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AMERICAN HOSPITAL ASSOCIATION

HEALTH CARE TALENT SCAN



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Welcome

to the American Hospital Association Talent Scan

Our annual snapshot of America's health care employment

The American Hospital Association (AHA) is pleased to present the Health Care Talent Scan, which was developed after reviewing dozens of reports, studies and other data sources from leading organizations and researchers throughout the field.

From discussions with AHA members, we have heard challenges related to recruiting, retaining and managing a qualified and engaged workforce, which are further exacerbated by the shifting health care landscape, increasing use of technology and changing consumer demands.



To help members meet these challenges, the AHA, with support from the AHA Board of Trustees, has outlined a framework in four areas:

- **CAPACITIES:** Ensure that hospitals have sufficient workforce **capacities** through a pipeline of talent that hospitals can hire, retain and grow to be able to successfully support health in their communities. Includes issues of workforce strategic planning, supply and advocacy efforts.

- **COMMUNITIES:** Support and tap into health professional **communities** to build resiliency and a healthy, safe and diverse work environment.

- **COMPETENCIES:** Identify, promote and develop required workforce **competencies** for current and future needs.

- **CATALYSTS:** Provide tools, programs and services to be **catalysts** for member and field action to change and adopt new technologies and models for care delivery to create the future of work.

The AHA Talent Scan will help put the health care labor shortage and related issues into perspective, and can inform your strategy for developing a workforce to meet patient needs for today and tomorrow.

Some key findings:

- The health care talent gap is large and extends to many segments, including medical school faculty.

- Community health programs, patient-centered medical homes, remote patient monitoring and telemedicine are all reducing preventable hospital visits and the need for hospital staff.

- Artificial intelligence (AI) and other advanced technologies can reduce clinician workload, but also introduce other workforce challenges.

- Hospital leaders are facing these issues head-on by making investments to reinvent the workplace, increase staff and expand partnerships with nonhospital providers to pursue digital innovation.



FOR TOOLS AND RESOURCES to help your health care organization address workforce issues, please visit aha.org/workforce.

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Introduction

Health care is currently the largest and fastest-growing segment of the U.S. economy, according the U.S. Bureau of Labor Statistics (BLS). Hospitals alone support 16.5 million jobs (about one in nine total U.S. jobs) and almost $3 trillion in economic activity.

Through the end of 2018, health care employment had grown 117 out of the 120 months in the past decade. That includes December 2018, when health care added more than 50,000 new jobs to record the highest single-month gain since the BLS began keeping records in 1990. Medical school and nursing school enrollment were also up during the year.

Despite the gains, the U.S. needs to hire 2.3 million new health care workers by 2025.[1] There were approximately twice as many job openings than new hires in 2018,[2] and the gap will persist, as there will be 1.3 million job openings annually through 2026, according to the BLS.

Clearly, there is still a lot of work to do, both to build the needed workforce and to care for patients. Not all of that work will be done in traditional ways. Hospitals are using a variety of methods to develop skills in their current workforces. They are also creating new paths to care, and applying new technologies and techniques to mitigate the talent shortage.

THE U.S. NEEDS TO HIRE

2.3

MILLION

NEW HEALTH CARE WORKERS BY 2025[1]



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State of the Workforce:
Can the Pipeline Offset the Drain?

The AHA projects that U.S. organizations will need to hire 2.3 million new health care workers by 2025.[3] The talent shortage is not a new problem nor an overlooked one, as most hospital leaders rate workforce as one of their top three concerns.

Aging Workforce, Aging Population

Basic demographics point to increasing pressure on the ability to provide care. The U.S. population is aging, and clinicians are no exception. More than a third of the physicians practicing in the U.S. today will turn 65 within the next 10 years.[4] The retirement issue may be more acute in nursing, as the percentage of RNs who were planning to retire in less than a year doubled from 2015 to 2017.[5] The U.S. health care system will need 1 million new registered nurses by 2022.[6]

These looming retirements will come at a time when the population at large is getting older and is likely to require more care. The Census Bureau projects that the number of Americans 65 or older will nearly double from 2012 to 2050, from 43 million to 84 million. In that period, the 65-and-older demographic will go from 14% of the total population to 21%. Meanwhile, millennials recently surpassed Generation X to become the largest segment of the U.S. workforce (35% and 33% respectively; baby boomers constitute 25%[7]).

Some physicians and nurses transition to retirement by reducing their hours before retiring completely. The overall average hours worked by physicians is also declining. If the current-hours-worked reduction trend continues, an additional 20,900 physician full-time employees (FTEs) would be needed by 2032 to offset the lost hours.[8]

Burnout can also contribute to the decision to retire. In 2018, 42% of physicians[9] and 16% of nurses[10] reported feeling burned out. Among nurses planning to leave their organizations, 50% cited burnout and 43% cited poor compensation.[11]

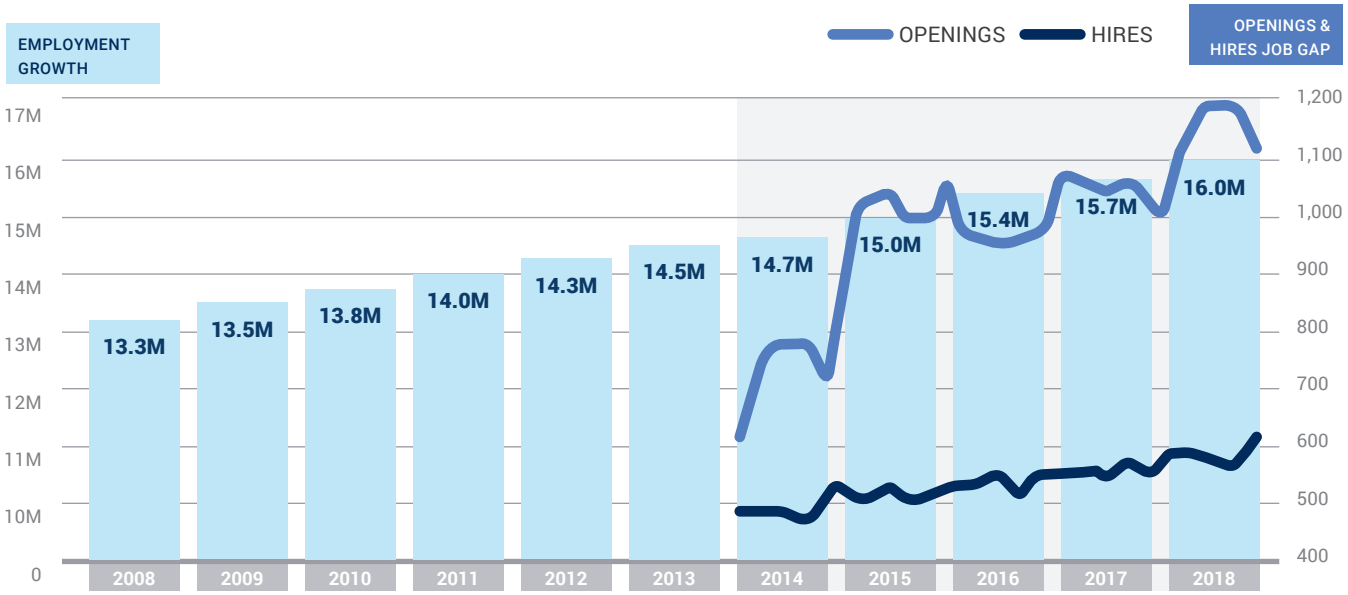


Could better population health make the talent shortage worse?

Improving population health is often viewed as a way to mitigate the need for increased care as populations age. However, living longer, healthier lives could exacerbate the health care talent gap. If the U.S. achieved its population health goals for weight loss, smoking cessation and better control of hypertension, hypercholesterolemia and hyperglycemia, the resulting decline in mortality (and corresponding increase in longevity) would require a *net increase* of 33,800 physicians; similarly, moving 100% of the insured population to a managed care plan would require 21,500 more physicians.

Source: American Association of Medical Colleges and IHS Markit

Health care employment is growing …



Sources: BLS (2018b), BLS (2018d). Note: In thousands.

… but, so is the gap between new hirings and job openings.



The Top of the Funnel Is Widening

Trained health care workers were absorbed into the workforce and replaced in educational programs at record levels in 2018, when health care hiring, medical school enrollment and nursing school enrollment were up. However, substantial workforce gaps persist. It will take years before increased medical and nursing skill enrollment will translate into workforce-ready professionals. Meanwhile, retirements and other attrition will add to the skills gaps.

- Various studies project that the new supply of physician assistants, advanced practice RNs and hospitalists will outpace demand growth.
- Approximately 500 hospitalists are retiring annually, while 1,300 are entering the field, according to one analysis.[12]
- In 2018, more than 10,000 more students applied for medical school admission in 2019 than the prior year, a 25% increase.[13]
- Medical school enrollment has increased by 30% since 2002.[14]

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- In 2018, more women applied to medical schools than men, which had not happened since 2004. 2018 was also the second-consecutive year more women than men enrolled in medical school.[15]

- Diversity in medical school enrollment also improved, as black applicants increased by 4.0% to 5,164 this year and matriculants (those who accepted) rose by 4.6% to 1,856 students.[16]

At a Glance

Here are some other facts and figures about the health care talent shortage.

- Total additional health workers needed by 2025: 2.3 million.[17]

- Projected physician shortage by 2030: 100,000.[18]

- Projected nurse practitioner shortage by 2025: 29,400.[19]

- Projected medical and lab technologist and technician shortage by 2025: 98,700.[19]

- Projected physical therapist shortage by 2025: 26,560.[20]



Enrollment Strains Schools

Medical schools are facing a talent shortage of their own — 94% of academic health center CEOs said faculty shortages are a problem in at least one of their medical profession schools, and 69% said it is a problem for their entire institution. Some reported that they are cutting programs because of faculty shortages.

Nursing school enrollment has increased every year since the start of the millennium, but nursing schools still denied admission to more than 64,000 qualified applicants in 2016 and 2017 because of faculty shortages, budget constraints and other factors.[2]

Sources: Association of Academic Health Centers; AHA TrendWatch Chartbook 2018



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How Hospitals
Are Attracting, Developing and Retaining Talent

To meet their staffing needs, hospitals are using many tactics ranging from the traditional (raising pay) to the novel (deploying robots). While the approaches can be different, there is a nearly universally shared belief that workforce development must be a high-level strategic priority. More than 90% of hospital leaders say workforce shortages will be one of their three most significant challenges,[21] and 75% have already invested or are planning to invest in what Deloitte calls "Future of Work" initiatives, which involve making changes to three dimensions: the nature of the work that gets done, the people who do the work, and the workplace itself.[22]

The most common tactics hospitals are using to ensure that they have adequate staff to provide all the services they want to offer include expanding their use of advanced practice providers (39% of hospitals have increased their advanced practitioner staff by at least 20%, and 27% of others say they are likely to do so[23]), raising pay, creating or expanding staff engagement programs, and increasing the recruiting budget.[24] Collectively, those efforts represent table stakes and often will not be enough to differentiate from other providers.

Shifting Approach to Adding Physicians

Note that the current common approaches do not include acquiring physician practices. Hospitals are still actively trying to expand their physician networks, especially by contracting with practices.

One of the biggest changes identified among hospital leaders in 2019 is their current eagerness to partner with health care staffing experts. Only 16% of hospitals have contracts with staffing firms, but 50% say they are likely to sign such partnerships.[25] Even more hospital leaders (88%) are partnering with primary, urgent, virtual and retail care outlets.[26]

Strong competition from private equity is one reason for the tapering in hospitals acquiring physician practices. Private equity investment in provider practices has soared in recent years. Private equity investors collectively spent $23.2 billion to purchase 84 U.S. provider practices in 2018.[27] In the preceding eight years (2010-2017), there was a 48% increase in deal volume and a 187% increase in acquisition spending for physician practices, hospitals and other care providers.[28]



20%

OF HEALTH CARE ORGANIZATIONS ARE USING NONTRADITIONAL RECRUITING STRATEGIES, TALENT SOURCES AND STAFFING MODELS.

Source: Deloitte Center for Health Solutions 2018 Health Care Future of Work Survey

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The Gender Gap Is a Leadership Gap

Women make up 65% of the health care workforce, make 80% of the purchasing decisions but account for only 13% of CEOs. Aside from CEO, relatively few women ascend to any C-suite roles — between 70 and 75% of health care providers and payers have no more than 40% of their C-suite roles filled by women.

These data come from the Oliver Wyman "Women in Healthcare Leadership 2019" study, which found several correlations between gender and leadership that hospitals can use to inform their leadership development practices:

- Men are more likely to seek, utilize and value mentors than women. The average male executive in health care has 3.7 mentors, compared with 2.6 for women.
- Men in health care are three times more likely than women to have profit and loss responsibility; 86% of health care CEOs had profit-and-loss responsibility before ascending to the position.
- Organizations with higher percentages of women in leadership have C-suites that are 1.5 times larger (by number of positions) than average.

How to close the gap? The Oliver Wyman report recommends three critical actions:

There are several misperceptions and leadership gaps specific to nursing. Most clinicians believe that nurse leaders are equal to physician leaders in their ability to deliver care, but only 25% of leadership roles are staffed by nurses.[29] Gender bias is cited as one potential reason.

Combating gender bias and other stereotypes appears to be a worthwhile path to encourage more leadership diversity and to increase the overall talent pool. How would the nursing shortage be affected if more male students went into nursing? Seventy percent of male nurses say stereotypes are the biggest challenge they face.

- Be bold. Step up your organization's commitment to the challenge.
- Purposefully balance the uneven playing field when it comes to sponsorship and mentoring.
- Explicitly address misperceptions. Change the behaviors that go along with them. Build new habits.

Most of Us Are Above Average!

"It's easy for leaders and organizations to express commitment to diversity — indeed, most organizations (70%) in our study received some sort of Inclusion & Diversity award, even those at the bottom in terms of female C-suite percentage."

Source: Oliver Wyman Women in Healthcare Leadership 2019 report

Technology to the Rescue?

Not So Fast

Technology is being introduced specifically to support human resource (HR) operations and for many other administrative and clinical functions. Automation is a key focus area. Many administrative processes can be automated to reduce labor requirements, and many tech solution developers are now trying to extend automation to support clinical activities. The Brookings Institute estimates that 40% of the tasks performed by health care support occupations can be automated, as can 33% of the tasks performed by health care practitioners and technical occupations.[30]

Increasingly, robotic process automation (RPA) technology that is used to automate repeatable administrative tasks is being infused with AI to automate or support more complex activities that require higher-level decision-making. Deloitte predicts 95% of all (not health care-specific) customer-driven interactions will involve AI within five years.

A team of 60 researchers and professionals at Partners HealthCare in Boston identified 12 AI use cases that could make the greatest impact on health care.[31] Only two could be considered primarily administrative (they relate to normalizing data for the Fast Healthcare Interoperability Resources standard and automating coding, billing and reporting activity). Clinical applications included improving radiology, identifying people at high risk for suicide and domestic violence, and early detection of malaria, eye disease and stroke. In another clinical support automation initiative, a Texas hospital completed a trial program in which a robot was used to transport samples from the patient bedside to the lab, deliver admission kits to patients and transport linens.

AI Meets HR

Health care professionals and technology developers alike believe AI technology can improve hospital HR department operations. Common use cases include applying AI and analytics to sort job candidates, and to combat turnover by predicting which employees are likely to leave the organization. Only 9% of hospital HR departments are using AI and analytics today, but 54% say they are likely to do so within the next five years, including 31% that are highly likely, according to the AHA's "Futurescan 2019-2024." However, one study (Bloomberg BNA 2015) warns that hospital HR departments that are funded at the typical level of 1% of the total budget may not be able to afford AI solutions.



54%

OF HOSPITAL HR DEPARTMENTS SAY THEY ARE LIKELY TO **USE AI AND ANALYTICS WITHIN THE NEXT FIVE YEARS**

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Despite the enthusiasm and some promising early results, there will be a slow transition to saving labor through more automated, tech-enabled processes. The amount of attention these efforts receive far exceeds actual implementation. While most organizations are planning to make such changes, most are in the process of analyzing workflows and staff roles. Only 27% have invested in technologies to automate tasks and processes so far, and only 20% have tried nontraditional recruiting strategies and staffing models[32].

AI technology may eventually do more to shift labor roles than it does to reduce labor requirements. Multiple studies have concluded that AI adoption results in a net employment gain. Deloitte predicts AI adoption (in all professions) will require a net gain of 58 million new jobs to support worldwide; the World Economic Forum (WEF) predicts 133 million[33]. Specialized IT professionals are needed to plan, integrate and run AI and other technology-driven programs, and there are worldwide skills shortages in those areas, too. Seventy-two percent of health care executives worry their ability to hire and retain IT talent will limit innovation[34]. These AHA resources (available on Market Insights AI web page) provide additional information:

- **Market Insights: AI's Impact on Health Care** (https://www.aha.org/center/emerging-issues/market-insights/ai)
- **AI and the Health Care Workforce** (https://www.aha.org/system/files/media/file/2019/10/Market_Insights_AI-Landscape.pdf)

ONLY

27%

OF HEALTH CARE ORGANIZATIONS **HAVE INVESTED IN TECHNOLOGIES THAT AUTOMATE TASKS AND PROCESSES**

Realigning Roles

Technology gives hospitals an opportunity to realign their staff roles and responsibilities, which is something many are doing already without relying on tech enablers. One way is by adding more advanced practice providers to free physicians for other activities. Another is to create shared services organizations that centralize operations like accounting or procurement. Outside of health care, centralizing shared services is often a precursor to outsourcing. Although outsourcing is on the rise among hospitals (IT is a common area), the practice is not widely used, especially when compared with other fields. Much more role realignment is occurring because hospitals are creating new pathways for their patients and community populations to receive care.



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New Paths to Care
Create New Staffing Opportunities and Challenges

Accountable care organizations, patient-centered medical homes, telemedicine, collaboration with community health workers and partnerships with retail clinics are among the ways hospitals are creating new paths to patient care. Against this backdrop, 88% of executives say hospitals are vulnerable to consumer-friendly offerings from nonhospital competitors.[35] Emerging care models, the transition to value-based care and the consumerism influence are changing the skills and roles that hospitals need to hire, and may also alleviate the workforce shortage.

Because of consumerism, hospitals must be ready to connect with patients when and how patients want to be served. Concurrently, staffing, regulatory and fiscal constraints require hospitals to steer patients to the most appropriate point of care, which might be a physician in the hospital itself, a community health worker, a telehealth consult or many other options. These practical and regulatory imperatives can easily be at odds with consumerism ideals, making it difficult for hospitals to maintain (and staff) the right mix.

Change Is Occurring

Hospitals are clearly investing to expand the ways they can reach patients. Patient engagement through mobile apps, telemedicine programs and collaborations are on the rise.

- 41% of health care organizations have restructured how work gets done, and 40% have process improvement or workflow optimization initiatives in place.[36]
- This year 61% of health care leaders said "offering a variety of facility-based access points" is a high priority or extreme priority for their organizations.[37]
- However, there is a widening digital divide among health care organizations. The Kaufman Hall Consumerism Index defines four levels of competence in addressing consumerism. In 2019, it rated 29% of providers at the lowest level, which was 12% more than the previous year. The authors noted that most of the organizations that declined in the ratings did not get worse, but did not improve enough to keep pace.



Patients, Providers Differ on Digital Disruptors

Digital native companies that don't have a specific health care background are poised to disrupt the market. One-third of consumers surveyed said they would trust Google, Amazon and Apple more than health care providers or insurers to develop the best online tool to help them find health care services. However, 61% of health care leaders surveyed feared competition from United Health Group/Optum and CVS/Aetna more than they did from Apple and Google.

Source: Kaufman Hall 2019 State of Consumerism in Healthcare

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Telehealth at the Intersection of Care and Consumerism

Today more than three quarters of U.S. hospitals offer telemedicine services and more than 60% are equipped for remote patient monitoring.[38] That is important, because 97% of patients were satisfied with their first telehealth experience and would recommend the program,[39] and 49% of patients want to communicate with their providers through videoconferencing, which is a notable gain from 36% in 2016.[40]

Most hospitals that have telehealth programs are expanding them, either by opening them to more patients and/or adding practice areas. Chronic-condition management has become the leading telehealth use case by hospitals and is also the leading practice area that hospitals are expanding.[41] Remote patient monitoring is also a fast-growing use case and aligns well with changing patient preferences — 53% of patients now expect their providers to support remote monitoring, including of consumer devices, up from 39% in 2016.[42] Other leading telehealth expansion areas are mental health care and serving rural populations.

Patient-centered Medical Homes, Community Health Workers and Their Implications for the Workforce

Emerging care models, the transition to value-based care and the consumerism influence are changing the skills and roles that hospitals need to hire, and may also relieve the workforce shortage.

For example, hospitals may play a coordinating role in patient-centered medical homes (PCMH) and, thus, require excellent communication and coordination skills. Based on documented reductions in emergency department visits among those in patient-centered medical home programs, PCMH expansion would result in the need for 9,400 fewer emergency physician FTEs and 2,000 fewer hospitalists.[43] Those declines would be offset by increased demand for primary care physicians (5,900) and various specialists (3,500) outside hospitals. Of course, hospitals would be competing to employ some of those physicians and specialists, and might also need to add program coordinators.

Community health programs also have been shown to reduce hospitalizations, and many hospitals are expanding their outreach by working with community health advocates and organizations. The 2018 AHA Community Health Worker Consortium meeting identified five key approaches for community health workers,[44] which readily map to characteristics to seek when hiring program staff or volunteers: active listening, health literacy, shared decision-making, wellness and self-care, and empathic connection.

The Consumerism Influence is a Digital Influence

Source: Kaufman Hall 2019 State of Consumerism in Healthcare

USING **DIGITAL TOOLS** TO ENGAGE CONSUMERS IS A PRIORITY FOR

77%

OF PROVIDERS THIS YEAR, **INCLUDING 42% THAT CONSIDER IT A HIGH PRIORITY**



The Rural Workforce Gap and Some Ways to Close It

- 95 rural hospitals closed between 2010 and 2018, and the number of closings in the second half of that period was more than twice as high as the first (AHA report, "Challenges Facing Rural Communities and the Roadmap to Ensure Local Access to High-quality, Affordable Care"); 673 more rural hospitals are considered at risk of closing because of proposed Medicare cuts.
  (National Rural Hospital Association)

- 20% of the U.S. population lives in rural areas, but only 11% of physicians practice there.
  (Rosenblatt RA, Chen FM, Lishner DM, Doescher MP. The Future of Family Medicine and Implications for Rural Primary Care Physician Supply. Seattle: WWAMI Rural Health Center, August 2010)

- The number of doctors per 10,000 residents is 13.1 in rural areas and 31.2 in urban environments. For specialists, the ratios are 30 per 100,000 residents in rural areas, 263 per 100,000 in urban.
  (https://hitconsultant.net/2017/01/11/37113/#.XP_bbC2ZP6I)

- Student loan forgiveness and assistance programs can be effective — 52% of National Health Service Corps (NHSC) participants practice in rural areas remain there for up to 15 years after meeting their commitment.
  (National Rural Hospital Association)

- 50% of physician assistants practice in rural areas.
  (AAPA National Physician Assistant Census Report)

- Regulations prevent PAs from certifying the need for home care and hospice, and prevent them from receiving direct payment for their Medicare patients.
  (AHA report: "Challenges Facing Rural Communities and the Roadmap to Ensure Local Access to High-quality, Affordable Care")

- The payment restriction is considered a major barrier to expanding mental health coverage in rural areas, where approximately 14,000 physician assistants provide routine mental health services to patients.
  (National Rural Hospital Association)



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Additional Resources

www.aha.org/workforce

is the American Hospital Association's hub for workforce-related resources. It includes relevant news, reports and white papers, links to upcoming conferences and webinars and archives of past events, case studies and a variety of resources for workforce development.



The AHA has multiple divisions that address workforce issues:

AHA Physician Alliance
(https://www.aha.org/aha-physician-alliance)

American Organization for Nursing Leadership
(https://www.aonl.org)

American Society for Health Care Human Resources Administration
(https://www.ashhra.org)



American Society for Health Care Risk Management
(https://www.ashrm.org)

Institute for Diversity and Health Equity
(http://www.diversityconnection.org)

Association for Health Care Volunteer Resource Professionals
(https://www.ahvrp.org)

Talent Scan
Ask the Experts

ELISA ARESPACOCHAGA,
Vice President, AHA Physician Alliance, American Hospital Association

What are the factors associated with burnout and how do they manifest on the job for physicians? What are the most common causes?

Burnout is a cultural phenomenon, and while personal resilience is a component, we know that the clinical environment, health system culture and broader regulatory factors are key drivers. Health care's shifts — from fee-for-service to value-based care, to the shifting payment landscape, to new structures — are providing unstable footing for physicians navigating the current waters. At the same time, regulatory and administrative burdens on clinicians and hospitals continue to trend upwards, all in a milieu where everyone is doing more.

With regard to the physician administrative duties and/or time spent on electronic health records plus other demands, what can hospitals do to offset resulting clinician burnout?

Physicians work hard, long hours and go the extra mile. But when those extra hours are spent doing data entry or other work they don't see connected to providing care for their patients, and when they are spending nearly half their day in the medical record system, they feel disconnected from their purpose and passion. Hospitals and health systems have worked with clinicians to address the burden of electronic health records in myriad ways, including careful review of data captured, shifting information entry to the team, hiring scribes, offering rapid response technology help and having physician coaches share their tips and tricks for navigating.

ROBYN BEGLEY,
Senior Vice President and Chief Nursing Officer, American Hospital Association and CEO, American Organization for Nursing Leadership

What changes to nursing roles would be most effective for mitigating the nursing shortage?

Nursing is one of the most innovative health care professions. By allowing nurses to work to the full scope of their education and training, coupled with expanding the nursing compact nationwide, we can work to mitigate the workforce shortage.

A national strategy should also include increasing federal funding to nursing workforce development programs and redesigning clinical roles to allow experienced nurses nearing retirement to remain in the work environment through full- or part-time employment opportunities.

Nursing schools denied admission to more than 64,000 qualified applicants in 2016 and 2017 because of faculty shortages and other institutional limitations. Are there any other realistic paths to the profession?

Nurse educators' wages simply have not kept up with those of nurses in the clinical setting over time. An experienced nurse educator, who holds, at a minimum, a master's degree, might command the same salary as an entry-level nurse. We need to pay faculty more. In my time as a nurse leader, many nurses have expressed to me that they would love to pursue advanced degrees and then teach — if they only could afford the pay cut. This especially affects nurses with student loans.

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Thinking creatively, we need to look at nontraditional sites for student clinical placements. For example, nurses studying pediatrics could do their clinical practicums in a primary care setting instead of an acute care unit.

The corpsmen/military medics are an untapped resource for the nursing profession. These are highly trained and experienced individuals who may graduate from a nursing program at an accelerated pace and transition into the civilian workforce.

Are there effective team structures, workflows or team-based care models that optimize nurse-physician roles or relationships?

Hospitals and health systems are incorporating technology and interprofessional team-care models, such as a hospitalist physician, pharmacist, nurse, respiratory therapist and support staff, to ensure quality and optimal patient outcomes.



JAY BHATT,
Senior Vice President and Chief Medical Officer, American Hospital Association and President, Health Research and Educational Trust

What are the most significant ways physician roles are changing, and what can hospitals do to help physicians adapt in the current environment?

As health care delivery continues to evolve, so must the teams and the ways in which we practice. Physicians are being asked to transform the clinical enterprise in partnership with administrative leaders, lead teams in providing care, and connect with their patients in new and different ways. All of these changes require building skills and a culture of teamwork, safety and support. Hospitals also must work to ensure that there are both training and support to employ key technological advancements (for example, telehealth) and provide the opportunity to create innovative approaches to deliver the care that matters most to patients.

Through the AHA you are exposed to a number of national, regional and local programs and initiatives to address workforce shortages, particularly in the physician ranks. What are you seeing that may prove a promising approach to physician shortfalls?

Workforce shortages are an ongoing challenge in a field where fundamentally we are people taking care of people. Throughout my travels around the country, I do see many organizations that are employing creative ways to address these challenges, including team-based care delivery, reducing barriers for advanced practice providers to support their communities, renewed efforts to create local graduate medical education opportunities and a strong movement throughout health care to help clinicians rediscover their joy and purpose in providing care by reducing administrative burden.

Do you think the physician talent shortage hospitals face is getting better or worse, and why?

The physician shortage issue is a complex one, with challenges by specialty, by geography and by demographic. As our largest generation continues to age, additional demands for access will stress our health care system. We need to pay particular attention to not only ensuring an appropriate pipeline of physicians, but to new models of care whereby we can ensure that even our most vulnerable communities have access. We also need to make it easier to help physicians do what they are trained to do, continue to advance regulatory relief, and encourage more physicians to pursue careers in more vulnerable communities across America.



SARAH FREDRICKSON, M.A., CHHR,
Director, Human Resources, Mayo Clinic

Realistically, how much can hospitals do to mitigate talent shortages, and how much needs fundamental, coordinated large-scale effort, such as overhauling medical education to attract more students and make it more affordable?

Given the perfect tsunami of an aging workforce and aging patients demanding increasing services, health care organizations need to be at the table of secondary and post-secondary education reform. This includes the need to drive career awareness programming and career training into secondary education. Early talent pipelining is one essential strategy to address the talent shortage. Health care organizations need to encourage educators to provide learners with more nontraditional (e.g., evenings, weekends, online) post-secondary education options. Greater flexibility and options will provide more opportunity for individuals to enter into the talent pipeline.



JOY LEWIS,
Vice President, Strategic Policy Planning,
American Hospital Association

From your perspective, what changes would be most helpful for mitigating the health care talent shortage?

First, we would put forward the concept that we should reframe the discussion around shortages. As a sector, it is worth evaluating how we deliver services and distribute our workforce. There may be a mismatch between where services are needed and how we deliver them. If we frame the challenge in this way, we may still have shortages, but they might be less severe and other solutions may mitigate them.

The second consideration is the use of robotic process automation (RPA) and other technology such as artificial intelligence (AI) to alleviate administrative burdens and address staff burnout. These technologies can help staff practice at the top of their licenses, and remove routine tasks from their workload. RPA and AI can also be applied in nonclinical workflows in areas including finance, revenue cycle management and human resources.

Addressing shortages requires that the sector identifies the care delivery tasks that need to be completed, and matches those tasks with the segment of workforce that has the most appropriate skill set. Through this approach staff will be better able to practice at the top of their license, and the sector may identify future workforce training and education needs.

Can we eliminate the health care workforce talent gap without large federal policy changes, for example, to make medical education more accessible, or to reduce state-by-state licensure limitations, or to expand reimbursement to more types of care and providers?

Strategies that can be deployed at a smaller scale can also be used at the federal level to make a more substantive impact on the health care workforce. Following are a few approaches:

- Hospitals and health systems can partner with academia to create better alignment between education curriculum and the needs of the workforce.
- Hospital and health systems can identify the tasks in care delivery that can feasibly and safely be provided by other types of providers, such as community health workers, peer supports, medical assistants and certified nurse midwives.
- To address scope of practice limitations in the long term, hospitals and health systems should consider continuing to expand and advocate for team-based care models that promote cross-functional teams. As this approach to care expands, it will build buy-in across disciplines and professions for scope of practice reform.

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Health Care Workforce
Overview

A by-the-numbers look at the state of health care hiring, and how supply and demand vary across markets.



154 million

TOTAL JOB CANDIDATES IN THE US



13.59%

OF TOTAL JOB CANDIDATES ARE IN HEALTH CARE



30

THE NUMBER OF CANDIDATES PER HEALTH CARE JOB OPENING



29 DAYS

HOW LONG THE AVERAGE HEALTH CARE OPENING LASTS BEFORE BEING FILLED

Markets where it is easiest to fill positions

Toledo, Ohio
Cleveland-Elyria, Ohio
Weirton-Steubenville, W.Va.
Salem, Ohio
Akron, Ohio

Markets where it is hardest to fill positions

Big Stone Gap, Va.
Olympia-Tumwater, Wash.
Medford, Ore.
Wisconsin Rapids-Marshfield, Wis.
Hermiston-Pendleton, Ore.

POSITION SNAPSHOT: Registered Nurse

2,804,000 # candidates

10 # candidates per job opening

28 # days – average job posting duration

Markets where it is easiest to fill positions

Cleveland-Elyria, Ohio
Salem, Ohio
Ionia, Mich.
Jackson, Ohio
Tuscaloosa, Ala.

Markets where it is hardest to fill positions

Hermiston-Pendleton, Ore.
Boise City, Idaho
Medford, Ore.
Albany, Ore.
Olympia-Tumwater, Wash.

POSITION SNAPSHOT: Family and General Physicians

133,000 # candidates

3 # candidates per job opening

32 # days – average job posting duration

Markets where it is easiest to fill positions

Oklahoma City, Okla.
Grand Rapids-Wyoming, Mich.
Lafayette, La.
Miami-Fort Lauderdale-West Palm Beach, Fla.
Spartanburg, S.C.

Markets where it is hardest to fill positions

Syracuse, N.Y.
Hermiston-Pendleton, Ore.
Olympia-Tumwater, Wash.
Providence-Warwick, R.I.
Corpus Christi, Texas

Footnote:

1 – CEB TalentNeuronTM, Gartner, Inc. www.data accessed October 29, 2019

1.1 – Occupational Supply is the total estimated Employable workforce available for the job position entered based on the Occupational Employment Survey of the Bureau of Labor Statistics and the Talent Neuron database factoring in Monthly employment rates, Location, Function, Occupation, Industry and Keywords.

1.2 – Candidates per Job Opening is the relative rate which compares the available potential candidates with the total number of job openings nationally. This shows how much demand pressure a recruiter is likely to feel in terms of filling this role nationally.

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