



RX FOR THE  
HEALTH CARE  
WORKFORCE

PROMISING PRACTICES  
AND THEIR IMPLICATIONS FOR  
STATE AND FEDERAL POLICY

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JOBS FOR THE FUTURE

April 2010

## ACKNOWLEDGEMENTS

This report was drafted for *Rx for a New Health Care Workforce*, a convening in Washington, DC, hosted by Jobs for the Future, March 1-2, 2010. The report was revised based on input at the meeting.

*Rx for a New Health Care Workforce* brought together 100 health care policymakers, funders, workforce experts and practitioners, and industry leaders committed to expanding access, lowering costs, and improving the quality of health care. They discussed the role of workforce policy in health care reform and the implications of this reform for the frontline health care workforce—the men and women who provide a great deal of the nation’s direct patient care and public health services, yet who earn low wages and have limited opportunities for advancement.

The convening drew on promising models from several JFF initiatives, including *Breaking Through*, *Jobs to Careers*, and the *National Fund for Workforce Solutions*. JFF will extend the work undertaken at the convening, with reports on innovations and challenges in practice and policy.

This report and the convening benefited greatly from the contributions of an advisory board of experts in policy and practice. Our thanks to each of them: Harneen Chernow, Massachusetts Director, 1199 SEIU Training & Upgrading Fund; Steven Dawson, President, PHI National; Cheryl Feldman, Director, District 1199c Training & Upgrading Fund; Cindy Fiorella, Vice President of Workforce and Economic Development, Owensboro Community & Technical College; Ron Hearn, Executive Director, Baltimore Alliance for Careers in Healthcare; Michael Hoge, Professor of Psychology (in Psychiatry), Yale School of Medicine; Chrissie Juliano, Policy Development Manager, Trust for America’s Health; Bob Konrad, Principal Investigator, Institute on Aging, University of North Carolina, Chapel Hill; Linda E. Lewis, Vice President for Academic Affairs, Southeast Arkansas College; Paul Osterman, Deputy

Dean, MIT Sloan School of Management; Jason Patnosh, National Director/Associate Vice President, National Association of Community Health Centers; Jim Pearsol, Chief Program Officer, Public Health Performance Team Association of State and Territorial Health Officers; Nancy Pindus, Acting Director, The Urban Institute; Robert Restuccia, Executive Director, Community Catalyst; Geronimo Rodriguez, Jr., Vice President, Diversity & Community Outreach, Seton Family of Hospitals Administrative Offices; Mary Jane Ryan, Workforce Development Manager, Partners Health System; Phyllis Snyder, Vice President, Healthcare Services and Mature Worker Initiatives, Council for Adult and Experiential Learning; Robyn Stone, Executive Director, American Association of Homes and Services for the Aging, Institute for the Future of Aging Services.

In addition, the following individuals contributed to this report: Vickie Choitz, Senior Policy Analyst, CLASP; Sherry Kaiman, Consultant; Dorie Seavey, Director of Policy Research, PHI National; and Marlene Seltzer, Richard Kazis, Maria Flynn, Kimberly Rogers, Rebecca Starr, Steven Quimby, Elizabeth Grant, Marc S. Miller, Grace Ausick, Jean-Pierre LeGuillou, and Rochelle Fontaine of Jobs for the Future.

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# RX FOR THE HEALTH CARE WORKFORCE



# PROMISING PRACTICES AND THEIR IMPLICATIONS FOR STATE AND FEDERAL POLICY

Health care reform engaged the nation in intense debate about increasing coverage, lowering costs, and improving quality. Largely missing from the conversation over the legislation was the need for a skilled health care workforce, particularly on the front lines of care—among the men and women who provide a great deal of the nation’s direct patient care and public health services, yet who earn low wages and have limited opportunities for advancement.

The nation cannot solve the difficult equation posed by health care reform—to deliver more and better care at lower cost—without working smarter and strengthening the pipeline for filling critical jobs in the health care system. That means we must invest in raising the skills and education of every member of the health care team, not just doctors and other high-level professionals. It also means we must rethink the way that jobs on the front lines are designed and rewarded—and even the ways that the health care workplace is organized—to ensure that every member of the workforce contributes to delivering high-quality, patient-centered care.

Frontline workers are often invisible in discussions about health care, yet they are critical to building a system that delivers affordable, accessible, high-quality care. Their jobs range from direct care to support and administrative roles. They include the home health aide caring for elders at the end of life; the medical assistant taking vital signs and collecting patient data; the technician ensuring that laboratory tests are run properly; the community health educator counseling teens on pregnancy or their parents about diabetes; and the substance abuse worker leading a group of recovering addicts. Without them, we cannot deliver care to millions of newly insured Americans. Without them, we cannot meet the needs of a rapidly aging population or benefit from innovative systems for electronic medical records.

All Americans have a stake in investing in frontline caregivers' skills, job quality, and career development:

- > **For workers**, it is the promise of more satisfying work as members of caregiving teams, with opportunities to learn more skills, take on more responsibilities, receive better benefits, and earn both more recognition and higher wages.
- > **For health care employers**, it is the promise of lower worker turnover, higher morale, and improved performance on the job—an improved bottom line.
- > **For organized labor**, it is the opportunity to engage strategically with employers and workers in supporting career advancement strategies that help move frontline workers into new jobs resulting from workforce changes as other jobs disappear.
- > **For consumers of health care**, it is the potential of better care, particularly on the front lines, from a fully staffed team with greater continuity of caregiving.
- > **For communities**, it is the promise of better health—through education, disease prevention, and management of chronic health conditions.
- > **For the nation**, it is ensuring success in a critical part of our economy and infrastructure—health care accounts for one sixth of our GDP and is the fastest growing source of employment.



We have a great opportunity: investments in building a skilled health care workforce can draw on many promising models from the education and workforce development sectors—on the job, in higher education, and in our communities. At the same time, extending these models on a wide scale will require concerted action—often from agencies and actors that lack a strong record of collaboration.

Realizing the changes needed in our health care workforce requires knowing the labor market challenges throughout the health care system. This report describes what is needed to match the demands of a reformed health care system with a supply of skilled professionals and supporting occupations. It outlines key models, grounded in practice, for enhancing the skills of the health care workforce while building the capacity of health care, educational, and community institutions to support training and advancement for health care workers at all levels.

Yet without strong public action, these models cannot be implemented on the scale required. Given the large challenges our nation faces in the health care workforce, small solutions will not do. The challenges come from present or expected shortages in key occupations, including primary care and direct care workers; specialists in health information technology; and public health occupations. Equally critical are shortages in the areas of “soft skills,” such as critical thinking, working in teams, and delivering culturally competent care. Perhaps less noted but no less important are barriers—in the workplace, the educational system, and the community—to building a health workforce pipeline while improving the quality of jobs on the front lines of care. The recommendations that conclude this report can provide policymakers with guidelines for making strategic investments in proven models and implementing them on a large scale.

## THE CHALLENGE: A WORKFORCE FOR TODAY AND THE FUTURE

The effort to reform health care starts with this fact: the United States spends more on health care per capita than any other nation, yet we are further down the scale in terms of access (Schoen 2009).<sup>1</sup> While the nation is at the forefront in many areas of delivering health care, there is ample room for improving quality—as well as for improving the health of all Americans (National Center for Health Statistics 2009).<sup>2</sup> As we expand coverage and strive to improve quality, we must ensure that the nation has a health care workforce prepared to meet not only today’s needs but also the longer-term, increasing demands of an aging and more diverse population.

A key segment of that workforce is found at the front lines—the men and women who provide most of the nation’s direct patient care and public health services. This is not a small group: frontline workers represent about half of the 12 million people employed in the health care sector (Schindel et al. 2006). They include medical assistants, nursing assistants, substance abuse counselors, and home health aides, among other occupations. Many of these workers earn \$40,000 or less per year. They are predominantly female, have less than a Bachelor’s degree, and are not licensed to practice independently. They tend to have fewer education credentials beyond a high school diploma, and little or no preparation for their work beyond on-the-job training and brief in-services (Schindel et al. 2006).

The rising demands on the health care system bring into sharp relief a number of short-term and long-term workforce challenges. These extend to the demand for workers in primary care, direct care, health information technology, and public health services. They also include the need for improvements in skills that span these categories, such as cultural competence—the ability to understand and engage the needs of a diverse population of patients, health care employees, and community members—and the abilities to work in teams and think critically.

## THE DEMAND FOR PRIMARY CARE WORKERS

Health reform legislation will boost the number of insured individuals by an estimated 30 million people. The greatest impact of broadened coverage will be felt in the institutions that deliver primary care, including community health centers, which have set a goal of serving 30 million new patients by 2015 (National Association of Community Health Centers 2008). By 2016, offices of health practitioners are

projected to be among the leading contributors to job growth, as will residential care facilities and private hospitals (Council of Economic Advisors 2009; Martiniano 2008).<sup>3</sup> Physicians, particularly those in general practice, are already in short supply and will be in greater demand, as will nurses (Health Resources Services Administration 2006; Kuehn 2007; National Center for Health Statistics 2009).<sup>4</sup> Rising demand is also projected in middle-skill occupations a step or two above frontline jobs, such as medical assistants and other allied health occupations, requiring postsecondary certificates or degrees (Martiniano 2008; Holzer & Lerman 2009).

## **THE DEMAND FOR DIRECT CARE WORKERS**

An aging population of 78 million baby boomers will increase demand for direct care workers, particularly personal and home care aides and home health aides, which are projected to be the nation's second and third fastest-growing occupations through 2016 (American Hospital Association & First Consulting Group 2007; U.S. Bureau of Labor Statistics 2007). An additional one million direct care workers will be needed in this time (Paraprofessional Healthcare Institute 2009). Growth in the elderly population, especially among the oldest (85 and over) and frailest, will require more nursing assistants and physical therapy assistants, as well as additional licensed professions, such as nursing and medical social workers (Council of Economic Advisors 2009; Institute of Medicine 2008).<sup>5</sup> The numbers of people living with physical and mental disabilities will add to heightened demand for direct care.

## **THE DEMAND FOR HEALTH INFORMATION TECHNOLOGY WORKERS**

Legislation promoting the conversion to electronic medical records signals growing demand for information technology occupations in health care. This extends to jobs in clinical settings managing and coding health records, jobs providing IT support, and jobs analyzing data and systems as part of efforts to improve medical care. These jobs will require postsecondary credentials ranging from an occupational certificate or an Associate's degree to Bachelor's degrees and higher. Job growth is expected in all of these areas (Dohm & Schniper 2007; Hersh 2009).<sup>6</sup>

## **THE DEMAND FOR PUBLIC HEALTH WORKERS**

A growing focus on prevention, chronic disease management, and health disparities will require increased skill levels among public health workers. This extends both to state and local public health agencies and to private organizations providing public health services, such as health education and outreach, environmental services, food safety, and emergency preparedness. Shortages in key occupations are predicted, ranging from laboratory technicians to community health workers (Trust for America's Health 2008; Association of Schools of Public Health 2008).

## **THE DEMAND FOR HIGHER SKILLED PERFORMANCE IN HEALTH CARE WORK**

Meeting our health care workforce needs requires more than meeting the demand in particular occupations: new demands for skill cut across all job areas. Improving quality while limiting costs is the watchword in health care discussions. Calls for accountability and higher performance—from government,

insurers, and consumers—place higher skill demands on all members of the health care workforce. Prominent among these in-demand skills are the abilities to work in teams, think critically, collect and analyze data, and use information technologies.

Equally important is cultural competence. Frontline workers are more likely to come from the communities and speak the languages of new and growing populations, putting them in a strong position to support the delivery of culturally appropriate care.

## **BARRIERS TO BUILDING THE HEALTH WORKFORCE PIPELINE**

Aggressive career education and recruitment, beginning in middle and high schools, are vital to keeping pace with health care workforce demand, as are strategies for retraining dislocated and mature workers and encouraging candidates from diverse backgrounds, particularly ethnic and linguistic minorities. But inevitably, employers and workforce systems will need to invest in “grow your own” or pipeline strategies based at health care workplaces—most of the health care workers of tomorrow are in the workforce today.<sup>7</sup> At the same time, they need proven models for retaining frontline workers and fully engaging them in the health care team. These workers represent untapped potential to deliver better care and fill higher-skilled professional positions.

Attempts to realize this potential confront significant barriers in the workplace, in education, and in our communities.

*Today’s health care workplace is not sufficiently “learner friendly.”* All too often, employers fall back on a human resources approach of “catch and release.” Lacking models for building and retaining a quality workforce, they treat high turnover in a low-wage workforce as inevitable. Without changes in human resources approaches, they may be right: the lack of formal paths within and between many health care occupations often block worker advancement, as does the lack of competency-based standards and formalized credentials that could validate what workers know and what they learn on the job. Moreover, many health care institutions are poorly equipped to give incumbent workers the educational and financial support they need, beyond orientation and brief in-service trainings, to further their training. And low pay, poor benefits, and the lack of full-time or permanent jobs further limit workers’ commitment and retention, as do insufficient career opportunities and a lack of respect for and recognition of their efforts.



*The educational system for health care is not sufficiently “worker friendly”* in terms of schedule, instructional methods, and openness to nontraditional students, particularly those who are adults, have low incomes, hold down full-time jobs, support families, and come with academic deficits. Regulations imposed by professional and academic accrediting bodies in health care also limit innovative means of delivering instruction and granting credit at the workplace. Higher skilled positions in health care almost always require postsecondary credentials, from occupational certificates and licenses to two-year degrees, four-year degrees, and postgraduate training.

*In communities, small-scale innovation is not enough.* Employers and educational institutions that are making the workplace learner friendly and the learning place worker friendly operate at small scale and usually in isolation from one another. Such initiatives are difficult to sustain, replicate, and expand in the absence of institutions to forge strong partnerships with employers and educators, finance innovation, and coordinate among disparate public and private workforce actors. Employers competing for the same pool of workers and consumers often avoid collaborating, missing opportunities for learning, exchange, and achieving greater efficiency and impact in the education and training of their combined workforce.

## MEETING THE CHALLENGE: PROMISING MODELS OF PRACTICE

In hospitals and community colleges, health clinics and community foundations, and a myriad of other institutions, promising models are emerging for building a skilled frontline health care workforce. Found in highly diverse settings, each of these models offers potential for meeting the workforce demands inherent in health care reform:

- > **In the workplace**, supporting the skill development, job quality, and career advancement of frontline health care workers to better serve patients and consumers and to fill critical job vacancies. For example, initiatives in behavioral health centers and teaching hospitals in Massachusetts and Pennsylvania illustrate the promise of workplace models for building an internal pipeline of health care professionals, engaging employees in learning, and increasing employers’ return on investments in worker education.
- > **In postsecondary education**, increasing the number of adults attaining health care degrees and other credentials, including individuals who currently have low incomes, low literacy, or face other challenges to advancement. At community colleges in Kentucky and Arkansas, for example, innovative strategies—on the job and in the classroom—dramatically improve degree attainment in nursing and allied health, while also filling critical shortages of professionals and anchoring local economic development.
- > **In the community**, leveraging public and private resources and partnerships to build the capacity of communities to support health care workforce development and job quality. A wide-ranging workforce partnership in Baltimore enables major hospitals to scale up internal career paths and models of employee coaching—meeting patient care needs while improving worker well-being.

Implemented in combination rather than in isolation, innovations like these offer new and effective ways to build human capital in health care.

## IN THE WORKPLACE: BUILDING SKILLS, ADVANCING CAREERS

Learner-friendly workplaces make learning part of the way business is done. The learning process engages all levels of the staff, from executives and managers in the front office to frontline supervisors and workers.

Innovative health care employers, in collaboration with higher education and other partners, are demonstrating how the workplace can support learning for the incumbent workforce and also bring new workers into health care fields. These employers support job enhancement, skill development, and career advancement by:

- > Providing clear and accessible career paths, both within the organization and across the health care industry;
- > Establishing learner-friendly human resource policies, including tuition assistance, coaching, release time for education and training, and dedicated staff time and resources for workforce development; and
- > Expanding the responsibilities of frontline workers and their supervisors, helping ensure that newly acquired skills are fully utilized and contribute to better care.

### Stanley Street Treatment and Resources: A Learner-Friendly Behavioral Health Workplace

Stanley Street Treatment and Resources, a provider of behavioral health services in Fall River, Massachusetts, offers a vivid example of making the workplace learner-friendly. In 2006, SSTAR, which specializes in substance abuse treatment, found itself short of staff to serve both in-patient and out-patient clients. It recognized the potential benefits of training unlicensed, frontline mental health workers for certified positions on the therapeutic team. Adding certified staff would also increase SSTAR's reimbursement levels. However, entry-level workers, many of them long-term employees, had failed to take advantage of previous opportunities for education due to a variety of barriers, including negative school experiences and family or financial constraints.

SSTAR overcame these obstacles by bringing instruction to the worksite and using the work process as a teaching tool, with the assistance of *Jobs to Careers*, a national workforce initiative supporting the training and advancement of frontline health care workers.<sup>8</sup> With two educational partners, the Trundy Institute of Addiction Counseling and Bristol Community College, SSTAR trained employees in addictions counseling, group facilitation, and family intervention. The training closely involved supervisors in courses, while the workers used journaling and examples from their work with clients. The worker-students formed study groups and offered informal supports to one another to prepare for the certifying exam. *All participants who entered the 270-hour course in addictions counseling completed it, and all but one passed the certifying exam for drug and addictions counseling.*

Making the workplace learner friendly benefits health care consumers and employers as well as employees. SSTAR can serve clients better with more and better-skilled staff, and it has reduced the waiting time for service from one month to a maximum of one day. More clients means more revenue: *SSTAR's bottom line is in the black for the first time in 20 years.* Frontline workers are more motivated—and with this learning success under their belts, some continue to pursue their education in counseling, social work, or nursing, among other career choices. Relationships among peers are deeper, breaking out of departmental “silos” and contributing to smoother client referrals and coordination of care.

### Partners HealthCare: Employer-Led Workforce Development

Partners HealthCare in the Boston area is a pioneer in making its affiliate hospitals “learner friendly,” both for frontline employees and for community residents seeking job opportunities in health care. The affiliates include Brigham and Women’s Hospital, Massachusetts General Hospital, and other leading teaching institutions. Shortages in key occupations, such as nurses, radiation technologists, and allied health positions, spurred individual hospitals within Partners to develop education initiatives.

One solution is the Partners Healthcare Training and Employment Program: Boston residents of the hospital’s neighborhoods receive job training, placement in hospital jobs, and career development services. The program began over a decade ago as a federally funded welfare-to-work initiative, and Partners HealthCare stepped in to continue funding it when federal support ended.

In December 2003, Partners HealthCare launched the Partners Career and Workforce Development program, a “community pipeline” and incumbent employee advancement strategy that it fully funds and has institutionalized with support from the Community Benefit and Human Resources departments. Under PCWD, Partners has created an infrastructure for workforce development activities across the system. It includes a career development Web site ([www.partners.org/pcwd](http://www.partners.org/pcwd)), a workforce development manager who provides technical assistance across Partners, and career coaches who help to support and advance incumbent workers.

Partners continues to maintain the Healthcare Employment and Training program with a full-time program director, career development coordinator, and office staff. Its goal continues to be to help low-income individuals attain jobs in health care, providing them with family-sustaining income while meeting Partners’ urgent need for skilled health care professionals,



including nurses, radiology technologists, surgical technologists, and respiratory therapists.

Partners currently seeks to fill future workforce needs by using a three-tiered pipeline approach, with programs targeting youth, community residents, and incumbent workers. It uses various strategies to expose individuals in these groups to career opportunities and to help them attain the education and supports they need to enter and advance in the health care workforce.

### **District 1199C Training & Upgrading Fund: Labor-Management Solutions to Workforce Challenges**

Labor-management training partnerships play a distinctive role in developing the health care workforce. They align the needs of health care providers and patients with those of employees and their representatives. They afford health care workers a voice in determining solutions. And they leverage contributions from employers with funding from public and private sources. Workers and their representatives have the everyday knowledge “on the floor” to detect evolving skill needs, opportunities for training, and ways to integrate learning at work with the least disruption of care.

One of the oldest, most distinguished of these partnerships, Philadelphia’s District 1199C Training & Upgrading Fund, has served health care employees and residents of Southeastern Pennsylvania for almost 40 years. The Training Fund is affiliated with Local 1199C, American Federation of State, County, and Municipal Workers (AFSCME), which represents over 50 health and hospital workplaces. It runs the nation’s only union-based school of practical nursing and has helped thousands of lower-income workers gain a first job and ascend career ladders in hospitals, nursing homes, and behavioral health facilities. Participants receive career coaching, instruction in academic and clinical skills, and assistance with entering and succeeding in college programs.

A key example of making the workplace learner-friendly is the Training Fund’s unique partnership with a psychiatric hospital, Temple University Hospital/Episcopal and its unionized workforce, and Philadelphia Health Management Corporation, which runs several residence-based treatment programs and is not unionized. Both Temple University and PHMC sought higher performance and better jobs for mental health technicians, an occupation that lacks formal training requirements or credentials. Yet they are called upon to serve patients with severe



behavioral and substance abuse conditions. On the initiative of the Training Fund, this partnership mapped the competencies required for performing these jobs, and then designed a curriculum to teach those skills on the job, using everyday duties such as interviewing patients or reading their charts.

The partnership's efforts are already paying dividends in both the quality of patient care and the quality of workers' jobs and career prospects. Graduates of the behavioral health initiative earned college certificates at Philadelphia University and credits applicable toward Associate's and Bachelor's degrees. Their employers report that the year-long course contributed to marked improvements in patient chart notes—critical to better care, the better capture of reimbursement dollars, and increased competence in working with patients. The initiative has also spurred improvements in the work environment, with more involvement by supervisors in mentoring frontline workers and clear standards and pathways for jobs that previously lacked both. The Training Fund now consults with other Philadelphia-area behavioral health employers about adopting the competency-based curriculum model more widely.

## **IN POSTSECONDARY EDUCATION: INCREASING ATTAINMENT OF DEGREES AND OTHER CREDENTIALS**

Exemplary postsecondary institutions—community colleges, in particular—are responding to educational challenges in the health care workforce by accommodating to the schedules, learning styles, and life situations of working adults. Colleges have also made strides in advancing lower-skilled learners from developmental education to programs that culminate in occupational degrees and certificates.

To support career development and degree attainment in health care, worker-friendly educational institutions collaborate closely with employers: instruction and learning resources are often provided at the worksite, taught by college faculty or by instructors on the staff of a health care employer and accredited as adjunct instructors. Teaching is based on principles for effective adult education, and educational methods are geared to nontraditional learners. For example, the curricula are contextualized to health care, and programs are accelerated to lead to credentials more quickly. Workers receive credit for work-based learning, prior learning, and learning under other experiential models. Career pathways allow for “easy entrance and exit,” with modular, stackable credentials. Curricula are competency-based, with employer staff and educational faculty conducting regular assessments. Comprehensive supports assist students in balancing work, education, and family life.

Two good examples of making education work friendly can be found at Owensboro Community & Technical College in Kentucky and Southeast Arkansas College.

### **Owensboro Community & Technical College: The Hospital as Campus for Nontraditional Nursing Candidates**

Owensboro Community & Technical College, in partnership with Kentucky's second largest hospital, Owensboro Medical Health System, has developed an accelerated pathway to a nursing degree. The program, designed for hospital employees on the lower rungs of employment, including nursing aides, pharmacy technicians, and unit clerks, responds to OMHS's urgent need for over 500 Registered Nurses in the next five years. The college's Community and Economic Development Division has instituted a program that is innovative in its approach to the curriculum, instructional methods, and supports for student-

employees. It was initiated with the support of both *Jobs to Careers* and *Breaking Through*, a national, multiyear demonstration project to assist community colleges in building more effective pathways to occupational and technical degrees for low-literacy adults.<sup>9</sup>

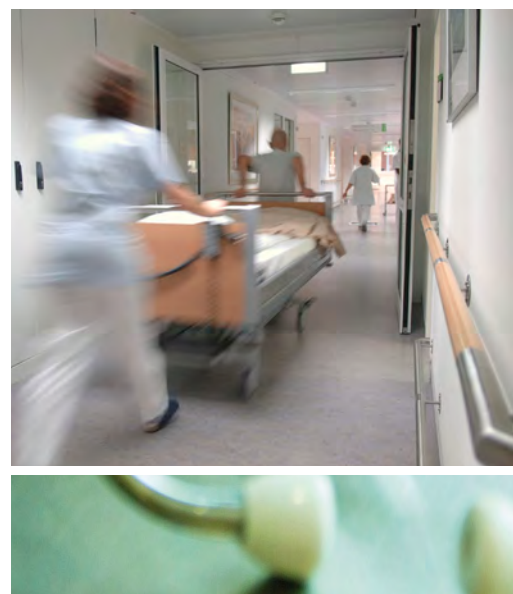
The course compresses the time required for degree completion: a full-time worker can attain an Associate's Degree in Nursing in three years. Paid release time—eight hours every two weeks—and employer-paid tuition support, along with online and classroom instruction at the hospital, allow students to maintain their income while studying. Students also receive intensive coaching and case management to identify academic and life barriers that might interrupt progress toward the degree. Moreover, the students support one another: they study as a cohort and stay connected through Facebook groups and other means. Students who encounter severe but temporary obstacles can drop out temporarily and reenter the program when they are ready.

Traditionally, weak academic skills, particularly in math and reading, have deterred prospective candidates from pursuing careers in nursing. At the same time, the college's developmental education courses have had low success rates and have not provided the skills needed by the nursing profession. After consulting OMHS nursing staff, the college crafted an intensive sequence in developmental math, grounded in nursing and customized to each student's skill level. Students move directly from "MathRx" to the nursing curriculum.

*Retention rates in the program have ranged from 75 percent to 89 percent, comparable to or exceeding national retention rates in nursing programs, despite the barriers that entry-level workers face. Seventy-five percent of all enrollees are expected to earn an RN credential.*

### **Southeastern Arkansas College: A Fast Track to Allied Health Credentials**

Southeastern Arkansas College, in Pine Bluff, created its Fast Track program to close gaps in academic fundamentals among potential candidates for health professions: 95 percent of the college's entering students require remedial work in reading, math, or other basic skills. Fast Track's accelerated program of developmental education is tailored to students in Licensed Practical Nursing (LPN) and other allied health professions. It compresses the time required to complete basic education requirements to one semester, giving working, low-skilled adults a better opportunity to raise their incomes and enter a career path in health care.



Fast Track has succeeded with students who enter testing as low as the fourth grade. It is immediately followed by a one-year, accelerated, interdisciplinary Practical Nursing track that is delivered in four eight-week modules and one sixteen-week session. As in Owensboro's Registered Nursing program, students receive intensive coaching and support from the college. *The result is a 96 percent completion rate (compared to 63 percent or worse in traditional developmental education courses). In addition, all students in the first cohort and 80 percent of the second cohort passed the National Council Licensure Exam for Practical Nurses.*

Southeastern Arkansas College is expanding the model of contextualized and compressed developmental education throughout its LPN and allied health programs. The model is supported by pairing general education and developmental education instructors.

The state of Arkansas launched a Career Pathways Initiative in 2005 based on a pilot model first tested at Southeastern Arkansas College, an important example of how states are stepping up to the plate to support and scale up such initiatives. This model, which aims to improve student retention, completion, and employment, applies many of the worker-friendly practices honed in Fast Track, such as improved instructional practices and a compressed program of developmental education that bridges lower-skilled health occupations to professional credentials in nursing and allied health. *Student performance at CPI sites has exceeded the traditional performance standards of two-year colleges in Arkansas.*

## **IN THE COMMUNITY: PARTNERSHIPS BUILDING THE CAPACITY TO SUPPORT WORKFORCE DEVELOPMENT**

Addressing workforce challenges requires a systematic approach: identify problems, align vision and strategies, assemble resources, and convene the public and private stakeholders necessary to support skill development and career advancement on a significant scale. A growing number of workforce partnerships throughout the United States are undertaking such efforts, and many of them focus on health care. The most effective collaborations enlist leaders from business, labor, government, education, and philanthropy with the power to make community-wide changes in the institutions that plan and deliver workforce and educational services. These efforts achieve results because they target both sides of the labor market—workers and employers.



## Baltimore Alliance for Careers in Healthcare: Community Partnerships to Fill Critical Vacancies

The Baltimore Alliance for Careers in Healthcare, one of the nation's most notable workforce partnerships in health care, came together in 2005 to address critical labor shortages in the city's health care industry and the needs of unemployed and underemployed city residents for training and jobs. BACH's founders included seven major hospitals, including Johns Hopkins Medical Center and Mercy Medical Center; two-year and four-year colleges and the Baltimore school system; regional municipal workforce agencies; and community-based and philanthropic organizations. It has subsequently received support from *Jobs to Careers* and the *National Fund for Workforce Solutions*, an effort by national philanthropies to leverage local and regional support for workforce partnerships.<sup>10</sup> BACH's partners recognized that Baltimore's resident workforce represented a large but untapped resource for filling health care positions, but it was a resource that would require considerable preparation. Nearly one-third (31 percent) of city residents lack a high school diploma; only 23 percent have a postsecondary degree.

With the support of its funding partners, BACH has mapped career ladders in five member hospitals, illustrating how lower-skilled workers can advance to higher-paying jobs. As a strategy for retaining staff and helping them advance, employers and foundation members have pooled efforts to support and scale up career coaching for hospital workers, and they offer professional development for coaches.<sup>11</sup> Currently, nearly six hundred workers across six hospitals receive coaching services, and they have received wage increases averaging 14 percent.<sup>12</sup>

Initially, though, even as the coaching initiative boosted wages and improved retention, serious shortages and vacancies persisted in many occupations. For example, the hospitals were sorely in need of more "nurse extenders"—clinical employees who assist nurses with wound care, EKGs, and other needs. By 2006, nurse extenders were turning over at a rate of 35 percent each year, with a 10 percent vacancy rate. To respond, BACH collaborated with the University of Maryland Specialty Hospital, Good Samaritan Hospital, and Community College of Baltimore County. Non-clinical staff, including dietary, transportation, and environmental services workers, received training to become Certified Nursing Assistants, and then completed additional training and internships to become nurse extenders, raising their hourly wages about \$4, to an average of \$13. Mentors and coaches helped trainees stay in the program, assisted them with their new work roles, and offered guidance on clinical skills and work/family issues. All employees who completed it passed the certification exam on the first attempt, a first for employees in these facilities.

BACH's reach as a workforce partnership helped make the nurse-extender program possible by overcoming two regulatory hurdles. First, in Maryland nursing assistants must receive training in a long-term care setting in order to be licensed, a regulation that would seem to require candidates for nurse extender certification to leave their jobs and find employment in a nursing home. Second, the Maryland Board of Nursing requires faculty who train CNAs to have had at least one year of experience caring for the elderly or chronically ill in the past five years. However, in BACH's model of work-based learning, the instructors are RNs employed by the hospitals, and they are unlikely to have recent experience in an elder care setting.

To surmount these obstacles, BACH leveraged the influence of its members, including the vice president of the Maryland Hospital Association. Her contacts and professional influence, coupled with the organization she represents, fostered a candid discussion of the issues, which ultimately led to a favorable interpretation on the regulations by the nursing board. The result demonstrates the role that robust partnerships can play with regulatory bodies governing the health care workforce.

## MOVING POLICY TO ADDRESS WORKFORCE CHALLENGES

Efforts like those outlined here represent a foundation for creating and scaling up innovative and effective health care workforce models. But given the size of the health care sector and the severe challenges it presents, growing the workforce will require serious investments—of funds and other resources and in the attention and commitment of policymakers and stakeholders. To guide those investments, and to move a “health care workforce agenda” forward, several policy supports will be critical:

- > Broadening knowledge and deepening commitment among policymakers and funders;
- > Strengthening investment; and
- > Improving coordination efforts and removing barriers to innovation and scale up.

Policy steps in each of these areas are offered below to initiate discussion about a fuller policy agenda and action plan for developing the frontline workforce in health care.

### **BROADENING KNOWLEDGE AND DEEPENING COMMITMENT: DIAGNOSING WORKFORCE CHALLENGES AND DISSEMINATING SOLUTIONS**

**Improve understanding of trends in the frontline health care workforce through dedicated funding for local, state, and national data collection, analysis, and dissemination.**

This is particularly important for direct care work, community health work, and other occupations that lack official recognition or classification despite their critical role in long-term and preventative care. A vital step was taken in 2008 when the U.S. Bureau of Labor Statistics redefined “community health work” as a distinct occupational category.<sup>13</sup> The Paraprofessional Healthcare Institute, a nonprofit that seeks to improve the lives of people needing home or residential care by improving the lives of the workers who provide that care, has proposed a cross-state project to monitor trends in this workforce. These steps should be encouraged and expanded to additional frontline occupations in public health, behavioral health, and acute care. More broadly, “frontline workers” should be defined across various health care sectors in federal statutes.

**Ensure that knowledge about the frontline health care workforce reflects current and projected labor market information on trends in supply, demand, skill needs, skill gaps, employment, and earnings.**

Workforce development systems must base planning on up-to-date information, yet most projections of labor market needs in health care predate the economic downturn. Ongoing investments in the collection, analysis, and dissemination of relevant and “real time” data are essential. This is a task well suited to partnerships that bring together the stakeholders in workforce development, given that one role for such partnerships is to ensure that strategic planning identifies and addresses the most pressing needs of the health care industry in a community.

That said, the skill gaps plaguing the health care sector will persist, even if the overall state of the economy may lessen demand and job growth in certain occupations temporarily. Similarly, even if high unemployment lessens turnover, current health care workers will still need to acquire higher-level skills in order to implement new information technologies and meet a growing demand for higher-quality care. Certainly health care providers will remain under pressure to improve their performance, which will depend on the active involvement of frontline staff.

To ensure the integrity and value of data collected, the design and collection process should include or consult with all stakeholders, and steps should be taken to ensure that the data are widely accessible to all. Employers and community-based organizations should be involved in data collection and analysis, and local Workforce Investment Boards should include frontline health care workers.

**Identify, disseminate, and replicate best-practice models of health care workforce development to employers, educational institutions, and other stakeholders. Fund and incorporate evaluation to identify models of best practice.**

One improvement would be to reauthorize and fund the Health Resources Services Administration’s National Center for Health Workforce Analysis Program and its regional centers for health workforce studies, as recommended by the Trust for America’s Health, a nonprofit organization dedicated to saving lives by protecting the health of every community and working to make disease prevention a national priority. Through cooperative agreements and contracts, six Regional Centers were funded. Their mission included performing direct research on the health care workforce, developing tools to assist in such activities, and providing technical assistance to policymakers regarding the health care workforce. With reauthorization, the centers’ research should encompass frontline and mid-skill occupations as well as physicians, pharmacists, nurses, and other high-skill health professions. It also should support best practices in models for health care delivery, with recommendations for concurrent changes in workforce practice.

## **STRENGTHENING INVESTMENT: PROMOTING AND SCALING UP EFFECTIVE MODELS**

**Provide federal matching funds to state and local governments, private employers, and labor-management partnerships that invest in the recruitment, retention, and training of frontline and mid-level health workers, and in both the public and the private workforce.**

Workforce partnerships, comprising health care employers, educators, funders, and the workforce system, provide an effective model for investing in training and career advancement, as shown by Baltimore Alliance for Careers in Healthcare. Targeting public funds to such partnerships—through matching funds and a national demonstration program—would leverage private employer and philanthropic investments and build capacity that can outlast short-term workforce programs.

In reauthorizing the Workforce Investment Act, the federal government could build on the precedent of the guidance for skills training investments that accompanied federal stimulus funding. The U.S. Department of Labor could specify the delivery of workforce services through sector partnerships focused on high-demand occupations and industries, including health care. The performance accountability system should be structured in a way that promotes the provision of career advancement services to low-skilled workers as well as to unemployed individuals and new entrants to the labor force. All such investments should include rigorous evaluation—to determine the impacts of health care workforce strategies for workers, employers, and health care consumers, and to identify effective strategies that can achieve significant scale. Investments also should promote collaboration at the agency level, breaking down the silos of current workforce programs managed by the Department of Labor and the Health Resources and Services Administration.

Perhaps most important, new public investments in the frontline workforce in health care should require a broader approach than training individual workers. Grant programs must also target investments toward changing practices and building the capacity of employers to develop their workforces. Employers like Partners Health Care, SSTAR, or Baltimore's Good Samaritan Hospital and others participating in BACH have applied private and public grant funding to make their workplaces more learning friendly. They have made deep commitments to career coaching for employees, expanded the skills and job responsibilities of frontline workers, and retrained supervisors to be effective mentors and instructors.

**Create permanent, sustainable incentives for investing in the health care frontline workforce.**

Longer-term measures are necessary to end the stop-and-start funding cycles of federal and philanthropic grantmaking. Policymakers should build in incentives for investments in frontline workers—for example, through the federal “Medical Home” program, hospital reimbursement policies, and other federal and state policies governing health care providers and public health agencies. Also, workforce and economic development criteria could be included in the definition of a Medical Home, and frontline worker training could be a reimbursable expense, as nursing education is for some providers. Moreover, the time horizon of funded training should be extended to account for the lengthy period required for frontline health care workers to climb the career ladder.

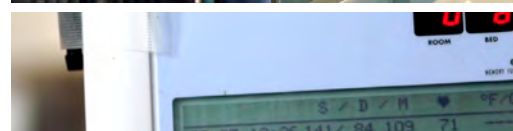
**Make grants to educational institutions to support scholarships, other forms of tuition support, and programmatic innovations for advancing frontline workers into high-demand health professions. Rationalize and align scholarships and other forms of tuition assistance for adults, including full-time workers and those in precollege, remedial, or workforce education programs, as well as those in traditional degree and certificate programs.**

The federal government should provide well-designed incentives and support for postsecondary education providers, including community colleges, to deliver education and programming that support working adults, especially those who are academically unprepared for college and at risk of not completing degrees and credentials. The Obama Administration recognized this priority when it proposed emphasizing students with educational and employment needs, as well as strong partnerships with employers and completion of credentials with value in the labor market.<sup>14</sup> The models developed by Owensboro Community & Technical College and Southeast Arkansas College, which make career ladders explicit and transparent for students, educators, and employers, exemplify two types of programs to support. The federal government should also encourage partnerships that promise to achieve significant regional scale by joining postsecondary institutions with employers, employer consortia, workforce development organizations, community-based organizations, and philanthropy.

**Expand and promote the federal student loan-forgiveness program for health care graduates and for frontline workers, as well as for doctors and nurses.**

The federal government's loan-forgiveness program currently applies only to study toward academic degrees and certificates. To aid frontline workers, it should encompass study toward industry-recognized credentials offered at, or under the auspices of, accredited educational entities.

The President's 2011 budget proposal for easing student debt also merits support. This proposal would expand "income-based repayment," which for individuals working in government or nonprofit jobs bases loan repayment on a student's discretionary income rather than the amount owed on a student loan—making repayment easier for struggling graduates. Under the Administration proposal, monthly loan



repayments would be limited to 10 percent of discretionary income, versus the 15 percent now required, and debt could be forgiven after 20 years of repayment. Individuals in public health and preventive health-related jobs would benefit from this provision limiting their loan-repayment liability. Incentives to work in public-serving “safety net” institutions providing charitable care or serving low-income communities should be supported.

## **IMPROVING COORDINATION AND REMOVING BARRIERS**

### **Establish a National Health Workforce Commission.**

Governmental and private-sector funding for education in the health care professions is fragmented, contributing to the workforce crisis. To strengthen and expand this workforce, it is essential for the various health professions, in conjunction with foundations, workforce development organizations, and the education community, to work together to develop and implement local workforce initiatives. A national body could support this effort by improving coordination among federal, state, and local agencies involved in health care workforce policies. The commission could develop an integrated, cross-agency, workforce planning and appropriation process that supports a high-quality health care delivery system and promotes alignment across departments and agencies, including Labor, Education, and Health and Human Services. It would be an independent entity and consult with relevant federal, state, and local agencies, encouraging collaboration on funding, reporting requirements, and other measures.

### **Review public and private rules, standards, and practices governing entry into and education for health professions.**

A task force, perhaps under the auspices of a National Health Workforce Commission, could examine state licensure and accreditation policies for health professions, focusing on inconsistencies and unnecessary barriers to supporting a high-quality workforce pipeline. For example, it would minimize “credential creep” by reviewing minimum qualifications for entry into each profession and for instructors. Members would work with health care providers to identify appropriate credentials and align required credentials accordingly. It also would look at the scope of regulatory and other restrictions on workplace learning. After conducting the review, the task force could issue recommendations for improving consistency and flexibility in licensure and accreditation policies, while meeting goals of professional competence and patient safety.<sup>15</sup>

### **Assess the impact of the reimbursement policies of Medicaid, Medicare, and private insurers on the capacity of health care employers to invest in developing and advancing frontline workers.**

Current policies for reimbursing health care providers—particularly in long-term care—place significant constraints on the ability of employers to invest in training, career advancement, and improved wages and benefits for frontline workers. Possible models include keying reimbursement for long-term care facilities to policies that reward quality care, including policies that encourage investments in the training of frontline workers.

One example is the North Carolina New Organizational Vision Award, a special state license that recognizes workplace excellence in home care agencies, adult care homes, and nursing facilities as a way to provide better care. The first program of its kind in the country, NC NOVA was developed by a broad-based team of providers, workers, consumers, state regulators, and educators. It provides rewards for meeting comprehensive, rigorous standards for frontline caregivers.

Another example could come from the National Center for Quality Assurance, a nonprofit that seeks to drive improvement throughout the health care system and elevate the issue of health care quality to the top of the national agenda. NCQA plans to use training and the incorporation of frontline workers in the health care teams of community health clinics as a criteria for assessing attainment of “Medical Home” status. This will affect reimbursement levels for community health centers.

**Support competency-based standards for preparing the direct care workforce across the spectrum of aging and mental and physical disabilities, and align federal training requirements with new standards.**

The Paraprofessional Healthcare Institute and the Annapolis Coalition, a nonprofit dedicated to improving the recruitment, retention, training, and performance of the workforce in the mental health and addictions sectors of behavioral health, have proposed the establishment of competency standards in frontline health care occupations. These proposals should be supported and implemented. Such competencies can become the basis for curricula guided by systematic reviews of skills and employer needs, as well as for establishing transferable credentials and career paths in the workplace, industry, and higher education.

## TOMORROW’S WORKFORCE

The prominence of health care in today’s economic environment offers excellent opportunities to ensure that all who need high-quality care can get it—at a reasonable cost. For the nation to realize those opportunities, however, policymakers, health practitioners, payers, and consumers must give full attention to the women and men on the frontlines of health care. This means investing in skill and career development to make the workplace learner friendly and the learning place worker friendly. And to fully leverage these investments, it also means building partnerships that span the public and private sectors, providers and educators, health care and workforce systems.

The current environment—in the political sphere and in the economy—lends special urgency to the conversation about health care’s frontline workforce. Need, interest, and opportunity may be converging for the benefit of health care workers, employers, consumers, and communities. Serious efforts to forge new approaches in the health care workplace, higher education, and the community can be expanded, but only with a coherent set of policy supports that drive quality, collaboration, and scale.

The models and policies presented here are not the last word. Rather, they are an invitation to continue this conversation with all who wish to create a health care workforce that matches our vision of excellence in providing care.

## ENDNOTES

<sup>1</sup> Health care expenditures total \$2.5 trillion annually—the equivalent of \$7,250 per person. According to Schoen (2009), this is more than twice the per capita spending on health care of other major industrialized nations.

<sup>2</sup> A 2008 study ranked the United States last among 19 industrialized nations in the rate of preventable deaths caused by chronic illnesses, such as diabetes, stroke, and pneumonia (Nolte & McKee 2008).

<sup>3</sup> Jobs in offices of health practitioners are projected to grow by 850,000, or 24 percent, between 2006 and 2016. These jobs constitute over one-third of all projected growth in the health sector (Council of Economic Advisors 2009; Martiniano 2008). These projections, conducted in 2008, do not take into account the impact of health care reform on employment demand.

<sup>4</sup> Over one million new registered nurses will be needed (2006-16) to fill new jobs and replace nurses leaving their jobs (Martiniano 2008). Nurses are the single largest occupation in terms of overall employment growth.

<sup>5</sup> Home care aide employment is projected to grow by 51 percent, 2006-16, while home health aides should expand by 48 percent (Martiniano 2008; Council of Economic Advisors 2009; Paraprofessional Healthcare Institute 2009).

<sup>6</sup> Medical records and health information technicians are projected to increase by 18 percent, to 200,000 in 2016. An additional 76,000 will be needed to fill jobs created and net replacements (Dohm 2007). According to the Office of the National Coordinator for Health Information Technology, an additional 51,000 workers are needed to implement the federal Health Information Technology agenda (U.S. Department of Health and Human Services 2009; Monegain 2009).

<sup>7</sup> Workers now in the labor force are expected to be 65 percent of the 2020 workforce and 43 percent of the 2030 workforce (Toosi 2006; Institute of Medicine 2008).

<sup>8</sup> *Jobs to Careers: Promoting Work-based Learning for Quality Care* is a five-year, \$16 million initiative sponsored by the Robert Wood Johnson Foundation, in collaboration with The Hitachi Foundation and the U.S. Department of Labor. SSTAR is one of 17 grantee partnerships of employers and educational institutions assisting frontline workers to advance. The initiative is designed to create lasting improvements in the way institutions train and advance their frontline workers and to test new models of education and training that incorporate work-based learning, which represents a novel approach to meeting workforce needs in health care as well as in other fields.

<sup>9</sup> *Breaking Through: Helping Low-Skilled Adults Enter and Succeed in College and Careers*, through a three-year national demonstration, supported Owensboro Community & Technical College, Southeast Arkansas College, and five other institutions in efforts to strengthen pathways through precollege and degree-level programs for lower-literacy adults. An additional 25 colleges participated in peer learning activities with these colleges. The demonstration initiative was funded by the Charles Stuart Mott Foundation and North Carolina GlaxoSmithKline Foundation. It is being scaled up in selected sites and in statewide networks through the support of the C.S. Mott Foundation, the Ford Foundation, and the Bill & Melinda Gates Foundation.

<sup>10</sup> The *National Fund for Workforce Solutions* is a consortium of philanthropic investors that combined resources in 2007 to create a \$30 million pool for seeding or accelerating investments in local workforce partnerships. The National Fund to date supports 22 funding collaboratives across the United States, which in turn have invested in workforce partnerships in diverse industries, including health care, construction, advanced manufacturing, and “green sector” jobs, among others. National investors include the Annie E. Casey Foundation, the Ford Foundation, the John S. and James L. Knight Foundation, the Hitachi Foundation, Microsoft Corporation, the Walmart Foundation, the Harry and Jeanette Weinberg Foundation, Prudential Foundation, and the U.S. Department of Labor.

<sup>11</sup> The coaching initiative was originally grant-funded. As of December 2008, BACH hospital employers contributed between 50 and 75 percent of the cost.

<sup>12</sup> This information is based on unpublished documents of the *National Fund for Workforce Solutions*.

<sup>13</sup> See: [www.bls.gov/soc/2010\\_responses/response\\_multiple\\_docket\\_7.htm](http://www.bls.gov/soc/2010_responses/response_multiple_docket_7.htm).

<sup>14</sup> The American Graduation Initiative (and proposed HR 3221 Title V, the Community College Initiative) would fund innovative programs that support the attainment of degrees and credentials, as well as states implementing systematic reform of community colleges.

<sup>15</sup> *Out of Order Out of Time* states that “voluntary, self-regulatory processes like accreditation are often subject to inconsistencies that have adverse effects on the health workforce” (Association of Academic Health Centers 2008). “Although many health professions have established nationally standardized examinations, states often require additional tests or demonstrations of competency that undermine consistency and create barriers.”

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