraprofessionals as peers in training, broad job design demonstrations, and innovative patient care models
230. Partnerships – other recruitment partners (faith, community and charity-based organizations)
231. Military transition/certification
232. Image campaign (Healthcare Hero)
233. Apprenticeship

## Washington, DC "Did You Think of This"

234. Pay incentives for supervisors that send employees to education and training
235. Increasing innovative types of employee benefits vs. just pay > comp time, in-kind, etc.
236. Encourage employers to offer services that are needed by the busy parent of today – post office, dry cleaning, etc.
237. Career ladders that incorporate career counseling/coaching/mentoring
238. Incorporate incentives – child care, transportation, tuition reimbursement, living stipends
239. Pay increments tied to career ladders

### *Pipeline: Recruitment and Retention: Ensuring the Skills of Entry-Level Workers*

## Washington, DC Solutions

(Eliminated in Salt Lake City, UT and Chicago, IL)

240. Competency-based assessment system – applied research linked to quality
241. Preceptor/mentor programs
242. Articulation of skills needed for entry at all levels (uniformity)
243. National standardized certification/licensure for allied health
244. Management training for license (nurses)
245. Virtual E-learning training centers, explore distance learning options
246. Conduct internal CGNA certification classes
247. Partner with partners to share skill needs
248. National leadership on training needs of the healthcare workforce (local and state)
249. DOL resources committed to training staff, credentialing the trainers
250. Develop cooperative program with institutions – learn while in school
251. Work incentives linked to training
252. Partnership with certifying bodies
253. Better understanding of language problems (assessing abilities, new models of language instruction)
254. Analysis of characteristics of successful worker
255. Re-entering into practice on-the-job re-entrants
256. Train on the shift they work
257. Careful selection process of applicants
258. Development and delivery of continuing education modules
259. Industry and education collaboration on needs
260. Asking workers what they need help with
261. Articulated reciprocal educational arrangements
262. Reality-based training for paraprofessionals – e.g. CNAs

## Washington, DC "Did You Think of This"

263. Externships
264. Career Coaching
265. Mentoring

### *Pipeline: Recruitment and Retention: Dare to Dream*

*Employment and Working Conditions*

266. A national "walk in my shoes" day – asking major political/administrative leaders to follow a C.N.A.
267. Nursing services should be reimbursed by billable hours to insurers
268. National/state advertising of healthcare jobs sponsored on every major sporting event on T.V.

269. Creation of new classification of nurse "licensed geriatric nurse" to career path certified nursing assistants to L.G.N.s in facilities through a combined effort of apprenticeship and community college oversight
270. National "healthcare for healthcare workers" insurance carve out

### *Non-Traditional Workers*

271. Incumbent employees are trained and given time to mentor new non-traditional employees
272. Non-traditional workers matched up with non-traditional (cultural/linguistic) benefits and providers and pay trans. or relocation for matching
273. Incentive to attract male nurses (hiring bonus?)
274. Credit is more available for prior work experience

### *Ensuring the Skills of Entry-Level Workers*

275. Kaplan develops, delivers and sells basic skills/language instruction in healthcare facilities
276. ITA funds are available for training at entry-level
277. National skills standards – tied to virtual …
278. One-Stop/job match system based on O*NET
279. All employees must list jobs with AJB
280. Head to head with Manpower, Inc.

## System Capacity

### *Lack of Alignment between requirements and curriculum*

#### Salt Lake City, UT Solutions

281. Industry leads curriculum development committees – curriculum review committees (corporate funding) Health care academics more accountable. Promote the development of a sector initiative between nursing education and provider/professional associations to identify weakness in curriculum and ways to fill the gaps.
282. Academic faculty required to have constant clinical experience. Job shadowing clinical/academic – so that the curriculum is up to date
283. Provide flexible entry points – multiple entries and exits to fit industry needs better. No need to graduate everyone in April every year.
284. Develop training the way industry would develop training.
285. Better screening of textbooks and lab material publishers
286. Allow additional links to cover allied health training easily so a person can be a nurse and also provide other services off that linkage (i.e. physician assistant, nurse practitioner, lab tech, radiology, etc).
287. Money for faculty development
288. Health care of the future will be high tech – need to incorporate IT into the curriculum.

289. Workforce Investment Boards should facilitate taskforces made up of K-12, community colleges, universities, economic development corp. and industry to bridge the gaps.
290. Critical thinking skills and preparation for life-long learning need to be introduced early in the educational process.
291. Teach thinking and leadership to nurses and others who may be leading.
292. Include internships or cooperative experience into programs.
293. Advisory board terms not to exceed 2 years.
294. Bring licensing agencies into the discussion, so the time lines and curriculum can be refined.
295. Inservices by clinical facilities to colleges as they move to new technologies.
296. State accreditation agencies monitor more closely.
297. Long range goal: Align CNA's under the nursing umbrella where practice is recognized as a basic/entry level for nursing. Thus, CNA training and development is always considered in funding and funding programs.
298. Coordinate recognized competency standards with curriculum mandated clinical component (i.e. MRI Certification Program).
299. Professional days at colleges (Let faculty and students talk with those in the field).
300. Integrate national quality improvement efforts with nursing education to better prepare RN's in continuous quality improvement efforts.
301. Nursing curriculums need to incorporate concepts of working as teams with members of different skill sets.
302. University based programs need to be encouraged to provide courses that can be taken by working nurses and other health workers.
303. Math, science and reading skills need to be emphasized in K-12 so people are prepared to enter health care fields.
304. Provide greater coordination among K-university curriculum development (in math and science).

## Chicago, IL Solutions

305. Healthcare Industry Driven Curriculum
    a. Competencies
    b. Standard Curriculum
    c. Up-to-Date Curriculum
306. Partnership between Industry and accrediting agencies for a realistic alignment
307. Curriculum for new models of care.
308. Develop a regional matrix of aligned programs between training providers (HS, community colleges, PA and up)
309. More state-to-state standardization of requirements. Standardize a nationwide credentialing process and standard of care
310. Mini courses (or CEUs) to meet changes in field
311. Develop educational programs to deliver practitioners to teach new techniques/procedures as they are being developed

312. The future of healthcare requires the development of new models of care and the curriculum that supports it.
313. Regular communication between schools and ‘end user’ as to current and projected needs.
314. HC employer/institution driven curriculum
315. Need better feedback from employers to understand what grads are not able to do
316. Ongoing collaboration between providers and academic institutions to ensure curriculum is changing at same pace as actual practice
317. To combine input from academics and service personnel on curriculum issues.
318. Fund demonstration project to ascertain requirements of the professions in the workplace in order to develop curricula
319. Greater ‘voice’ from healthcare industry in designing and reviewing curricula
320. Include representatives from health care industry in designing/redesigning programs. Better alignment between academia and industry.
321. Engage the department of Education in helping fast track changes in legislation to support national standards
322. Nationally define the competencies (outcomes) for various HC professions. Encourage curriculum around competencies
323. Standardizing curriculum so that instructors can be mobile
324. Fund demonstration projects to determine entry level, mid-level, and advanced practice.
325. Cored curriculum reduces repetition of core courses across HC occupation curriculum ( reduces instructor duplication of effort)
326. Update curriculum to provide ‘core; than can be inter-changed as technology moved field forward
327. Create certification program to critical care training post ASN or BSN
328. Address the current curricula which are already full and overburdened. Can’t just add new technology. Got to get rid of old curriculum or lengthen programs
329. Judicious use of credentials or certificates as alternative to advance degrees.
330. Educational programs cover behavioral and regulatory as well as clinical requirement so of job.
331. Bring business, education and accreditation agencies to table for realistic alignment.

### *Lack of academic and clinical instructors*

### <u>Salt Lake City, UT Solutions</u>

332. Increase faculty salaries so they are competitive to clinical practice salaries.
333. Subsidize (from industry) BSN and MSN students and professionals to continue their education to become instructors
334. Provide paid time off and flexible work schedules for those that decide to advance their education to teach or want to serve as part time instructors (both academic and clinical)
335. Workforce investment act funds for 4 year MS degree programs.
336. Innovative delivery: non traditional modular approach to teach the teachers

337. Utilize experienced CNA’s to teach basic care giving skills such as bed making, front-line costumer service, etc.
338. Provide time off during work week for faculty to work in clinical facilities to update/maintain their skills.
339. Encourage nurse education at earlier stages in the education process (i.e. middle school or elementary school levels).
340. Make job description for like positions more common across facilities so the teaching institutions are addressing all required instructional needs.
341. Articulation agreements between high schools, community colleges and universities to avoid overlaps and delays for students.
342. Link the career ladder to an educational ladder (e.g. CAN, CMA, LPN, RN, MSN) that builds on one another and have credit for each level.
343. Make sure credits earned in lover level classes are transferable to later degrees and out of state universities
344. Require faculty to spend a certain number of hours per year working in the field.
345. Incentives to schools who implement programs like ‘job sharing’ between clinicians and faculty
346. Require teachers to have clinical experience every two years.
347. Salary subsidies are provided from industry sources to encourage professionals to become or remain in faculty positions.
348. Subsidies are provided for BSN and MSN nursing students to increase the pool of faculty for nursing programs.
349. Health care organizations provide nurses to become adjunct faculty for academic programs. Provide release time for nurses while teaching.
350. Signing bonuses of negotiated wages (moving away from traditional contracts, work with local college and nursing unions).
351. H1B visa money for advanced nursing degrees.
352. DOL provides training funds to prepare clinical nurses and other allied health care workers in classroom teaching skills to improve their skills as teachers.
353. Call upon retired RN’s to assist in training and mentoring programs.
354. Subsidies are provided to add clinical instructors for radiology technologists to increase the number of students each hospital training site can take at one time.
355. Mentoring and outreach programs for new faculty.
356. Tap into and develop links to distance learning programs to bring educational sessions (1 instructor) to teach multiple students over many states.
357. Have partners in the community provide scholarships and start-up funding for higher educational programs (e.g. providers, workforce services, universities, foundations).
358. Remotely educate from where instructors are (i.e. online schooling, web based schooling).
359. Request support/assistance/create affiliations with technical and professional society leadership members.
360. Increase faculty pay to the level of MSN floor nurses
361. Competitive salaries to faculty.

362. Increase salaries to make them equal to clinical practice.
363. Provide grant money to instructors to enhance or retool their skill sets
364. Provide supportive families, spouses, cars that don't break down, kids who take care of themselves, and endless monetary resources as well as quick minds and plenty of sleep (and housekeepers).
365. Shorten the time period for articulation from BSN to MSN in order to increase teaching ranks.
366. Change the teaching modality to allow increased numbers of students for clinical rotations.
367. Increase the number of people with advanced degrees in non nursing health professions.
368. Create a "loaned executive" program to local community colleges. This program would be funded by a corporation.
369. Develop instructor training for Master Science in nursing and in doctoral program to train in instruction.
370. Shared faculty among programs (nursing – radiology).
371. Faculty chairs are endowed by industry philanthropic sources
372. Greater funding to schools to reimburse for health care training (federal funds to help state payments for instance).
373. Bring masters level training to the rural areas to train educators that will likely stay in the rural community.

## Chicago, IL Solutions

374. To develop older RNs into instructors – help keep them in healthcare. Reach out to retirees to come back to work as instructors; must make it easy or them to be licensed instructors (e.g., Georgia model)
375. Provide incentives for health care professionals who want to be clinical instructors
376. 'Un-couple' content and increase the use of technology to 'teach' those areas that can be taught that way, i.e., online, computer assisted. Use live interaction for those areas that require it.
377. Better use of technology that can augment face-to-face instructors(e.g. distance learning, simulation programs)
378. Train practitioners as instructors by partnering with industry – top
379. Enhance academic instructors. Compensations so it is competitive with practitioners
380. Distance education
381. Demonstrate cost savings to health systems that participate in clinical education
382. Increase investment in training for target industry sectors (HC) from federal sources such as FIA
383. Develop models promoting non-traditional pathways for someone to become an educator in there field of expertise. (a way so they can keep their current job in educations)
384. Provide funds for instructors from staff of HC institutions (adjunct professors)

385. Attracting more into joint appointment roles. Allowing currently practicing professionals an opportunity to share their knowledge and experience and diminish burn-out.
386. Incentive: share funding for clinical instructors with health system
387. To offer incentives for faculty who sign up for clinical assignments
388. Development compensation programs to encourage clinical staff to become academic and/or clinical instructors
389. Industry partners add to education salaries, e.g., endow charities to attract and retain faculty at industry salary
390. Partner with local entities (chamber of commerce, city office, etc) in a plan to share costs
391. Training/education/apprenticeships/approaches to the conversion from practitioner to faculty
392. Provide training opportunities for heath care professional who want to become educators
393. Provide skill/education development of HC personnel to increase number of staff with instructor credentials
394. Fund academic faculty positions
395. Increase funding at state and federal levels
396. More grants for allied health professionals to obtain advance degrees to teach.
397. Create more opportunities for educators to obtain higher degrees (scholarships stipends, etc.)
398. To provide resources to engage current front-line employees (technologist, nurses, others) to be able to obtain thee education to become faculty
399. Clear practitioner to faculty competencies
400. To offer incentives for training, i.e., scholarships, relocation benefits, tenure opportunity
401. To enhance faculty/teachers salaries to be competitive with the practitioners salaries
402. To increase salaries of clinical instructors and academic faculty
403. Increase salaries of instructors in educations institutions to reduce disparities with HC industry
404. Increase pay for instructors to be more equitable with practicing professional
405. Link increase compensation and instruction, especially for practitioners
406. To reward healthcare site clinicians for instruction and mentorship with students
407. Adjunct faculty salaries increase to recruit/retain quality education
408. Pay differential costs to health OCC instructors
409. Improve the pay to instructors
410. Must provide education and training for clinical instructors. Many 'teach' without having basic understanding of how to teach. They are technicians who teach the students in the hospital and clinics.
411. To provide resources to guide academia (both clinical and academic) thru job security issues ( in light of multiple programs closing since managed care)
412. Train and use practitioners as clinical instructors and as appropriate academic instructors

413. Need educational programs to train clinical instructors on how to teach in the clinical setting
414. Develop mechanism to promote clinical instructors to academic faculty – will need advanced degree based on the entry-level preparation for field
415. Offer incentives for training to become faculty – general
416. Enhance salaries for academic institutions to match practitioners
417. Train and use practitioners at institutions with partnership of industry
418. Non-traditional education pathways to develop instructors (keep and retain employment)
419. Encourage practitioners to become clinical faculty through incentives to the faculty and individual
420. Fund academic positions
421. Fund higher education of faculty
422. Use external $$ to support instructors costs (WIA, state funds)
423. Partnership between education and industry so that educators can stay current with new trends in industry
424. No Poaching
425. To enhance faculty mentorship programs, i.e., experienced faculty specifically assigned to newer faculty or graduate students to encourage academic participation.
426. Regionalize programs: strategic determination of location of HC courses in region (e.g. Radiological Technologist program in northern MN) and reduce duplication of efforts. Instructors
427. Provide more instruction outside of traditional times and methods and seek to recruit instructors who find these times more compatible with their schedules
428. Engage in strategies that result in legislative solutions. Plug strategies for funding and increasing focus on critical skill shortages through reauthorization of Higher Ed Act; directed use of Perkins state/local funding streams.
429. Promote articulation among AS to RS to MS and on (not only for employees but will smooth transfer for educators)
430. Need to create ability to educate/train faculty members in non-traditional settings or areas without access to education institutions
431. Resurrect diploma program
432. Use industry professionals as guest speakers to classroom teaching to let students know of current trends
433. Address the stigma of education
434. Tied to generation, differences of student pool
435. Lack of funding
436. Decrease in job security if program closes
437. Why would I want to leave my stable job for this hassle?
438. Retention of student in coursework
439. More mileage out of each instructor
440. Mentors for new hires to increase retention
441. Articulate programs between training providers and share instructors

442. Identify potential instructors from providers and have them certified or placed in a position to be certified
443. Partner with local health providers in developing pool of instructors
444. Involve education and industry partners for 'loans' or joint appointments
445. More communication between providers and academic institutions about how partnerships and resource sharing could alleviate problems
446. More support for the clinical/site side of the practicum experience. Clinical site may be a great place to identify potential faculty.
447. Sharing agreements of scarce faculty – alternative acceptance of coursework
448. Align degrees needed to teach with experience infield. Need accrediting organizations at table.
449. Address the fact that many professions have engaged in credential creep (mandating that educators have one level higher in education).
450. Educate and direct students on opportunities for academic and clinical incentives
451. To utilize more teaching assistant programs (grad students) in healthcare to assist instructors in the classroom and in the field.
452. Develop programmatic pipeline to grow local instructors. K-12 and higher
453. Need to develop faculty skills in using technology, e.g. Web-based learning, to deliver education to students in distant sites.
454. Development of 'faculty supports' to make a double role more viable.
455. Use of mentors and online mentoring systems to take some load off instructors.
456. Offer programs to educate the current workforce staff about the potential of becoming an educator with continually support once someone takes this program thru career centers.
457. To increase high school student counseling re: nursing instructor careers including onsite visits to meet college faculty
458. Promote/create a network promoting these clinical and academic positions. Most technologists are not aware of such opportunities or when they do find such they don't know where to find resources.
459. To offer flexible, short term teaching or clinical assignments for older faculty or those with children who require a less structured work routine.
460. Intense recruitment campaign with incentive thru staffing agencies with access to potential pool of instructor candidates
461. Promote education and academia as a viable career pathway
462. Marketing to change of career folks

### *Lack of facilities and resources*

## Salt Lake City, UT Solutions

463. Use of available facilities (i.e. k-12 buildings, hospitals, long term care, colleges, one-stop centers, etc) during non traditional school hours.
    a. Distance education and learning
    b. Internet (online courses)
    c. Telehealth
    d. Mobile labs

    e. Take course to students

464. Expand training (community colleges) programs – funding needed
465. Larger community college districts with multiple sites are combining facilities to build one large facility to decrease costs.
466. Use K-12 schools as extensions of adult teaching facilities
467. Dollars to fund/incentivize schools to offer non traditional approaches (night programs, etc).
468. Cooperate across the educational boundaries for facilities. Make multi-user lab facilities that different schools can use. Use facilities in after hour, nontraditional ways.
469. Hospitals provide clinical teaching laboratories and classroom space for nursing programs.
470. Shared resources (e.g. hospital labs and college classrooms not being used on nights and weekends).
471. Clinical sites offering on-site training during alternative hours/shifts.
472. Develop programs at night and weekends for incumbent workers utilizing high school labs, hospitals as clinical labs, under utilized space and distance learning in academic institutions.
473. Partner with all kinds of health care industry
    a. Manufacturers of equipment
    b. Community health agencies
    c. Alumni
    d. Etc.
474. Establish common teaching facilities among competing hospitals for high shortage jobs (i.e. patient care tech) that are flexible to identified needs in the community.
475. Have more hospitals become training hospitals.
476. Subsidize transportation and child care so that people can get to classes and have child care during class hours.
477. Provide dollars (matching or full) for capital equipment.
478. Mobile labs – travel to rural communities (sponsored by colleges and industry).
479. Develop self supporting (and not state funded) programs.
480. Provide funding to expand community college programs.
481. Partnering with cities, community colleges, industry and workforce investment boards to build training facilities in rural areas.
482. Use technology to increase productivity and quality of instruction
483. Involve private sector business (facilities) to cosponsor programs in exchange for employment opportunities – preceptorship/internship/apprenticeship

## Chicago, IL Solutions

484. Partnerships among providers, training and education and public officials to use facilities
485. Clearing house of resources
486. Space
487. Funding

488. Equipment
489. Donate/Lease Equipment to stay current
490. Provide resources (FTE, $) for clinical sites to upgrade teaching strategies (film teaching files and cases, manual exams with photo copy examples vs. online with actual films)
491. Partner with industry to provide technology to educators (software, product models, technology, display hardware and software as well as informational knowledge of new technology
492. Address the rapid changes in medicine and additions in technology; molecular imaging, gene TX, new peptides, monoclonal antibodies, fusion imaging.
493. Distance learning
494. Use of online and simulated models when appropriate (not to replace site-based training, but to stretch that resource)
495. Effective use of e-learning
496. Use of technology to produce virtual hospitals – enhance experiential learning if no site available
497. Take advantage of distance education and put the students where clinical sites are located – rural, e.g.
498. Use of distance education when appropriate (no clinical)
499. To offer tax incentive to corporation that sponsor and contribute to academic programs or student support.
500. Review and develop a plan to address gap between didactic completion of some allied health programs and long wait times to get into clinical programs. RT – up to 2-3 year wait with 2 year AS programs at local vocational technology programs
501. Clearing house
502. Better communication between providers and academic institutions about availability of space, equipment, computer labs, etc.
503. Provide centralized clearing house for grants (HRSA and other Fed, Foundation and industry) lists.
504. Community inventories of facilities and resources with rewards for sharing and collaboration
505. Develop a comprehensive 'portal' of resources ($, for healthcare education and training (not by agency, grantor, etc. one place to identify various resources)
506. Regional collaboration for use of scarce facilities
507. Regionalism
508. Partner with hospitals and other clinical sites to provide supplemental funding of educational programs
509. Provide incentives to college universities to maintain develop education programs
510. Develop industry/government partnerships to help share cost of programs
511. Partner with industry for providing clinical experiences from industry folks (to teach pharmacology and other specialties
512. Eliminate duplicate pf curriculum development. Should develop across educational institutions (Wisconsin, 'Regionalism')

513. Industry making their facility available to education for students
514. Partner with municipalities, schools and providers on developing facilities (use of bonds, medical districts, sharing space)
515. Provide incentives for health care industry to provide clinical sites
516. Look to non-traditional partners for space (churches, restaurants, hotels)
517. Partnership between education and industry to use facilities
518. Use healthcare facilities for instruction (particularly off-peak
519. Participation with healthcare facilities and community colleges for in-site classes
520. Lease vs. buying equipment in order to stay current with industry updates
521. Reach out to suppliers (equipment, pharmaceuticals) for donated resources
522. Partnership between education, industry and manufacturers donating used equipment to education.
523. Donate/loaned state of the art equipment form equipment suppliers/manufacturers
524. Encourage industry to partner by providing resources – equipment, supplies, etc.
525. Loans of cutting edge technology experts
526. Government grants for facilities, equipment, planning for high growth field
527. Provide education on grant writing to the program directors
528. To intensify philanthropy efforts focused on healthcare scholarships or student placement – college age foundations
529. Increase funding and see money to start up new programs and increase clinical affiliate sites
530. Student retention strategies
531. Budget funds for equipment and supplies for labs and maintenance service contracts
532. Develop incentives for schools who offer health career programs
533. Provide incentives for rural health facilities to participate in supporting clinical education
534. Develop ways for schools to share resources (facility, equipment, labs, etc.)

### *Capacity of Workforce Organizations*

## Washington, DC Solutions

(Eliminated in Salt Lake City, UT and Chicago, IL)

535. Partner with those that know how to design curriculum quickly and use available community resources, ed/training providers with hospitals; use hospitals as teaching facilities; on-site training and education for employees; develop proprietary nursing programs in hospitals or long-term care facilities with training providers or community colleges.
536. Increase University programs to get practitioners to study teaching. (adult learning concepts); Cultural competency training and teaching education (adult learning theory) for clinical staff so they can go from providing care to teaching how to provide care.
537. Faculty loan repayments – allow teachers or clinical staff to learn how to teach and pay their loans, and pay their loans if they teach.

538. Prioritize training to protect training classes from state budget cuts in areas of high demand, i.e. community college nursing programs.
539. Stretch faculty further using retired to teach online courses or serve as part-time faculty.
540. Integrate public school financing with workforce planning so schools are teaching the needed skills/knowledge for tomorrow.
541. Incentives for health care providers to release credentialed staff to teach health care development programs.
542. Demonstration projects for improving system capacity that can be replicated, exempt from WIA outcomes.
543. Articulation agreements between universities, community colleges, workforce system, employers to update curriculum and employ graduates.
544. Faculty from other healthcare disciplines to teach basic healthcare skills – expand faculty and share.
545. Focus on specialties – training providers train in own specialties and have a continuum partnership, i.e. 1 training provider = math, English, ESL; 1 training provider = employability skills; 1 training provider = healthcare skills; 1 training provider = credentialed programs.
546. Experimental pilot for paying preceptors to teach and provide clinical experience for students.
547. Interim strategy for more PhD programs, but in the meantime to partner with other potential faculty and training people; requirements for teaching in BSN programs.
548. Rejected students – placement strategy so they are not discouraged and still go into healthcare.
549. Decrease recidivism in nursing with mentoring programs; offer modular curriculum so you could not wait 1 year before re-entry..
550. More money for providers that serve as educators..
551. Expand healthcare training advisory committees to represent all sectors and stakeholders.
552. Money for core knowledge, math, science, ESL, literacy..
553. Modular curriculum that can be distributed and customized; just-in-time training; HS-AS-MSN.
554. Faculty shortage in community colleges: releasing nurses from clinical work to go in as faculty or clinical faculty.
555. LTC, community college and technical college image is lower than universities – attract faculty by bettering the image and increase income (salary and incentives).

### *Midterm Projections*

## Washington, DC Solutions

(Eliminated in Salt Lake City, UT and Chicago, IL)

556. Database of different occupations with like descriptions: real-time, numbers, wages (JHU/ABELL); Funding.
557. Agreed assumptions to base projections on: demographics, qualitative indicators..

558. Input by stakeholders, HHS, etc.; Communication with educators for budget/policy decisions.
559. Increased funding of LEHC database; social security info, etc.; community profile of available workforce with what occupations/skills living in proximity to available jobs, education/training.
560. Expand ES202 data; real-time surveys of employers; basis for selecting survey sample: hiring? contracting? in what occupations? wages? trends? vacancies? turnover?.
561. State-wide analysis of employment setting.
562. Clearinghouse of new procedures or changing practices/procedures (non-invasive surgery, radiology special procedures); Keep education/training current with technological advancement.

### *Addressing Occupational Gaps and Geographic/Market Distribution*

## Washington, DC Solutions

(Eliminated in Salt Lake City, UT and Chicago, IL)

563. Expand career lattices.
564. Partnership building: getting basic info on resources, jobs, etc.
565. Recruitment and retention strategies to assist and market distribution issues: Tuition reimbursement.
566. Distance education.
567. Improve understanding of different occupations by workforce development system: Identify workforce needs; tighter partnerships.
568. Certificate programs: Tiered certifications with articulation between occupations.
569. Quality of work life: EE involvement; organizational decision making; team problem solving; cultural transformation; implement recommendations of American Hospital Assn "In Our Hands" report; Assns develop uniform exit interview; certificate of initial mastering.
570. Increase diversity of the pipeline.
571. Supervisor training: gather and disseminate curriculum/share.
572. Reward supervisors who train their staffs.
573. Bringing education to the worksite.
574. Loan forgiveness for employees or new hires in return for number of years worked in an institution.
575. Career mobility: Clinical preceptorships; distance learning; leverage resources.
576. Education loan repayment
577. Who to invest in: keeping trained people; help with childcare for people who stay in community.
578. Understanding breadth of healthcare core curriculum: math, English, science and career exploration.
579. Case management: more training for interdisciplinary case management.
580. Rural issues: distance learning; better recruiting of young people; more support of young people; family support; transportation and in-home computer support.

581. Increase capacity for in-home care: appropriately trained, paid; incorporate tech-trained workers.
582. Knowledge and image of long-term care: Info/educational campaign regarding long-term care.
583. Targeted partnerships for rural areas; health parks with multiple companies: long-term/short-term, case management, etc., everyone close by with multiple career opportunities.
584. Career counseling; marketing and advertising; multiple approaches/flexibility of staffing.
585. Military transitioning: get licensing before they leave.
586. Shortage of case management professionals: Recruit clinicians who have left the field; look off-shore to other English-speaking countries.
587. Rural workers moving to larger areas: Form public-private partnerships.
588. Long-term care workers moving to hospitals: Look at retention in each occupation and see a move from one occupation to another as a "win" if retention exceeds the average; on-site training; improve conditions; incentives.
589. Shortages on regional level: Funding for partnerships; assess, partner, implement.
590. Apprenticeship training: work while you learn; distance learning with rural recruiting.
591. Working with declining industries: better partnerships – local/regional career counseling.
592. Making perceived poor jobs into good jobs: Look to call center model.
593. Strengthen National Health Service Corps, or similar.

### *System Capacity -- Did you think of this?*

594. Innovation in Flexible work schedules and Training Schedules
595. Dr. Hours – Redesign of MD's
596. Adequate and Competent Workforce
597. Core courses for Allied Heath
598. Torte Reform
599. National Standards for Training so Credentials Transfer Across Boarders
600. Ban of Acronyms
601. Adequate Specialties of MD
602. Standardized curriculum teaching MDs now to treat patients
603. Improved Rural HC – Telemedicine
604. Zero Errors
605. Diversify Workforce
    a. Providers
    b. Educators
    c. Partner w/WIB
606. Image and Perception
607. Seamless Career Pathways
608. Respect and Team Building at All Levels – Cultural
609. Cultural Change

610. All Partners Need to Play
611. Embracing Technology
612. Elementary Students Know Numerous HC Careers

### *System Capacity -- Dare to Dream*

613. National skill standards for all occupations.
614. Long-term care and geriatrics will be held in same esteem as acute care(i.e. funding, image)
615. Career ladders for every health care discipline, with needed training, employment data.
616. State-by-state annual top 50 best health care places to work (benchmarking).
617. Free child care, health care benefits for those who are learning.
618. All Elementary/JHS/HS have a "healthcare careers program.
619. Facilitate the transfer skills/credentials of foreign workers/military for their U.S. licenses.
620. Group to project, anticipate systemic workforce needs: employers, community colleges, universities, workforce system partners.
621. Continuous lifelong learning for public policy decisions will be based by part, on LL (?).
622. Full funding for ESL.
623. Continuum of lifelong learning: flexible to move throughout industry and resources to support.
624. Health Education Council in regions/counties (regional centers).
625. Living stipends.
626. Core national curriculum: Cuts across disciplines; customizable/adaptable to local needs; recognized knowledge; transfer of credits.
627. Other/broader cross-training for allied health occupations.
628. Licensing requirements reevaluated.
629. National rather than state licensing.
630. Full scholarships based on need for all/most occupations.
631. Accurate database on state/regional HR planning.
632. Full release time paid for employees to go to training that employers do not pay for.
633. Just in Time training as the needs occur
634. Virtual labs in health care settings
635. 10:1 Turnover
636. Career Counselors (with industry)
637. Academic Programs at every level for working people (alternative schedules – universities).
638. Employers interested in quality of education vs. numbers
639. Money
640. Good affordable child care
641. Use school child care programs
642. School readiness programs (industry)
643. Elderly parent care

644. More flexibility of WIA funds to increase capacity (example: higher paid ed people to be reskilled).
645. Transportation subsidies
646. Compensation and benefit structures for the retired
647. Determine ideal skill sets for nurses what other skills can be delegated (convert voice to print)
648. Model in 5 years and determine skill sets
649. Future planning and assessments
650. New vision for future of health care work force ("the look" of the criteria and aptitudes)
651. Health care system based on quality not reimbursement
652. Paperless technology (M.D. adopt). ….for physician orders, charting, etc.
653. Academically prepared faculty
654. Reevaluate the environment
655. Retrain incumbent workers for tech.
656. Subsidies so people can go to school and work fewer hours.
657. Loan and grant program – simplified
658. Loan forgiveness programs – allied health
659. Take on drug companies and allow importation of drugs.
660. Utopia would consist of accurate role delineation studies for all professions. These studies would delineate the knowledge components; competencies and attitudes necessary for success in each profession/occupation. All Educational and credentialing requirements would be designed to ensure attainment of these competencies, knowledge and attitudes.
661. Enact a National Licensing System base on professional certification and educational requirement sot that providers are nationally "approved" and states add specific regulations so that providers could look nationwide where needs are seen.
662. National funding annually guaranteed to Allied Health Promotion Education.
663. The culture of AC system – demonstrate to workers at all levels that they are valuable.
    a. All organization investing in developing HC workers with community.
    b. Investing in community education system based on ability/interest: economic barriers non-existent.
664. Education system that includes promotion/graduation/certification based on competency.
665. Healthcare accessibility for all.
666. Create a competency and measured proficiency system. Doesn't matter where learning occurred (other state, other country, self-taught). Live in global economy and must accept global talent. Americans are biased and our educational system isn't superior to many countries.
667. Competency-based systems coupled with asynchronous (i.e. a program that can be taken at any time as contrasted with synchronous programs that require program be taken at the same time) or tutored learning (self-taught). In this competency-based system there would be no penalty for attempting to acquire

a different skill multiple times. Records would compound as skill level increased.

668. College would have a feeder system from high schools that have early health care exploration and basic healthcare classes and scholarship/tuition assistance for those students.
669. The education systems K-12 should have a national set of value and standards (competence) that support entry into all work settings.
670. Funding for healthcare (either federal support or reimbursement) recognizes the importance of continued development of the healthcare workforce and the subsequent effect on quality of care. Then contract for payment that includes not just cost of care but investment in workforce.
671. All health professions would start out with the same core courses all taken together – socialization in career tracks would come only at the end – e.g., doctors, nurses therapists, technicians, everyone – would learn about how to communicate with patients together. Benefits: cost effective, promotes interdisciplinary respect and understanding.
672. That there would be a system to bring together the values, needs and vision of the core constituents in health care:
    a. Consumers
    b. Employers
    c. Educators
    d. Employers
673. Require mandatory civil service post high school for all in health care, education or military. Service would expose young adults to careers and role models in caring professions before they enter post secondary school education.
674. Provide federal incentive awards to colleges and universities who are willing to bring the classroom to the student.

## Skills Development

### *Incumbent Worker Training*

#### Salt Lake City, UT Solutions

675. In partnership with local education, identify skills needed and develop online programs which can be offered on-site.
676. Offer basic skills and common general education courses at the worksite on several shifts (ESL, computer keyboarding, medical terminology, English and math). Combine with information blitz on job opportunities/career information and career counseling to help workers decide what they are interested in and know how to get there. Partner with colleges (possible distance learning).
677. Community colleges can offer courses on worksite for units (college credit)
678. Employer provides opportunities to take classes to increase skills in a way that can be done while keeping up with current workload.

679. Create a learning culture that provides time, access and compensation for learning
680. Provide incentives to continue education (after a BSN earns the same as a 2 year RN). Also, need to incentivize nurses to get advanced degrees to have availability to teach and relieve faculty shortage.
681. Explore attractive funding or reimbursement options, grants, tuition, reimbursement, higher salaries, cooperation with industry, loan forgiveness, etc.
682. Expose middle school and high school students to health care professions that aren't as visible.
683. Provide incentives for current employees to increase skills and remain in health care industry
684. Incentives need to be offered to encourage current employees to receive additional training for specialized areas
685. Provide multiple exit points and career support for workers who aspire but are unsuccessful to save their employment with in the health care field.
686. Enhance the educational programs that teach LVN to RN.
687. Health care needs to provide a welcoming and supportive of staff system to retain and promote from within (grow our own).
688. Provide inservice training for current low level skill workers. Workshops should include a step by step process of carious options for gaining/increasing new skills needed for the next level.
689. Provide "job fair" for current employees
690. Education requirements that can be stepping stones to other opportunities.
691. Provide access to other positions within organization (e.g. career ladder). Learning is presented as a benefit to employment
692. Support nurse reentry in your community to capture those not practicing in the field.
693. Provide a model and available classes/training for workers to easily access that identifies needed steps to come back into the field after having left to raise children, etc.
694. Create a position within health care systems and hospitals that provides career growth/development opportunities and knowledge within the organization and crossing including all job areas/professions.
695. Communicate training opportunities: flyers with timecards, websites, brownbag lunches, staff meetings, -- *over communicate*.
696. Define potential career tracks for current workers and publicize and provide opportunities on-site for educational training
697. Work with agencies, facilities to offer opportunities and solutions to address curriculum/certification/ registry barriers to incumbent workers across states, certification bodies/boards, schools such as challenge exams and non-traditional equivalencies.
698. Job shadowing within organization
699. Encourage exploration of other fields within healthcare by providing internship or shadow opportunities

700. Establish precise articulation/certification among seemingly unrelated areas such as military, apprenticeship, private sector and public sector to define career lattice and curricular pathways to career advancement.
701. Create educational and training partnerships that impact incumbent worker
702. Develop partnerships with other regional health care provider in collaboration with educational institutions develop programs to meet needs of local in house workers – more cost effective with more partners.
703. Forge multi-employer academic – labor partnerships to offer specialized/tailored programs to meet particular training needs. Involve employers in refining prioritizing competencies to train to.
704. Flexible scheduling of courses with training, accommodation of work schedules, use of alternative delivery methods.
705. As possible, help workers attend training on aid time or with salary or benefits supplement.
706. Provide competency based training for the skilled work and on-the-job training for higher education credit.
707. Provide funding options for entry level worker preparation.
708. "Case Manage" employees while they go through school – link them to resources (child care, financial aid, how to work with managers to adjust work schedule).
709. Provide child care for non-traditional ours, allowing employees to go to school or training
710. Develop a systematic plan of staff development that addresses current needs/changes of industry
711. Create work-based study groups for those wanting to advance their training.
712. Take the training to the student – possibly during paid work hours.
713. Increase flexibility of when courses are offered (evening/weekend/distance). Tailor to the adult worker.
714. Use part time health care workers to help teach on the off shifts.

## Chicago, IL Solutions

715. Online distance learning systems for common courses (medical terminology) and work to get these transferred to community colleges
716. Portability and consistency of training in core skills
717. Identity management and HR skills and competencies and train middle management
718. Org. skills, financial management skills
719. Create review boards to recognize other states skills/standards licensure
720. Programs for foreign-trained professional to get through exams, etc.
721. Mentorships
722. More higher-degree/level positions in Healthcare
723. Flexibility in certifications
724. Federal tax credits for on-clock training
725. Compile career ladders best practices clearinghouse. (BRG)
726. Create individual employee development plans
727. Provide training that maintains skills and job satisfaction

728. Work with CBO to teach technical language skills
729. Bring school to the students/workers
730. Make being nursing education/teaching more attractive
    a. Portability
    b. State of the state
    c. Within the profession
    d. Latticing across jobs
731. Core skill sets to move within healthcare
732. Related career development areas
    a. Management
    b. Financial management
    c. Leadership
    d. HR systems
    e. Mentorship
    f. Apprenticeship
    g. Shadowing
733. Take advantage of incumbent worker training dollars available through WIA, through states. Make the case for need and job opportunities. Stress new skills needed.
734. Provide tax credits employers who provide skill development for this group, such as they receive for college education
735. Provide federal tax credits to employers whoa re willing to allow release time to workers to attend training. Tax credits for each hour of release time paid.
736. Nurture existing workers – formal skills review of workers with regularly scheduled repetitive training which focuses on maintenance of necessary skills and not just training regarding new technology.
737. Object – increase job satisfaction - decrease adverse incidents
738. Partnerships with school and cultural groups to teach workers clinical foreign language terms to increase communication skills with changing demographics of patient and provider population
739. Can development of skills for success for all healthcare workers. This should be beyond orientation-more like continued development. It would be nice to refine a notion that learning is life long in the workforce include:
    a. organization skills
    b. financial management
    c. healthcare issues
    d. personal finance
740. Identify and credential management skills/competencies for supervisors/managers – AHA's commission report (LTC managers are certified now)
741. Team management training – not just one group – works toward culture change. Core competencies:
    a. financial
    b. communication
    c. management
    d. modeling

742. Can separate out care skills and create certificates – so that any HP could build upon acquired skill sets.
743. Structure on the job training based out of brooder skill sets. For instance; jobs requiring medical terminology use the same preparation. That way the employee may meet a requirement for a future job.
744. Develop a national distance learning system to deliver courses needed by large groups, e.g. ABE, Med Term, Physiology and Anatomy – same as entry-level, make it easy to implement.
745. Spearhead effort to make classes like Med Terminology transferable to CC's/for credit (now requires state-by-state approval).
746. Provide part-time for skills upgrade. Use studies showing impact on bottom line. Incorporate into performance. Supervisors as career coach
747. Encourage development of career moves through review of goal setting at 6 month – 1 year review.
748. Develop clearly defined career ladder with continuing education credits that allow incumbent workers the ability to earn advanced certification without quitting their job and going back to school full or part-time – be more flexible in the timeline to complete training.
749. Identify interest in field – allow shadows on work time in individual assessment, career counseling.
750. Include mentor responsibilities in job descriptions and evaluations. Rate performance by mentor and person mentored.
751. Building career ladders for entry-level. Compile 'best practices' clearing house and share/promote e.g., how to set up job sharing, job shadowing, mentoring. Building an RIO for I.W. Training investment.
752. Portability of educational credits across health professions. Encourage recognition of credits for basic course work across professions
753. Provide scholarship reimbursement money to hospitals or medical facilities who are will to hire entry-level workers and agree to hire them at other levels when complete training.
754. Develop a career path that lead back to education and values HC faculty.
    a. Make it attractive.
    b. Portability of credentials
755. Develop career paths and educational programs that lead to other health care opportunities
756. Look for ways of locating, attracting and encouraging immigrants who have health skills/living in US and not currently working in health care to be able to take jobs in healthcare industry
757. Develop educational programs within health care. Skilled provider who wants to advance must go to education or management – What about advanced degrees in health care that teach these skills?
758. Identify immigrant who are credentialed in their native country and under employed in the US. – Develop programs to meet their specific needs and fast track them. Must be able to define skill requirements and develop exams or proficiency test to demonstrate skills so foreign workers can be accepted and certified into our health care professions.

759. Lots of trained HC non-US citizen workers live here. Let's work with community organizations, AC organizations, and immigration organizations to develop core trainings to fast these folks through licensing/certification – provide child care.

760. Nationalize professions laws – experience nurses from CA (20+ years) could not get license in Illinois because her clinical practice had used (non-faculty) preceptors rather than facility supervision - OR – create review boards that would allow potential candidates to perception for licensing within another state as long as their skills were deemed to be effective and safe.

761. Portability of credentials
    a. Encourage simple reciprocity for licensing HC workers who move in the US.
    b. Encourage uniformity of licensing requirements for health profession. Use professional societies for guidelines.

762. Reform state legislation and regulations to unify state differences - consistency across states based on a national standard

### *Entry Level Worker Preparation*

## Salt Lake City, UT Solutions

763. Develop basic health care management courses/for all certification programs. Employees interested in pursuing supervisory and management positions in partnership with local academic institutions and health care administrations

764. Incorporate general courses on health care delivery systems, reimbursement, medical care, etc., to which all health care professions regardless of discipline attend together, to break down cultural differences in health care professions.

765. Provide strong articulation between 2 and 4 year academic institutions to create more effective career ladders.

766. Develop partnerships between local education institutions of higher education (2 and 4 year) and health care institutions to develop customized and educational solutions for that local, regional entry-level worker skill development.

767. Create coalitions between industry and education to share the burden of training and remediation if needed.

768. Enhance 2 + 2 programs high schools and community colleges – (begin teaching needed basic skills in high schools) – health academies at the high school.

769. Outside of the box solutions for assistance with planning career changes with concern for familial responsibilities.

770. Expose elementary school students to applied science through partnerships with hospitals and health care providers utilizing field trips, speaker bureau, demonstrations, and science career days. Include applied basic science in curricula.

771. Develop partnerships between local health care institutions and secondary schools to mentor high school students and encourage them to enter the health care workforce.

772. Increase exposure to health care workforce environments in jr. high, high school through school and private sector partnerships.
773. Create a health care “Big Brother/big Sister” program at the jr. high /high school level with focus on profession/worker relationship – not as much emphasis on personal development.
774. Introduce/utilize ESL training to expose potential students to health care.
    a. Include basic math, skills in English needed to continue on with education.
775. Provide “ESL” training to ethic populations/low level entry.
776. Access to programs that meet/fill deficiencies (help to prepare them to meet minimum entry requirements)
    a. E.g. GED preparation
777. Language skills
778. ESL training for students in every school or training facility.
779. Promote hospitals and other health care facilities for community service programs for local high school students.
780. Promote hospital/back room visits for aspiring health care workers and others who work outside of traditional health care fields i.e. environmental techs, maintenance techs, medical equipment techs, ambulance drivers, etc.
781. Offer job-shadow opportunities to incumbent workers and high school students, displaced workers, community, to help them learn about health care and the many opportunities available.
782. Evaluate and quantify academic skills necessary for success in these fields to be matched to effective/proven tools for recommendation of these skills.
783. Tutoring services for students needing help in basic reading/math and health courses.
784. Create training models that focus on skills training rather than purely academic. More competency based training to focus on individual students needs.
785. Change academic curricula to eliminate unnecessary courses that are not relevant to the skills and knowledge needed for a specific profession/career. Focus coursework on direct applications that are needed with less general requirements.
786. Evaluate non-academic personality traits for effective participants in health care fields then compare these traits to aspiring students/workers in these fields.
787. Provide short-term specific courses at the college level where students can explore career options in health – earn a college unit and proceed with additional courses (increase their awareness and interest in health).
788. Offer vocational training in high school: CNA, pharmacy clerk. Teach medical terminology in context of health car. Give health care workers opportunity to teach.
789. Presence of support systems to enhance self-esteem/confidence in ability to acquire and practice skills.
790. Educate public about career opportunities through ladders, shadowing, and mentoring programs with local health care providers, medical schools, academic institutions and community leadership development programs.

791. "One Stop" shopping for health care careers.
792. Acknowledge different learning styles of workers – provide options if at all possible (e.g. print, self study, web etc.).
793. Create "mentor" program for those entering professions; for those in lower level, provide work/school programs for exposure to health care environment.
794. Go beyond skill development and provide orientation to culture and assure worker of ability to impact that culture.
795. Identify interested high school students and provide paid internships and scholarships for additional education
796. Develop internship programs at local health care institutions for high school students. Could be summer paid internships with meaningful work – not just filling.
797. Curriculum and cross curriculum issues are often barriers for entry level workers.

## Chicago, IL Solutions

**Entry Level Worker Preparation – definition (from Chicago)**

- Employability
- Desire to Work
- Personal Skills
- Soft Skills
- Patience (to advance)
- Career Interest (early on)
- Gateway Prep (ESL refresher)
    - English occupational
    - Basic Literacy
- Criminal Screens/Prior Backgrounds

798. Work with temp agencies to broker training, etc.
799. Identify needs and implement skill remediation programs (on work time)
800. Structured orientation program/ongoing process
801. Early career exposure/school to career/exploration/job shadowing (should begin in middle school) Also include learning about skill requirements
802. Hospital – adopt a school with a healthcare track—Industry – sponsorship, scholarships
803. Broad track for healthcare careers:
    a. Soft skills
    b. Core skills/allied health
    c. Science and math
804. Market allied health careers for K-12
805. Online learning
    a. Employer provides computers
    b. Computer literacy training
806. General employability/work readiness skills for HS level
807. Learn to earn – short successful HS work experience

808. Train employers on how to train workers (learning techniques/styles)
809. Expose to male career professionals (military)
810. Promote use of English skills in social context (for non-native speakers)
    a. Rewards/incentives
    b. Motivations
811. Engage workforce intermediaries (immigration, CBOs)
812. Effective communication skills
813. Work with foreign trained nurses to move them up here
814. Create supportive work environment and culture
    a. Flexible work schedules
    b. Childcare
    c. Beyond wages
815. Community service piece for pre-college (MS/HS) that serves as introduction to industry
816. Use healthcare examples into all general curriculums in K-12
817. Improve diversity in workforce (older workers, A-A, Hispanic) thru outreach recruitment
818. Programs for employers to gauge risk of high-risk employers (parking lot)
819. 21st century basic skills credential, for employability (HS graduate level)
820. National distance learning system for basic literacy (at 1-stops, libraries, etc.)
821. Curriculum for new immigrations in their native language re, American work culture and expectations.
822. Work readiness - closet tattoo removal, dental, etc.
823. Provide seminars to employers on how to train entry level workers on the job. Explain the different type of learning styles. Help employers to understand the essential steps in their work process so they remember to teach it. Check for understanding. Take your time and do it right. Could be online training – Internet based.
824. The instant gratification generation presents a challenge for training (on the job) in entry level positions. One possibility is to vary training techniques. Not relying on only one method.
825. Train and encourage health care careers in the poor/unemployed. Teach basic skills through community programs to fill workforce shortages from the pool of unemployed or underemployed – develop a basic healthcare course at community level and recruit to underserved areas.
826. Work with temp agencies to broker training and screening resources. Research available tax credit incentives for win-win situation.
827. Supportive work environment
828. Respect (internal and external)
    a. Dollars/Budget
    b. Childcare
    c. Schedule flexibility
829. Volunteerism – work with getting youth/young adults into HC setting.
    a. Exposure to work environment
    b. Community service piece
    c. May be able to be a starter for skills development, career choice

d. Utilize internships (paid or unpaid) to introduce new workers to the field. Street core values/competencies needed in designing fob and evaluation instruments.

830. Teach patient interaction thru high school programs.

831. Teach healthcare skills in elementary and high school – simple skills such as taking a temperature/feeling a pulse, using a stethoscope, studying and x-ray machine, etc., can be taught at an early age and would develop interest in a future health care worker

832. To increase English language skills – create social clubs in neighborhoods/schools/churches where English is required to be spoken. Have some sort of incentive for participation
    a. Games requiring language skills attractive prizes
    b. Outings to first run movies

833. Emphasizing to non-English speaking children the importance of English language in the workplace. Practice English with other non-English speaking children outside the classroom. Build in rewards or incentives for those who practice English outside the classroom. Language skills are essential in the workplace.

834. Work with local immigration offices to reach out to hospitals/HS settings. Communities provide programs in HC training language proficiency, cultural pieces, etc. (timeliness, dress, accountability). Not just language but communicates effectively.

835. Diversity as a business imperative. Identify role models in the Hispanic and African American community. Older workers – retirees from public sector.

836. Assist people with personal appearance
    a. Set up 'loan closets' where people can get business cloths for interviews
    b. Tattoo removal programs
    c. Appearance/.grooming workshops (partner with cosmetology programs)
    d. Dental work

837. Develop a 21st century 'basic skills' credential. GED has negative connotation, but something like this, that has a positive, motivational 'brand'.

838. Poll employers to see what skills are missing across professions and use the data in training programs. Teach a basic set of skills to all healthcare professions. If each profession was taught basic communication/ethics issues/professionalism/ basic management in a uniform consistent way – skills would be expected at entry.

839. Generic preparation tract for students interested in healthcare careers that includes science math and communicators (written and verbal) on the high school level. I suggest to keep this broad the average high school student can't definitively c omit to an exact job/career.

840. Emphasize employability skills at the middle/high school levels. Accountability/employability skills such as attendance, desire to succeed, and English/grammar skills.

841. Develop curriculum in K-12 that teaches workplace skills. It should be a required class each year building on previous years learning. Curriculum should include: following and taking directions, following rules, working in

teams, being on time, understanding how what you do affects others, being responsible, etc. Bring in employers to high school classes to explain their expectations and why they hire people, why thy fire and who gets promoted.

842. To increase desire to work – work with high schools to introduce students to short, successful work experiences for compensation. Ideal of these are health related.
843. To attract more men, provide exposure to male role models – military techs, pharmacy technicians, nurses, radiologists, etc. Early on decisions are made about careers. Basic job skills.
844. Provide education to employers on the to provide on the job training
845. Target youth. Non-traditional groups and other workers who would have an interest in HC by providing orientation programs that are put together to generate interest.
846. Utilize distance learning tools by using a wide variety of venues including the workforce system. Educational system and business to deliver ESL; basis computer skills, math, reading, etc.
847. Utilize distance learning and provide mentorship/shadowing experiences at local community.
848. National distance learning system that offers regular courses in classes commonly needed by very large groups of people, e.g., reading, math, basic computer, ESL. Classes could be offered in various venues, e.g. employers sites and one stops. They would be packaged for easy implementation in an effort tot maximize and accelerate access.
849. Employers to provide computers to assist workers to advance skills – provide computer training.
850. Partner with adult education resources to enhance reading and math, grammar and communications, etc. Skills specific to industry (e.g., in Michigan Partnership for Adult Learning). Workforce development and education.
851. Offer exploration time for interested potential workers such as healthcare sponsored explorer clubs for teens and adults. This should give a more realistic view of career options in healthcare.
852. Health careers should be introduced in middle school. Make sure students know what is required.
    a. National Consortium for Health Science and Tech Education
    b. Chicago workforce Board/CPS/Tribune Program
853. Work with DOE Local Board of Education to encourage opportunities in K-12. Local industry could partner with schools to support students: science programs, computer training, higher education tuition reimbursement, volunteer/intern/extern opportunities for pay.
854. Develop interest in allied health at K-12 level. There are professions other than medicine and nursing that most people know nothing about. Inform the public about the 100 other health care professions so that interest, and therefore education begins early and is complete by entry level time.
855. To increase employability work with grade schools and high schools to introduce science and math content in an interesting way so that students view health careers as an attractive option and they will have the background to

gain entry into programs. Hospitals could adopt local schools and provide some of the content.

856. Real work practices in employability traits prior to work life e.g. work/study HS by feed back. Also career specific information early on.
857. Early training or orientation while in HS career orientation; exposure to industry thru field trips and/or emphasizing to educators/counselors of skills necessary for maintaining a job, exposure to career ladders, assessments of basic literacy/English occupational and assistance for development of English skills, education/information giving at early states at schools and advising of criminal screens with regard to careers.
858. Orientation programs that are 6-8 weeks duration which emphasize the organizations function and culture. Orientation programs that truly review entry level skill competencies and identify skill deficiency and remediation. Process for formal feedback by entry level workers and use of buddy system.
859. Assessment of skills at the time of hiring and periodic re-evaluations to access improvement. Training in deficient areas during work time. Increase salary commensurate with improved skill base. Remediation jobs for those with criminal backgrounds. Check to limit patient care. Workers with dependent children don't have time to go to school after work – too many other responsibilities on the weekend (or their time off). Provide training during work time (day care not an issue) with homework. Provide computer access to workers with training in how to use them. Reward employers for their ability to display patience (counter-culture).
860. Work with successful WIA projects that have developed 'soft skills' models for entry level workers. See assessment and training tools found effective 'YO' model.

### *Targeted Specialized Skills Areas*

## Salt Lake City, UT Solutions

861. Develop mentor programs at all levels in career ladder
862. Develop a "Leadership Academy" for those moving into management positions
863. Develop basic health care management courses/certificate programs for all employees regardless of profession, interested in pursuing management positions in partnership with academic institutions and health care administrations.
864. Provide supervisory training opportunities (e.g. communication skills, conflict resolution skills).
865. Bring together managers, educators, recruiters, workforce planners to identify other groups that may already have skills in another setting – offer training to bridge the gap.
866. Review job skills and training to see what professions' skills may overlap so can utilize skills – especially in rural areas. (i.e. EMT to pharmacy tech) and relieve shortage areas
867. Devise career lattices for multiple entry and exit points for all increases in specialization

868. Provide information to current workers on specialized areas, the requirements, how to fulfill those requirements.
869. Information readily available in health care settings about specialties, advantages, education, etc.
870. Target lower entry levels and high school students of opportunities in specialty areas so they can be working toward that goal from the start.
871. Addressing certification creep could greatly diminish problems caused by explosion of new, unique specialized skill areas.
872. Quantify precise academic and kinetic skills necessary to perform these tasks and then develop methods to evaluate and remediate if appropriate.
873. Provide aptitude testing or surveys to assess current staff for specific areas.
874. Identify specialty skill areas that could be addressed by part-time or shared employers to pull "stop outs" back into the workforce.
875. Expose 3rd and 4th year nursing students to specialized areas of nursing (CCA, ICU, Emergency care).
876. Provide on-going computer training that can benefit all employees and enhance productivity in all areas of operation.
877. Employers who make it easy for workers to become trained in specialty areas such as giving them time and pay for receiving additional training.
878. Health organizations need to identify current and future needs to begin to advertise and recruit staff.

## Chicago, IL Solutions

879. Work culture tools
880. Subspecialties within professions
881. Preparation for management
882. Certifications/continuing education
883. Career exposure to related skill areas and career progressions
884. Transition of less demanding role (later career progressions)
885. Both academic and industry provided solutions
886. Partner with educational institutions to deliver on-site training
887. Early ID of interest and mentoring
888. Rotate employees into new specialized areas
889. Employee reimbursement for certifications
890. Partner with professional organizations on design of curriculum
891. Provide assistance for special needs workers
892. Older workers/incentives
893. Incentives to nurses for going into specialties
    a. Tax
    b. Early retirement
894. Create skills transferability roadmap from one specialty to another
895. Use virtual learning combined with local clinical experience
896. Create a clearinghouse of best practices (BRG/DOL)
897. Transitioning out workers.  Train incoming workers.
898. Develop model to share facility responsibilities and floor responsibilities
    a. Incentives

b. Flexibility

899. Work with schools of nursing to encourage graduate nurses to seek employment in specialties with shortages.
900. Incentives to offer specialty courses/electives
901. Increased exposure in these area
902. Professions should accept credentials or education from other professions to minimize time to entry-level
903. Early identification of persons who feel drawn to/interested in specialized area. Development through mentoring and place in training for the specialized career area of inters through internships.
904. Employers utilize rotation of employees to new areas after 2 years of service for 3 month periods to enhance skills used. Produce interest in specialized areas.
905. Partnering with educational programs to instruct workers in subspecialties – using the proposed federal funds provided to institutions to allow workers to return to school.
906. Partner with academic programs to offer training for skills/certifications.
907. Employers sponsor review courses and reimburse cost of certification for those who successfully complete certification.
908. Bring together health care specifics and management skills to design curriculum (SHRM and other groups)
909. Development of incentives to encourage nurses to go in to specialties with shortages (OR, critical care, ER, etc.)
    a. Monetary
    b. Early retirement benefits
    c. Tax incentives
910. Employees provide dollars and other incentives upon completion of new skills
911. Utilize virtual learning opportunities to learn skills, develop fellowship (3 month rotation) to gain practical experience for new skills.
912. Create a clearinghouse for best practices in building career ladders. Market it!
913. Early identification of need for transition into a less physically demanding job into a one that would nurture less experienced/newer staff. Veteran employee would be able to train and mentor in specialized area.
914. Network between professions. Nationally or state or within institution to know what each other does
915. Use HPN
916. Use Allied Health Prof Week.
917. Map out skill sets and credentials that are transferable
918. Provide avenues that encourage the seasoned HC worker to be able to move within the system and explore opportunities
919. Develop models to share faculty
920. Funding assist to help skilled older workforce transition to faculty position with a worker to teacher transition program.
921. Provide incentives (grants) for incorporation of assistive devices in specialized work area to assist healthcare workers to stay active.

922. Develop job sharing program for older workers transitioning and newer entrants to field
923. Develop clearly defined grids or database that depicts the transferability of skills and course work t\from one specialty area to another and outline the skills or course deficiencies that must be obtained to move to another health care specialty.
924. Work with employers (or employee culture) to see that their skills are transferable and to consider new areas in healthcare.
925. Develop models to share faculty/direct care responsibilities. Including incentives components, flexible scheduling, etc.

***Skills Development -- Dare to Dream***

926. Health care employers sharing resources and not competing
927. Collaborate rather than compete within health care industry "stop eating our own". Eliminate the caste system.
928. K-12 strategy in place - mentor, encourage to come into the field, profession, evaluation
929. Seamless strategy from high school to college. Transferable skills to go from one profession to another.
930. Required core curriculum for all health care professions to include courses on general health care...would promote dialogue and collaboration among disciplines
931. Transferability of classes
932. Status of health care occupations other than Dr\s. Many have left field.
933. Legalities of private/public partnerships don't impede programs.
934. WIBS - some are easy to work with, others aren't. Need a system that is more consistent and responsive to employers.

***Sustainability: Building sustainable partnerships, addressing demographic shifts and labor market trends***

## Washington, DC Solutions

935. Identify relevant champions/stakeholders
936. Define and redefine occupational skills in health care
937. Use community service/character awareness (trends in high school)
938. Establish partnerships with associations and organizations like HOSA (health occupation student association)
939. Public sector funding to leverage private sector dollars
940. Articulation of vision, mission, and goals
941. Earmark workforce dollars to increased demand in health care occupations
942. ID resources available to partnerships
943. Payment system aligned with health occupations
944. Require periodic reports and assessments on workforce collaborations
945. Central core of workers larger core of associates
946. Highlight exclusive and inclusive self-interest
947. Foster interdisciplinary research among agencies

948. Educate the workforce system about health care system and visa-versa
949. Legitimization and sanctions in place to support planning, etc.
950. Change image of health care workers
951. Change culture of interaction
952. Use DOL to facilitate shared employment across sectors
953. Connect Unemployment Insurance and other social programs to vocational needs
954. Establish regional coalitions
955. Establish peer-to-peer and face-to-face meetings with human resources and case managers
956. Require a collaborative process between public and private workforce system and health care system (policy)
957. Establish industry /education partnerships
958. DOL to lead by example
959. Public models that are working (best practices)
960. Ongoing partnerships to assess accreditation
961. Establish minimum competencies for all jobs – pushing credential down instead of up
962. Understand that solutions that work are locally led and driven
963. Address long-term care financing so as not to enforce low wage jobs
964. Highlight education
965. Establish sheltered workshops where appropriate – OJT
966. Use one-stop system as broker
967. Strategic match making
968. Common technology – different focus
969. Coalesce certifiers, technology, and service providers
970. Structure funding to support collaboration
971. Life-long learning
972. Need vs. budget decisions
973. Incumbent worker training as important as worker training
974. Change of work environment (culture)
975. ID and quantify non-academic issues required to sustain and persist
976. Demonstration projects
977. Local planning for workforce priorities
978. Raise employer awareness of supplementing care-giving
979. Parent body/initiator
980. Close gap in education/marketplace divide
981. Provide incentives and acknowledge contributions of others
982. Better career counseling for college bound students
983. Alignment of immigration policy
984. Balance the grant percentages over the health care continuum
985. Better school/work connection (science and math/K-12 occupational information)
986. Insert career ladders and formal articulation agreements
987. Results – Outcomes
988. Assimilation of immigrants into the health care occupational pool

989. Charter partnerships and clear memoranda of understanding
990. Engage the public school system with health care industry and for-profit industry sectors
991. Use DOL to establish reciprocity among accreditors
992. Systems point of view rather than programs point of view
993. Partner with entertainment industry to address cultural and generational differences
994. Charter partnerships with clear MOUs
995. Adaptability to the changes in the industry, i.e. the need to redefine occupations
996. Using the one-stop system as a broker

### *Sustainability Did You Think of This?*

997. Build ESOL/literacy structures to build a qualified pipeline
998. Distance learning for pipeline for rural jobs
999. Target a high school or junior high school to partner with a hospital or LTC facility – In other words, the business mentors the students throughout their education
1000. Refocus on bringing back individuals with health care training
1001. Federal incentives to provide interstate licensing reciprocity

# Sustainability: Leadership, Policy & Infrastructure

## Salt Lake City, UT Solutions

(Further notes are documented on the Matrix- Solution #82.)

When we went over the "issues" to drill into for our group they wanted to "tweak" the projections focus that we listed – the group felt that the workforce projections that are needed for the industry should include workplace changes that impact skill needs & service delivery models & expectations of the new entrants into HC professions.

Will this be a National HC council? A National HC alliance?

Composition of the National Alliance or Council:

The smaller lead group will be comprised of some federal agencies such as DOL, DHHS, DOE, insurers (private and public) Labor Unions, a governor, providers, consumer organizations. Aspen Institute, the Advisory Board, Higher Ed or Community college representation.

There will be focused sub-committees in conjunction with smaller council/alliance.

This Alliance/Council will be charged with working through a neutral lead organization that will convene the group – to establish a common ground for the work of the group; achieve consensus; guide research and dissemination of findings and key information;

leading innovation through demonstration projects; broker solutions to barriers (i.e. policy and leading the quiet deliberations to gel, strengthen and maintain relationships).

Policy recommendation from the "national council" must be reflected in federal agency plans – therefore legislation to convene this "national council" may be needed

The council must be empowered to make change happen and not just make recommendations.

*Mission Statement:*

"To articulate the imperative and craft an on-going response for a national model that will reach national consensus on the urgency & critical areas of the health care workforce."