Solutions to a National Crisis

by Lee E. Mortenson, D.P.A.

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The health care industry, and oncology in particular, is facing a significant workforce shortage that is expected to continue for the next 10 to 20 years. The shortage of nurses, pharmacists, imaging technicians, and radiation therapists, among others, has become hospitals' number one concern, superseding financial reimbursement, which was rated most important over the last eight years, according to a 2001 workforce survey commissioned by the American Hospital Association (AHA). Hospital vacancy rates for nurses, pharmacists, and imaging technicians are currently well over the 10 percent mark (see Table 1).

Today nearly 35 million people are over the age of 65, and by the year 2030 that number is expected to reach 70 million. With more people vulnerable to cancer and more cancer patients surviving to older ages, the demand for health care providers—and oncology nurses in particular—will increase.

Hospital workforce shortages affect both urban and rural areas across all regions of the United States, and also exist outside of the country. Historically, the United States has been able to turn to other nations—most often Canada—to fill vacant health care positions. Today that practice is looked on with disfavor by countries experiencing the same global workforce shortages as the United States.

"The health care worker shortage is a snowball that we never can get in front of. We should have started addressing the problem 15 years ago," notes Joyce E. Johnson, R.N., F.A.A.N., D.N.Sc., senior vice president of hospital operations at Georgetown University Hospital in Washington, D.C.

Increasingly, Johnson and other hospital administrators are expressing frustration with staffing shortages, which contribute to lower staff morale. More than one-third of the hospitals responding to AHA's 2001 workforce survey reported increased patient complaints or decreased patient satisfaction because of staffing shortages.

Table 1: Top Hospital Vacancy Rates

Position	Mean Vacancy Rates
Imaging technicians	15.3%
Registered nurses	13.0%
Licensed practical nurses	12.9%
Pharmacists	12.7%
Nursing assistants	12.0%
Laboratory technicians	9.5%
Billers/Coders	8.5%
IT technologies	5.7%
Housekeeping/Maintenance	5.3%

Source: American Hospital Association

Outlook for the Future

Solutions to address current and future health care workforce shortages are being developed and implemented in both the public and private sectors. The AHA, the Oncology Nursing Society (ONS), the American Registry of Radiologic Technologists (ARRT), and other health care organizations have conducted studies to assess the growing workforce shortage, the impact of the workforce shortage on the delivery of care, and possible solutions. ACCC is planning a Center for Workforce Shortages, and other health care organizations are seeking legislative solutions and collaborative partnerships, as well as international cooperation.

Hospital administrators faced with workforce shortages should:

- *Understand the work cohort.* Today's workforce consists of men and women from four generations—veterans, baby boomers, generation X, and generation Y. Each has unique expectations, needs, habits, and work ethics that need to be considered when creating a balanced and optimized workforce.
- *Conduct internal risk assessments.* Research the average age of staff, years of service, age distribution by specialty, and staffing projections for future years to create an overall forecast at the institutional and departmental levels.
- *Customize the recruitment/retention strategies.* Professional development must be a high priority. Merit, recognition, and compensation awards, such as sign-on bonuses and salaries based on performance, also need to be considered.

Earlier this year, the AHA Commission on Workforce for Hospitals and Health Systems released a report entitled "In Our Hands: How Hospital Leaders Can Build a Thriving Workplace." The report concludes that a new approach to hospital work is needed. "Workers and managers must come together from all levels and from all departments of the organization to design fresh approaches to today's job requirements. Retention and recruitment efforts will not succeed in the long-term unless workers have responsibilities that result in meaningful work." OI

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Nurses

by Joyce E. Johnson, D.N.Sc., R.N., F.A.A.N.

PHOTOGRAPH/PICTURE QUEST

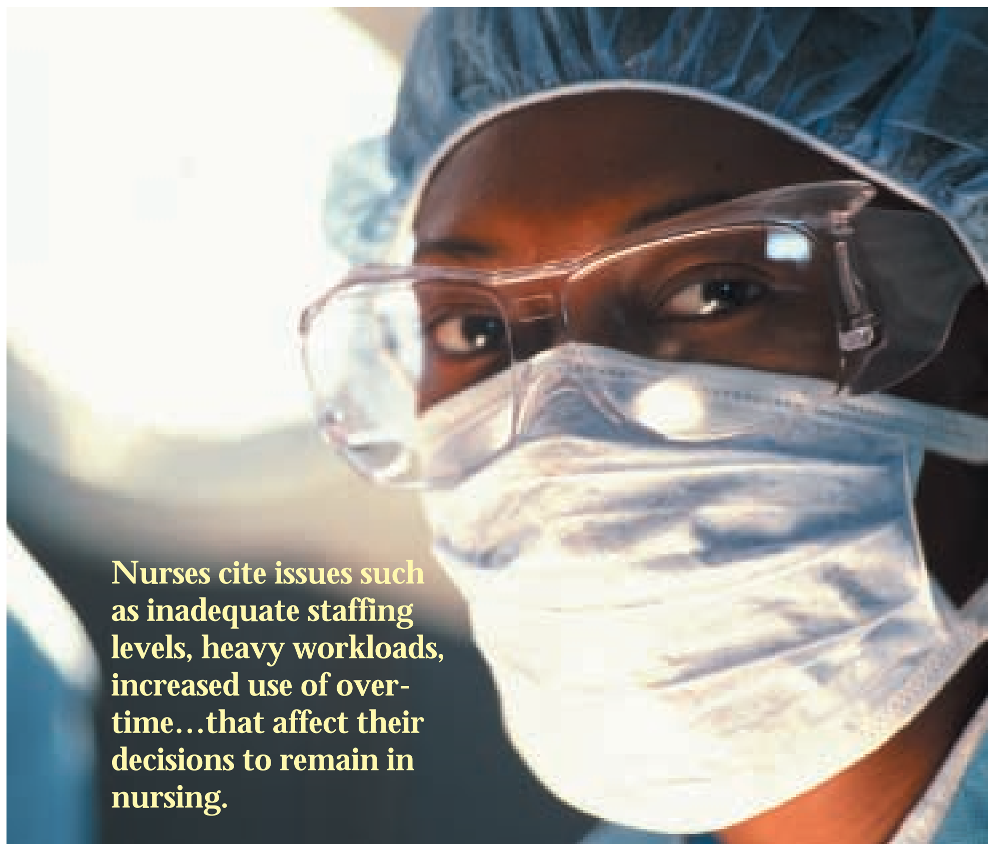
Hospitals and community cancer centers are both struggling with a serious and recurring question in the health care industry today: Who will care for our patients? Difficulties finding registered nurses (R.N.s) with oncology experience were reported by the majority of nurses and oncologists responding to a 2000 study done by the Oncology Nursing Society (ONS).[1]

R.N.s comprise the largest segment of health care professionals in the United States. Current data indicate that the nearly 2 million full-time nurses in the workforce represent the largest group of nurses in the nation's history. Still, vacancy rates for R.N.s range from 14.6 percent for critical care to 6.5 percent for nurse managers.[2] The national turnover rate was 21.3 percent in 2000, and predictions are that the demand for nurses will exceed the supply in the year 2020 by 20 percent, or well over 400,000 nurses.[3,4]

To fill vacant nursing positions, hospitals are forced to offer expensive sign-on bonuses and use agency or "traveling" nurses (usually defined as nurses who travel to find employment because of a lack of opportunities in their local areas). In a time of budgetary constraints and shrinking reimbursement, both of these propositions are costly for the hospital's bottom line.

Fifty-six percent of hospitals use agency nurses, and 41 percent of hospitals use sign-on bonuses that sometimes go as high as $10,000 or more.[3] While agency or traveling nurses can fill vacancies, they often are not familiar with hospital policies, protocols, and standards, placing additional burdens on already overworked nursing staffs.

Nurses cite issues such as inadequate staffing levels, heavy workloads, increased use of overtime, lack of sufficient support staff, and inadequate wages as work environment problems that affect their decisions to remain in nursing.[5]



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Factors Behind the Shortage

Although cyclical shortages of nurses have occurred in the past, opinion leaders and extensive research findings suggest that today's current nursing shortage in the U.S. is different and far more alarming.

Nursing schools are facing fewer admissions and faculty shortages. According to the American Hospital Association (AHA), the number of nursing school graduates dropped from 23,946 in 1996 to 19,326 in 2000, a 20 percent decline. Although, a 4 percent increase in B.S.N. graduates was reported in 2001, the concern is that many of these individuals will not work as R.N.s, but move into other careers.

Nurses don't need to stay at the bedside anymore. Some are choosing careers in nonhospital settings or choosing to be nurse practitioners or advanced nurse

Learning from the Success of Magnet Hospitals

Research has shown that the recruitment and retention of nurses are heavily influenced by three organizational areas (the institution's practice, management, and governance philosophy and methods), as well as the ability of professionals to control their destiny within the institution where they are employed.[7]

Community cancer centers can use a number of strategies to ensure a fully skilled nursing workforce (see box on page 27). In addition to these techniques is what many consider the most effective, simple nursing recruitment strategy of all: offering nurses the opportunity to be part of a community-based care culture in which respect, collaboration, and involvement are paramount and competitive wages are not the defining factor for job satisfaction.

Such cultures exist today in "magnet hospitals," where the culture of the organization, not wages, is the major attraction,[8] and can be seen in community cancer centers as well.

More than 20 years ago, a study conducted by the American Academy of Nursing[9] identified hospitals that could attract and retain nurses as "magnet" hospitals. The unique features of these hospitals included a flat organizational structure, unit-based decision making, influential nurse executives, and investment in the education and expertise of nurses.[10] Based on these insights, the study recommended a number of solutions for the nursing shortage that are especially relevant today:

- A philosophy of caring from top management that pervades the patient care environment
- Leaders who are visible and accessible
- Participatory management with practicing nurses engaged in decision making at the unit, departmental, and hospital levels
- Facilities that contribute to better care for patients
- Directors that interact frequently with nursing staff one-on-one
- Extensive involvement of nurses in planning new services and selecting technology
- Quality assurance programs that identify and resolve problem situations
- Nursing administration that recognizes the autonomy of the professional nurse
- Leadership that encourages nurses to continuously develop.

This type of caring culture can attract highly qualified staff even during times of great competition. A new 70-bed hospital with "healing interiors" attracted 3,800 resumes for 415 staff positions in St. Paul, Minn.[8] In Birmingham, Ala., plans exist to build a "digital hospital" in which charting time would be reduced by 50 percent. Follow-up studies, which compared magnet versus nonmagnet hospitals,[10] showed that magnet hospital nurses suffered less burnout, their patients enjoyed better care, and patient length of stay and time in intensive care were reduced. Hospital leaders also reported that the distinction of being a magnet hospital served as a powerful nursing recruitment strategy.

In the midst of all the complicated analyses of the nursing shortage, magnet hospitals communicate a powerful message that may have been forgotten. Community cancer centers can build a niche in the nursing market by simply giving nurses what they want—patient-centered care in an atmosphere in which nurses are listened to, in which they work for and with people who care, and in which they can learn and be part of a team.

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executives, positions that offer a chance to move up the administrative ladder. In 1970, 90 percent of R.N.s worked in hospitals compared to 59 percent in 2000.

Aging is another factor in this workforce shortage. The current median age of R.N.s is 45.5, and one half of the 1.9 million R.N. workforce will reach retirement age in the next 15 years. The upside is that the average age of new graduates from nursing school is 31 and represents more than one generation of workers.

Many nurses believe that the public perception of the nursing profession is not as high as in the past. Leaders in the nursing profession agree that the public must realize that nursing is meaningful work. Most importantly, nurses themselves need to encourage others to enter the profession rather than discourage them by telling them how hard the work is.

Rising Concerns for Patients and Providers

Many in the health care system are beginning to question whether it will be possible to deliver quality patient care *and* stay afloat financially in the future.

Personnel challenges have caused health care facilities to decrease services, close entire units, delay surgeries, and lose revenue that is badly needed to offset the pay incentives used to retain staff. A study[4] by the American Association of Nurse Executives (AONE) reported that the impact of the shortage was "substantial" in terms of:

- Higher costs to deliver care (69 percent)
- Emergency room overcrowding (51 percent)
- Diversions for more than four hours a week (26 percent)
- Closing beds (25 percent)
- Increased waiting time for surgeries (11 percent)
- Reduced or eliminated services (6 percent).

These challenges have sparked mandatory overtime policies and have weakened both consumer confidence in the health care system and staff satisfaction.

Government Intervention

Since market forces in the private sector have not yet succeeded in bringing the supply and demand for nurses into

continued on page 28

6 Search-Find-Keep Strategies for Nurse Recruitment and Retention

Concerned about nurse recruitment and retention at your patient care center? Organizations seeking a fast "silver bullet" solution to the nursing shortage will undoubtedly be frustrated because the nursing shortage is a complex phenomenon with many contributing factors. The practical reality is that a series of small, proactive decisions need to be addressed by the leaders of health care organizations. The dozens of small decisions made each day can really make a difference to complicated challenges in health care institutions.[10]

Here are six strategies that can help you find and retain qualified registered nurses.

1 Sweeten the local signing bonus. This first-line approach is a contemporary version of the old standard "carrot and stick" theory. Recruitment success can be improved by simply offering a different, better, and bigger reward for signing on as a new nurse with an organization. Although some competitors and critics call this age-old approach "short sighted," it does work.

In St. Paul, Minn., Regions Hospital was successful earlier this year in recruiting 60 new local nurses by offering $10,000 sign-on bonuses and/or offering to pay any outstanding student loans.[11] In addition, some hospitals are offering relocation payments for new nursing recruits and employee incentive bonuses for those employees who refer new hires.

2 Expand recruitment efforts into other American cities. When the local supply of nurses runs dry, expand recruitment campaigns to other regional locales outside of traditional recruiting areas. This strategy of "raiding the competition" can trigger some ill will among other organizations within the region, but it works.

The Minnesota Fairview Health System—with seven hospitals in the Twin Cities—has recently extended its nurse recruitment campaign to 10 other cities in Iowa and Oklahoma where the nursing salaries are typically lower than in Minnesota. Nurses who were making $14-$18 per hour in Tulsa, Okla., can move to Minnesota and increase their earning power to $22-$32 per hour.[11]

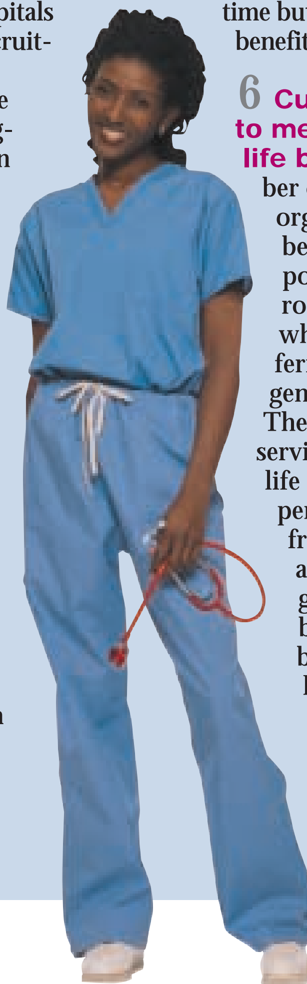
3 Go global (again). When feeling relentless recruitment pressures, try reactivating attempts to recruit registered nurses from other countries. Historically, in times of shortages, the American nursing community has looked to countries such as Canada, Ireland, and the Philippines for fresh supplies of nurses, who were attracted to the higher pay and greater opportunities offered in the U.S. The current pressures of limited supply and greater demand for nurses have again stimulated U.S. hospitals to go global with their recruitment efforts.

Minnesota hospitals are currently involved in long-term recruitment efforts in both Canada and the Philippines, where nurses who agree to immigrate to the U.S. receive financial and administrative support with the immigration process in exchange for a multiple-year work commitment.

4 Revisit the professional development "package" offered to registered nurses. Given the laws of supply and demand, nurses today are in a commanding position to choose the employer that offers them the best employment package. Now may be the time to improve professional development offerings. Consider enhancing the following benefits: the type and flexibility of tuition reimbursement, the quality of employee orientation, the availability of funds for nursing research, e-learning opportunities, funding for certification exams in nursing specialties, clearly defined clinical ladders, and approaches for differentiating types of clinical practice.

5 Take a hard look at scheduling. Another part of the employment package that new nurses look for is a variety of scheduling options. Today, nurses resist the old norms of rotating shift work in health care and instead seek more flexible scheduling options. These options might include four-day workweeks, weekend options, straight shifts, unit float pools, unit self-scheduling, and in-house nurse registries. An increasing and popular option is working less than full time but receiving full-time benefits.

6 Customize benefits to meet greater work-life balance. Join a number of other health care organizations that have begun providing support services or "environmental satisfiers," which align with the differing values of the new generation of nurses. These concierge-type services, which can make life a bit easier for nursing personnel, run the gamut from on-site childcare and elder care programs to dry cleaners, beauty salons, foot and back massages, and lawn care. Free, convenient, and safe parking as well as loan assistance and respite transfers might also be included. ¶



PHOTOGRAPH/COMSTOCK

better balance, government action appears to be necessary. In 2002 the government addressed this issue and both houses of Congress passed legislation related to the nursing shortage.

The Nurse Reinvestment Act (H.R. 3487) of the House expanded the Nurse Education Loan Repayment Program to include scholarships for nurses who agree to work in health care organizations that have a critical shortage of nurses. This bill was especially relevant to community cancer centers because the definition of the nursing shortage was expanded to include hospitals, home health agencies, community health centers, and skilled nursing facilities. Also included in the bill was authorization for the funding of public service announcements that focus on the advantages and rewards of nursing.

The Senate version of the bill established a National Commission on the Recruitment and Retention of Nurses and the National Nurse Corps Scholarship Program to provide nursing education scholarships in exchange for service in critical nursing shortage areas. Also included were grants for masters and doctoral education for nurses, nursing training in long-term care, and a fast-track loan program for nurses.

On July 22, 2002, both the House and the Senate approved the Nurse Reinvestment Act. President Bush moved quickly, signing the bill into law on Aug. 1, 2002. The legislation does the following:

- Launches a campaign of public service announcements to promote the nursing profession
- Offers scholarships for nursing students who agree, upon graduation, to work for a period of time in a facility facing a critical shortage of nurses
- Cancels student loans for nurses who seek advanced degrees and agree to join the faculties of nursing schools
- Provides nursing schools with special grants to train nurses in geriatric care
- Includes strategies to attack the burn-out and frustration that are driving many people out of nursing
- Provides grants to hospitals and other medical facilities that are willing to offer career incentives to nurses to advance in their field
- Authorizes (but does not fund) “magnet” facilities, where nursing staff members are given larger supervisory roles. Such “magnet” facilities retain nurses an average of more than eight years, twice as long as hospitals without such programs.

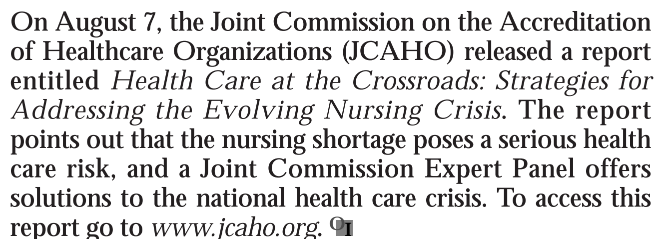
Now that the nursing bill has become law, many hope that the congressional appropriations committees will substantially boost the current annual $93 million earmarked for nursing education money year by year .

Options for the Future

According to the AONE, if the root causes of the nursing shortage are not addressed, the “profession will continue toward a shortage of unmatched proportions—one in which nurses will simply not be available to support the patient care needs of the nation.”[6]

Options for stabilizing the workforce and making nursing more desirable as a career include:[6]

- Increasing the supply of nurses through dynamic recruitment into the profession
- Providing additional educational resources and funding to prepare nurses for today’s increasingly complex clinical setting
- Retaining currently employed nurses by changing the work environment



- Demonstrating the value of nurses’ contribution to the quality of health care to other members of the health care team, administration, and the general public
- Using nurses with higher levels of training appropriately and providing salaries commensurate with their skills so more nurses will want to advance in the field and more health care providers will create opportunities for them to do so.

On August 7, the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) released a report entitled *Health Care at the Crossroads: Strategies for Addressing the Evolving Nursing Crisis*. The report points out that the nursing shortage poses a serious health care risk, and a Joint Commission Expert Panel offers solutions to the national health care crisis. To access this report go to *www.jcaho.org*.

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Medical Oncologists

by Timothy Lary

Today more job openings exist in medical oncology than physicians seeking positions. With an aging population and medical oncology training programs less than full, the trend doesn't seem to be headed in the right direction. In 10 years, only about half the needed oncologists will be available, according to the *Physician Compensation and Production Survey: 2002 Report Based on 2001 Data*, which is co-published by the Medical Group Management Association (MGMA).

With 5,200 practicing medical oncologists dedicated to patient care and about 300 graduating fellows entering the full-time practice of medicine each year, about 5,500 medical oncologists are available to treat those diagnosed with cancer in the U.S. Assuming that 8 percent or more (416) of practicing physicians will retire or die each year, even with 300 graduating fellows, a net loss of more than 100 practicing oncologists will occur every year.

To further complicate the issue, in any given year more than 7 percent of practicing physicians will relocate. Physician relocation exacerbates the workforce shortage because, invariably, physicians tend to relocate to more desirable areas, often leaving the less popular areas with perilous shortages.

In addition to a declining work force and isolated shortages, the increased demand for medical oncologists has driven up the salaries of those seeking new positions. In the past six years, for example, US Oncology (USON) has added more than 390 physicians to its affiliated network of physician-owned practices. During that time, salaries have increased by more than 53 percent, and sign-on bonuses, which are also growing in size, have become the norm at USON.

Oncology is one of the high-demand specialties experiencing significant inflation in pay levels for both new recruits and experienced physicians. Compensation for oncologists, specifically, increased at a steady rate of approximately 35 percent over the last five years. While the 2002 survey reports a slight increase in compensation, these data represent 2001 and do not reflect the impact of the 5.4 percent average reduction in Medicare reimbursements that went into effect on Jan. 1, 2002. The combination of this reduction and the recent industry-wide increases in medical liability premiums and drug costs will lead medical groups to experience a far different compensation and production landscape in 2002, predicts the MGMA.

The influx of more part-time physicians into the field of oncology and the greater number of women entering health care are further confusing the issue of compensation. (Currently the number of women entering medical school outnumbers the men.) Part-time medical practice has become a viable alternative to full-time practice, and the number of part-time physicians is expected to increase.

The changes in the characteristics and distribution of medical oncology staffing in the U.S. will continue to create new challenges for the profession's physician and administrative leadership for quite some time. As in any industry, the groups and individuals that stay abreast of changes, adapt to the market, and seek new and creative ways to differentiate themselves from their competition will be the most successful.

Timothy Lary is the associate director of physician recruitment for US Oncology, a network of 9,000 physicians, clinicians, and support staff. He has been involved in the recruitment of physicians for more than 10 years.

In 10 years only about half the needed oncologists will be available…

PHOTOGRAPH/COMSTOCK

Radiation Therapists

by Rebecca Schuster, M.H.A., M.B.A., R.T. (T)

About 60 percent of patients who are diagnosed with cancer will receive radiation therapy at some point during their disease process. Even so, the nation's health care system is confronting a significant shortage of radiation therapists. The Bureau of Labor Statistics reported 12,000 practicing radiation therapists in 1998, and estimates that an additional 4,000 will be needed by 2008. This workforce shortfall must be resolved to meet the growing cancer care needs of an increasingly aging population.

At the same time the nation is experiencing a shortage of trained radiation therapists, the number of radiation oncology facilities has increased. In 1999 there were 1,860 radiation oncology facilities nationwide, an 11 percent increase since 1996, according to The Technology Marketing Group, Inc. The growth in the number of facilities has been primarily driven by the increasing number of freestanding centers.

The American Registry of Radiologic Technologists (ARRT) reported a record-breaking 1,000 first-time radiation therapy examinees in 1994, followed by a steady six-year decline, with the lowest number of first-time examinees (389) reported in 1999. Although that figure climbed to 579 in 2000 and 600 in 2001, this number is still far too small to meet the nation's needs.

The number of graduates in radiation therapy dropped 40 percent between 1997 and 1998 and continued to decline in 1999, according to the Joint Review Committee on Education in Radiologic Technology (JRCERT). The number slightly increased to 403 in 2000 and 434 in 2001, but remains too small. At the same time, the number of approved radiation therapy training programs has decreased to just 70 in 2002 from a high of 107 approved programs in 1996. In January 2002, 30 certificate programs, 18 associate degree programs, and 22 baccalaureate programs were available. A number of these programs have closed due to limited interest and enrollment.

Work-related burnout is one contributing factor to the workforce shortage of radiation therapists.[1,2] Burnout is exacerbated by both problems with working conditions and the fact that around 50 percent of patients who receive radiation therapy for cancer die of their disease. Attrition in the workforce has also contributed to the staffing shortage.

PHOTOGRAPH/COMSTOCK

In 1997, the American Society of Radiologic Technologists (ASRT) funded a study to review the employment plans of radiation therapists between 1998 and 2002. The findings showed that 7 percent of the respondents planned to retire or leave the workforce during the next four years. Another 27 percent of the respondents anticipated leaving the workforce before the year 2002 for other reasons. A career change was the number one reason listed for leaving the profession. Uncertainty about employment in health care, caused by the number of mergers, downsizing, and restructuring of institutions that took place during the 1990s, was also given as a reason for leaving the profession. Raising a family was listed as another alternative to pursuing a career.

Hospital-based radiation therapy programs generally operate on a narrow profit margin. The combination of increased costs and decreased reimbursement has reduced, and in some cases eliminated, the profit margin in radiation therapy. JRCERT's 2000 Annual Report points out that 1994 was the last year that radiation therapy programs, on average, made a profit. Radiation therapy programs have experienced financial losses each succeeding year, with the greatest net loss of 15 percent reported in 1998. This downward trend appears to have reversed in 2000 with a net financial loss of only 10 percent, but because of these losses, purchasing new equipment or upgrading to the latest technology in order to improve patient outcomes may be more of a struggle for the community hospital. Radiation therapy program directors have faced increasing difficulties justifying their programs to hospital administrators since they cannot show a positive financial contribution to the institution's operating margin.

A Question of Degree

In the early 1990s, the ASRT passed a resolution requiring a baccalaureate degree for entry into radiation therapy beginning in the year 2000. Soon after, many hospital-based programs closed voluntarily because they could not meet the "perceived" requirements.

Before the ASRT resolution can be implemented, the ARRT and/or the JRCERT must

mandate the baccalaureate degree requirement. To date, neither organization has taken any such action, although the ARRT is currently studying the issue. The ARRT has not yet required a baccalaureate degree before students can take the radiation therapy examination, and the JRCERT has not yet required the baccalaureate degree for program accreditation.

Although supporters of the baccalaureate requirement point to studies showing that baccalaureate students have improved problem-solving and critical-thinking skills, others maintain that a baccalaureate requirement is not necessary and might even lead to the elimination of the associate degree and certificate programs, severely reducing the number of candidates entering radiation therapy.

How to Alleviate the Staffing Shortfall

The health industry can begin to increase the number of available radiation therapists in the workforce by promoting the radiation oncology profession, beginning at the high school level by participating in career day events. Since positive clinical experiences often translate into future employees, high school students with an interest in math and sciences should be invited to tour radiology departments and be given application forms to area radiation oncology programs. Hospitals should ask their radiology program director about the possibility of integrating a two- or three-week introduction to radiation oncology for high school students.

Hospitals should also affiliate with a local or regional university or college and become a clinical site for radiation oncology students in order to "grow their own." If a hospital is already a clinical site for an area radiology program, the hospital should initiate student rotations through the radiation oncology department. Many staff therapists are rewarded by acting as student clinical coordinators or becoming guest lecturers or course instructors for the radiation oncology program at local educational institutions.

Although salaries have skyrocketed over the past few years, therapists continue to leave the field because of factors other than money. Administrators dealing with a shortage of radiation therapists should identify whether the shortage is a result of job burnout and, if so, develop ways to reverse the trend. A positive work environment remains the most critical factor to successful retention. Radiation oncology departments are multidisciplinary teams that include everyone in the division—from physicians to patient registration personnel. Respect for one another must be the number one value espoused by all members of the team to maintain a positive work environment.

Another retention suggestion is offering continuing education units (CEUs) at the facility so therapists won't have to spend as much time away from family or personal activities to obtain the required CEU credit hours for continued licensure or certification.

Instituting flexible work hours as staffing and patient volume permit is another good idea. Options include working four 10-hour days, working a 40-hour pay period in nine days rather than 10, or job sharing between therapists. Annual retention bonuses for full-time employees are also useful.

New Solutions Being Developed

The Society of Radiation Oncology Administrators (SROA), the American College of Radiology (ACR), the American Society for Therapeutic Radiology and Oncology (ASTRO), the American Association of Physicists in Medicine (AAPM), and the ASRT have formed a consortium to tackle the recruitment problem and devise better solutions to the workforce shortage.

One step in reversing the workforce shortage is a recruitment-focused web site. The ASRT is developing a *Recruitment and Retention Tool Kit* accessible via the Internet at www.asrt.org. Featured topics will include human resource information, institutional support for radiation therapy education programs, regulatory and demographic information, workforce distribution information, and technology and patient education.

These resources will help educate, recruit, and market radiation therapists locally. Working together, step by step, community by community, this burdensome workforce shortage of radiation therapists can be reduced, if not eliminated. Some positive results have already been noticed. Enrollment in radiation oncology programs in 2001 was up 22.3 percent from 2000. This improvement is based, in part, on the cohesive recruitment efforts made by the professional organizations listed above, but professionals in the field must also promote radiation oncology within their local communities.

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Health Information Technicians

by Bob Garrie, M.P.A., R.H.I.A.

The current shortage of medical records personnel is not surprising. The field has virtually transformed itself in the last two decades, and people entering health information technology today must have skills unheard of in the 1970s.

Twenty-five years ago, medical records personnel were thought of as clerical workers. Now called health information technicians (HITs), they are responsible for coding all the entries in medical records and performing tasks related to the use, analysis, validation, presentation, abstracting, storage, security, retrieval, quality measurement, and control of health care data, regardless of the physical medium in which the information is maintained.

In addition to being computer literate and meticulously detail-oriented, HITs must have a thorough knowledge of anatomy, physiology, pharmacology, medical terminology, the ICD-9 codes for diagnosis, the CPT/HCPCS codes for procedures and drugs, and be aware of the HIPAA regulations and state laws on confidentiality and privacy.

Today coding equals dollars. An error made 25 years ago was just a clerical problem. The same error today can cost an institution money. In addition to being tied to reimbursement, the number of codes has increased and become much more complex and specific because government and insurance payers want more detailed information about why patients seek medical treatment.

According to American Health Information Management Association (AHIMA) statistics, approximately 50 percent of medical records personnel work in hospitals. The other half work in a variety of health care settings, including doctors' offices, nursing homes, and home health agencies, or as consultants for computer companies that write health information software programs. Some collect data for insurance companies.

Instead of being trained on the job, HITs must now earn at least an associate degree in health information technology from one of the 176 colleges accredited by AHIMA and the Commission on Accreditation of Allied Health Education Programs (CAAHEP). If HITs want to advance, they can earn a baccalaureate or post-baccalaureate degree in health information administration from one of 46 approved institutions.

Degree programs cannot expand quickly enough to meet the need for graduates. Enrollments have dropped in all of the allied health professions in the last six or seven years, but even with maximum enrollment, the demand for health information technicians and managers would still outstrip the supply.

AHIMA is doing all it can to promote the profession of health information technology. The organization has created a recruitment toolbox that members and academic programs can use to attract more students, and is conducting an image marketing and awareness campaign. Fortunately, a hard sell is not needed. According to the Bureau of Labor Statistics, health information technology is one of the country's 20 fastest growing occupations and salaries are rising. AHIMA data show that registered HITs (RHITs) usually earn between $20,000 and $30,000 a year, while registered health information administrators (RHIAs) start between $30,000 and $50,000. After five years, RHIAs can earn up to $75,000 annually, depending on the geographic location in which they live and their job responsibilities.

The health information technology field is one of the workplace's best-kept secrets. Health information management is where health care and technology meet. Since the field competes with information technology for young talent, those already in the profession must let more young people know about the benefits of a career in health information management.

AHIMA has commissioned the Center for Health Workforce Studies at the State University of New York at Albany to perform an analysis of the present and future workforce shortages in health information management. The study will be done in phases over three years and should be completed by 2004. The information will be used to better understand the current shortages, and to improve the field's professional education curriculum and accreditation policies, thereby increasing support for the colleges and universities that have RHIT and RHIA programs.

A qualified HIT should be found in every setting where a medical record is generated. Their duties have evolved from maintaining paper files to being the people who are most responsible for ensuring that health care institutions are properly reimbursed. They also have a significant role in guarding patient privacy. These challenges are exhilarating rather than burdensome, and hopefully will draw intelligent, energetic, responsible people to this fulfilling profession in the near future.

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PHOTOGRAPH/COMSTOCK

Hospital Pharmacists

by Marion Dinitz and Monique J. Marino

Although the overall number of pharmacists has increased in the past decade, the demand for pharmacists has sharply increased as well. Vacancy rates are rising and hospitals are experiencing difficulty hiring qualified pharmacy personnel.[1] Nineteen percent of hospitals queried by the AHA in its 2001 study on health care workforce shortages reported vacancy rates of more than 20 percent for pharmacists.[2]

With 80 percent of patients leaving the doctor's office with a prescription, and medications (in particular cancer drugs) becoming more complex and expensive, pharmacies are playing an increasing role in America's health care system.[3] Today, the pharmacist is required to fill a broader range of professional roles than ever before. The health care and pharmacy professions have embraced the concept of expanded pharmaceutical care, which makes pharmacists part of the clinical team and responsible for providing drug therapies that improve patient outcomes. Pharmacists are also engaged in efforts to improve the quality of the drug use process and to identify ways to reduce medication errors.[4]

Outside of their traditional role of dispensing medication, pharmacists can help the oncology team by:

- Offering insight into billing practices
- Managing investigational drug supplies
- Helping develop and maintain the nursing administration charging system
- Creating ordering and production standards
- Developing pharmacoeconomic standards and assessments
- Keeping physicians from violating the pharmaceutical anti-kickback laws.

The Department of Health Resources Services Administration's (HRSA) 2000 *National Center for Health Workforce Information and Analysis Study*[4] indicated the emergence of a pharmacist shortage and a sharp increase in the demand for pharmacy services. The authors of the study concluded that the factors behind the shortage are not likely to abate without fundamental changes in pharmacy practice and education.

Pharmacy schools have transitioned from a Bachelor of Science (B.S.) in Pharmacy to a Doctor of Pharmacy (Pharm.D.) degree, which lengthens the education process, increases the amount of practice experience needed, increases the number of faculty members and resources needed by pharmacy schools, and ultimately reduces the number of graduates.

According to the HRSA study,[4] the pharmacist shortage negatively impacts the profession and the public by:

- Reducing the time for pharmacists to provide patient counseling—a role of increasing importance because of the complexity of new medications
- Increasing job-related stresses because understaffing causes fatigue and increases the potential for medication errors
- Reducing professional satisfaction because of longer work hours and reduced scheduling flexibility
- Reducing services to underserved and vulnerable populations such as the elderly, rural communities, and people dependent on publicly-supported services
- Encouraging pharmacy faculty to leave the profession, which results in a lower number of pharmacy graduates.

Hospitals are competing with pharmacies and biotechnology firms for licensed pharmacists. Retail chains are growing and they are offering better hours, higher pay, and other incentives to recruit staff. In fact, the HRSA study found that the majority (slightly more than 60 percent) of the nation's pharmacists are employed in the retail or community pharmacy sector, and only 29 percent are employed in institutional settings, principally hospitals.

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