

Clinical Support Personnel in U.S. Hospitals: Jobs Trends 2010-2014

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BACKGROUND

The aging population coupled with expanded health insurance coverage creates an increasing demand for medical services in the United States. The use of various forms of Clinical Support Personnel (CSP), who perform healthcare tasks under the supervision of registered nurses and other licensed healthcare providers has been used as a primary strategy for managing professional shortages (Huston, 1996; Zimmerman, 2000). The purpose of this analysis is to better understand how hospitals are using CSP, and to explore changes that may have occurred since the 2010 passage of the Affordable Care Act.

METHODS

Authors used five-year data (January 1, 2010 – December 31, 2014) drawn from an operational database maintained by Premier, Inc. (Premier). Premier is the nation's largest healthcare performance improvement alliance with more than 3,600 hospitals. This database contains detailed information on basic facility characteristics, department description, job title and description, and staffing information (i.e. labor hours, expenses, and skill mix category). For study inclusion, hospitals had to have submitted operational data to Premier for at least one year. The final study sample included 438 of Premier's member hospitals.

This study employed a mixed-method approach. The qualitative analysis involved a crosswalk comparison of CSP jobs identified from Premier's data versus those reported by the Bureau of Labor Statistics (BLS). The authors categorized CSP jobs into three levels based on entry-level educational requirements. The quantitative analysis involved assessing the distribution of all three levels of CSP, identifying changes in each CSP job's total work hours in hospitals between 2010 and 2014, and comparing trends of total work hours across the three levels.

FINDINGS

This study identifies a total of 38 titles as CSP jobs, of which 17 are found to be closely matching Standard Occupational Code (SOC) occupations reported by the BLS. The remaining 21 jobs may correspond to three generic occupational categories: cardiovascular technologists and technicians, other health technologists and technicians, and other healthcare support workers. Job titles that closely match the SOC occupations also tend to match in hourly wage, while salaries of unmatched job titles vary significantly within generic categories, suggesting that they may not, in fact, correspond to the BLS category. For example, the average hourly wage of "other health technologists and technicians" ranges from \$19 for anaesthesia technician to \$29 for imaging technician.

KEY FINDINGS

1. A large number of CSP job titles are not reported in the BLS occupational classification system, and some of them account for a significant proportion of the CSP workforce.
2. The intensity of CSP use varied across hospitals, with larger hospitals, hospitals located in urban settings, and teaching facilities having relatively more CSP hours.
3. Hospitals seem to be reducing higher paying CSP jobs while increasing those that require the least education and remuneration during the past five years.

Authors found that among all three levels of CSP, level 2 CSP jobs comprised the largest proportion of hours (57 percent), followed by level 1 (26 percent) and level 3 (17 percent). Nursing assistant (15 percent) and patient care technician (11 percent) appeared to be the most commonly used CSPs in 2014, together accounting for 26 percent of total CSP work hours. Authors also found that the intensity of CSP use varied across hospitals, with larger hospitals, hospitals located in urban settings, and teaching facilities having relatively more CSP hours.

While the BLS has predicted general growth in post-secondary degree occupations and recent labor statistics show a strong growth in hospital-based jobs, authors found that only level 3 CSP jobs were growing, and that levels 2 and 1 jobs have been declining over the past five years. Consistent with such trends, the authors found that hospitals seem to be reducing higher paying CSP jobs while increasing those that require the least education and remuneration during the past five years.

CONCLUSION

This is the first study to systematically examine national trends in the use of CSP at the hospital settings. In the absence of representative data on CSP, this longitudinal analysis demonstrates the importance of examining the CSP workforce in greater detail than BLS is able to do. The sheer number of these workers suggests that we cannot afford to ignore them; they represent critical job opportunities for Americans and they are critical to delivering safe and cost effective healthcare. By differentiating jobs by educational requirements and wages, we were able to observe divergent trends, with the least skilled jobs constituting the primary area of growth, and the other two levels, contrary to aggregate analysis, showing a slight reduction. While the current analysis cannot explain why these changes are occurring, it does lay the groundwork for new research designs that can help answer those questions. It also sets the stage for future analyses of how the existence of clinical support staff relates to skill mix, particularly for nurses and other licensed clinicians. Ultimately, such studies should explore the relationship of specific CSP staffing mix ratios to quality and cost outcomes.

POLICY IMPLICATIONS

This analysis points to an opportunity for collaboration between HRSA and the BLS to explore whether the SOC job classifications should be updated to provide greater specificity in the job categories explored in this analysis. Generic categories such as “other health technologists and technicians” may be masking important differences between skilled and unskilled positions and could be skewing labor market analysis in the health care setting, one of the largest and fastest growing sectors of the U.S. economy.

It is noteworthy, in particular, that hospitals seem to be reducing higher paying CSP jobs while increasing those that require the least education and remuneration during the past five years. It is unclear why this is occurring; it could be part of an effort to reduce labor costs, or it could be attributable to changes in patient demographics, such as an increasing proportion of the older patients who require a higher level of personal care (LaMantia, et al., 2010; Chaudhry, et al., 2013).

At alternative explanation could be linked to minimum patient-to-nurse ratio laws. In 2014, the State of California mandated such a law, and previous research has suggested that such policies reduce hospital use of unlicensed clinical and support personnel such as aides and orderlies (Cook, Gaynor, Stephens, & Taylor, 2012; Aiken, et al., 2010) in California’s hospitals. Currently, 14 states have implemented varying degrees of staffing laws (American Nurses Association, 2015), and it is possible that these policies negatively affected the use of clinical support workers overall. Further research using national representative data needed to understand the association between nurse staffing regulation and hospital use of CSP.