AVAILABILITY & GAPS IN PSYCHIATRIC WORKFORCE IN SOUTHWESTERN CT

This report describes the 2015 behavioral health workforce of Southwestern CT with emphasis on prescribers (psychiatrists and psychiatric nurses) and discusses the capacity to meet demand, including cost barriers and other issues. It reports on the perceptions of prescribers surveyed and concludes with recommendations.

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CONTENTS

EXECUTIVE SUMMARY: AVAILABILITY & GAPS IN PSYCHIATRIC WORKFORCE

With one in five people experiencing a mental illness every year, mental health services are in great demand. People seeking help often report difficulties in finding mental healthcare providers who are affordable and/or accept insurance, and they report even greater difficulty in accessing care from psychiatrists. Behavioral health agencies have similar problems accessing psychiatrist care for their clients in a timely manner. Clients may therefore be able to begin therapy, but still have to wait for access to a psychiatrist or Psychiatric Advanced Practice Registered Nurse (APRN) who can evaluate their need and prescribe medication. As a result, the Southwest Regional Mental Health Board (SWRMHB) worked with members of its Catchment Area Councils and with a Student Consulting Group from Yale School of Public Health to study the behavioral health workforce in Southwestern Connecticut, with a particular emphasis on prescribers. This report discusses the current workforce and its capacity to meet demand, describes cost barriers, identifies issues and perceptions reported by prescribers surveyed, and makes recommendations.

- ➔ There are an estimated 235 providers per 100,000 population in Southwestern CT. The estimated ratio of 62 clients per social worker is significantly higher than the caseload range of 40:1 – 50:1 in community mental health services found by the National Association of Social Workers.
- ➔ With the current workforce, in order to reach *all* area residents in need, each mental health provider (of any type) would have a caseload of 79 clients. Each social worker would serve a caseload of 133 clients.
- ➔ By 2025, there will be a shortage of 46,000-90,000 psychiatrists across the nation. In Southwestern CT, many prescribers are not working full time. Their caseloads are very varied: the recent retirement of one hospital psychiatrist required a reallocation of his 400 clients. Apparent gaps include expertise in child/adolescent psychiatry, geriatrics, and addictions. 27% of prescribers responding to a survey were trauma informed. Hoarding is an area of concern where expertise appears to be lacking. The nonprofit and public sectors have difficulty attracting psychiatrists due to the salaries they command, with potential hires turning down offers of $200,000.
- ➔ Cost of care is prohibitive for many, including those who are privately insured. Responding prescribers reported charging $150-$750 for an evaluation, $75-$420 for a routine visit, and $75-325 for a medication management visit. Among 44 prescribers responding to the survey (representing 17% of prescribers in the region), 23 do not accept any insurance, slightly more than half accept private insurance, less than half accept Medicare and/or Medicaid, and only 19 provide a sliding-fee scale. Half of the private-practice prescribers neither accept insurance nor offer a sliding-fee scale.
- ➔ Spanish-language capability is needed. Out of 59 behavioral health programs & clinics contacted in the region, 42% of child practices, 59% of adult practices, and 50% of substance use practices have competence in Spanish.
- ➔ Recommendations include: Expand the services of Access Mental Health CT to other providers besides pediatricians. Consider expanding the scope of practice of clinical staff such as APRNs and psychologists and increasing use of peers. Create incentive systems to encourage doctors to enter the field of psychiatry. Streamline insurance and consider creating a website containing all formularies in a single location. Work to address psychiatrist concerns about insurance and to assist consumers with the financial burden.
- ➔ SWRMHB is working with State Representatives Terrie Wood and Cristin McCarthy-Vahey on legislation to begin to address this growing need.

I. AVAILABILITY & GAPS IN PSYCHIATRIC WORKFORCE

Southwestern CT's behavioral health resources are geographically accessible to most residents: the 14 municipalities are close together, linked by highways and public transportation routes. Six hospitals serve the region, along with many private, nonprofit, and state-funded provider agencies. However, providers are not equally distributed, and consumers frequently report difficulty accessing psychiatrists as well as other types of access barriers, such as expertise, language, and cost. (Long waits for an appointment are also identified as a concern, but are examined in a separate report.)

In order to look at these issues, SWRMHB's Review & Evaluation Committee began by identifying the numbers of providers by type and town. There is no one source of information on who the behavioral health practitioners in the region are or where they are practicing. While the Department of Public Health (DPH) licenses practitioners and can be thought of as a comprehensive source of information, many providers on the DPH list maintain their license but are no longer practicing or are not accepting new clients. In order to estimate the region's behavioral health workforce, data were compiled from DPH, the National Provider Identifier Registry, and Psychology Today, and lists were cross-referenced and cleaned as much as possible. The results were primarily based on providers' home addresses rather than location of practice and so should be considered estimates of the regional workforce.

To deepen the understanding of the issues involved in accessing psychiatrists, a Student Consulting Group from Yale School of Public Health worked with SWRMHB to conduct a survey of prescribers in the region, both psychiatrists and psychiatric APRNs. The student group reached out to all 265 identified prescribers in the region and received 44 responses, for a 17% response rate.[1] (A typical response rate for an external survey is 10%-15%.) The responding prescribers work in a total of 56 practices, of which more than half are private practices, 20% are community nonprofits, 9% are hospitals, and 7% are state-operated facilities. This distribution appears fairly representative, though the actual numbers of responses from each category are small.

A. Overall Workforce

Table 1, below, provides an estimate of the number of behavioral health providers in the region. Providers were defined as psychiatrists, psychiatric APRNs, psychologists, and social workers. With an estimate of 1631 providers for a regional population of 694,317 people, **the total equates to roughly 235 providers per 100,000 population.**

[1] **Demographics** of prescribers responding to survey: 36 were psychiatrists and 8 were APRNs. 25 were female, 18 male, and 1 other. 34 identified as Caucasian, 4 as Hispanic or Latino, 3 as Asian, 2 as African-American, and 1 as other. 12 prescribers have admitting privileges at local hospitals, and 12 practice in two locations. 38 out of 44 were accepting new clients.

Table 1. Overall Estimated Workforce in Southwestern CT (DMHAS Region 1)

Provider Type	Estimated Number
Psychiatrists:	221
Psychiatric APRNs:	44
Psychologists:	395
Social Workers (LCSWs and MSWs):	971
TOTAL:	**1631**

(Note: LMFTs and addiction counselors were excluded from this count.)

Currently, 18.6% of CT adults experience a mental illness in any given year (the statistic is higher among adolescents and young adults), but only 46.8% of CT residents in need actually receive mental health services.

➔ **Comparing the overall number of providers in the region to the population that is both in need *and* receiving services yields an average caseload of 37 clients per provider (all types), or a ratio of 62 clients per social worker**.

1. Discussion of Caseload Ratios

While it is difficult to determine appropriate caseload sizes for providers such as social workers due to the many different types of settings in which they practice, **this ratio appears high.** A 2006 study by the National Association of Social Workers (NASW) found that more than half of social workers studied served between 11 and 50 clients; only a quarter served more than 50 clients (workforce.socialworkers.org).

In order to provide comparative data, the NASW collaborated with the Case Management Society of America in 2011 on a joint Case Load Working Group. Their literature review identified the following caseload ranges for case workers:

- The highest rate was found in a social work clinic model of 365 clients to 1 case manager (365:1) (Wilson, Curtis, Lipke, Bachenski, & Gillian, 2005)
- 50:1 or 40:1 in community mental health (Hromco, Moore, & Nikkel, 2003)
- 26:1 or 32:1 in acute inpatient units considered less intense (Underwood, McKagen, Thomas, & Cesta, 2007)
- 20:1 in a maternity ambulatory outpatient clinic (Kane & Issel, 2005)
- 12:1 or 10:1 in the intensive Mental Health Case Management model (Dewa et al., 2003)
- 2:1 or 1:1 in acute inpatient intensive care settings (Underwood et al.).

With the exception of the highest ratio listed above (for case managers working in a social work clinic model), **all the other casework ratios identified in the literature are lower than the 62:1 ratio estimated for social workers in Southwestern CT.** The 62:1 ratio is based on the statistic that fewer than half of people in need of mental health services are actually receiving help. If the mental health system were to reach more people, the workload would increase to an unmanageable level:

➔ **With the current workforce, in order to reach *all* residents of Southwest CT estimated to be in need, each mental health provider (of any type) would have a caseload of 79 clients. Each social worker would have a caseload of 133 clients.**

NB: Programs seeking to identify appropriate caseload ratios based on comparisons with programs of similar scope of practice and delivery model may want to consult the **online "Case Load Capacity Calculator (CLCC)."** The CLCC was developed by the Case Load Working Group and launched in 2011. It is available at http://clcc.cm-innovators.com/.

2. Foreign Language Expertise:

Finding providers who are competent in another language, particularly Spanish, is a recognized barrier for many residents. SWRMHB identified 59 behavioral health programs and clinics in the region, including all state-supported nonprofits as well as large private practices. (No individual practitioners were surveyed.) These agencies were asked about languages spoken in their clinics during a phone survey.

- 42% of adult and 59% of child behavioral health practices surveyed in Southwestern CT have Spanish-language capability. In addition, 11% of adult and 29% of child practices have Haitian Creole capability.
- Among practices with expertise in substance use disorders, 50% had Spanish-language capability, including one (CASA) which exclusively serves the Latino population. Two substance use practices also reported competence in Haitian Creole.
- Five out of the 59 practices contacted (9%) have access to a translation phone service.

While approximately half of practices contacted had the ability to work with Spanish-speaking clients, the fact that half did not clearly limits mental health access for Latino immigrants. Additionally, our phone survey was weighted toward state-supported nonprofits. In the private sector and in smaller practices it may be harder to find Spanish-language competence.

B. Barriers to Accessing Psychiatrists

Access to one particular type of behavioral health provider—prescribers (psychiatrists and psychiatric APRNs)—is widely cited as a problem by both consumers and providers in Southwest CT. Since Connecticut has more psychiatrists than many other states, the study team looked at the reasons for this recognized barrier.

Research commissioned by the Health Resources and Services Administration (2009) indicates that the workforce should include 25.9 psychiatrists per 100,000 population. **SWRMHB estimates that there are an estimated 31.8 prescribers per 100,000 population Southwestern CT. While this estimate appears to indicate an adequate number of prescribers, it does not reflect several concerns:**

- a growing shortage in psychiatrists, including many who are not working full time;
- unequal distribution of prescribers across practice settings;
- lack of specialized expertise in areas of high need, such as child/adolescent psychiatry or addictions;
- most notably, a shortage of prescribers who are willing to accept private or state insurance, essentially putting their services out of reach of most of the population.

Each of these concerns is described below.

1. **There is a growing shortage of psychiatrists, projected to result in a deficit of 46,000-90,000 psychiatrists nationally by 2025**. Factors related to the projected shortages are listed in Box A, below.

Box A. Trends Affecting Projected Shortage of Psychiatrists

- Between 1995 and 2013, **the US population increased by 37%, while the number of psychiatrists rose by only 12%** (American Medical Association, reported in September 2015).

- **59% of US psychiatrists are age 55 or older** and are retiring or reducing their workload (Association of American Medical Colleges, reported September 2015). In Southwestern CT, our survey corroborates that many prescribers are not working full-time. **Psychiatrists responding to the survey from our region reported working an average of 29.6 hours per week, with 8 out of 44 respondents reporting working 10 or fewer hours/week.**

- Meanwhile, **demand among consumers is increasing**. More than 9% of CT residents are estimated to need mental health care yet are not receiving services; many among them have now gained coverage under the Affordable Care Act.

2. **Prescribers are not equally available across practice settings** (hospital, community nonprofits, private practice), as the following examples show:

    - Because of high demand for their specialized expertise, **psychiatrists command such high salaries that it can be difficult for nonprofits and state agencies to attract and retain them**. Locally, a large provider

agency that was hiring in late 2015 reported that psychiatrists were unwilling to work for a salary of $200,000.

- **When one psychiatrist retired from a local hospital in the fall of 2015, requiring his clients to be redistributed until a replacement could be found, there was a significant impact as he had a caseload of over 400 clients**. In comparison, prescribers in our survey, more than half of whom are in private practice, reported seeing 33-35 clients per week.
- In our prescriber survey, several respondents indicated concerns about working in the public sector, citing reputation, salary levels, and workload as concerns. Many indicated that they preferred the autonomy of private practice.

3. **There appears to be a lack of providers with expertise in certain high-demand areas.** Our prescriber survey asked respondents about their ability to work in Spanish and other languages, as well as their expertise in working with younger and older age groups, addiction, co-occurring disorders, trauma, hoarding, ADHD, PTSD, and other areas that the community identifies as being in short supply. While the total number of responses was small (44, representing 17% of prescribers in the region), the findings did support the community perceptions:

   - **Spanish** did appear to be a gap among prescribers responding to the survey, with only 7 out of 44 reporting competence.
   - The majority of prescribers responding to the survey were focused on the adult population. Only 13 out of 44 indicated special knowledge about working with **older adults**, 15 indicated expertise in working with **children**, and 18 in working with **teens**. Older adults and teens are high-risk demographics, identified as priorities both within the region and statewide.
   - Fewer than half of responding prescribers indicated expertise in **addiction or co-occurring disorders**, which are priority concerns.
   - 12 of responding prescribers reported expertise in **trauma**.
   - Only 4 prescribers reported special knowledge related to **hoarding** and 3 report expertise in working with **sexual/gender identity** issues.
   - The most commonly reported area of special knowledge was ADHD (half of respondents).

4. **The cost factor appears to be the most critical issue in accessing the care of a psychiatrist.** Consumers who are publicly insured may have difficulty finding prescribers who accept their insurance, but can still get access through state-funded agencies, though it may not always be timely. Meanwhile, consumers who are commercially insured routinely note that **the majority of private providers in the region do not participate in private insurance plans.** Our prescriber survey corroborated this perception.

   Among the 44 prescribers responding to the survey (representing 17% of prescribers in the region), 23 do not accept any insurance, slightly more than half accept private insurance, less than half accept Medicare and/or Medicaid, and only 19 provide a sliding-fee scale.

➔ **Among the 30 *private-practice* prescribers responding to the survey, more than half (17) do not accept any form of insurance. Of these, only 3 offer a sliding-fee scale.**

➔ **Among the 13 *private-practice respondents who accept commercial insurance*, 6 accept Medicare, 3 accept Medicaid, and 5 offer a sliding-fee scale.**

The survey asked prescribers why they chose not to participate in insurance plans. Six cited poor reimbursement rates. Four cited quality concerns such as wanting to spend more time with their clients than allowed by insurance plans and not wanting the insurance company to restrict the number of visits. One had applied but been turned down.

To assess the financial burden of non-reimbursed visits on consumers—many of whom may see a therapist weekly and a psychiatrist monthly--prescribers were asked to share their rates for different types of visits (see Table 2, below):

Table 2. Illustrative Costs of Visit to a Prescriber in Southwestern CT

Type of Visit	Range of Charges Reported by Responding Prescribers*
Evaluation	$150-$750
Maintenance visit	$75-420
Medication management	$75-325

**Based on 44 surveys, representing 17% of prescribers in the region*

- The cost per visit varies significantly within the region, with the highest charges associated with psychiatrists in private practice.
- There was significant variance among responding APRNs, with evaluations ranging from $150-$300 and medication management visits ranging from $75-$300. (All APRNs responding to this question were in private practice.)
- Only two community nonprofit providers responded to this question. Both nonprofits reported charges on the lower end of each price range but there was again a large difference in price: $155 vs $350 for an evaluation; $77 vs $145 for a routine or medication management visit.

➔ **Table 2 shows that any type of visit to a prescriber can be a significant expense, given that these are typically recurrent costs. Without insurance reimbursement, these visits are out of reach for the middle class.**

C. Prescriber Perspectives

The prescriber survey carried out in conjunction with the Yale Student Consulting Group offered prescribers the opportunity to share their views on the challenges clients face when accessing psychiatric care as well as their own proposals for improving the system. Respondents recognized similar barriers to those identified by the broader community of consumers and therapists:

- Limited number of providers, particularly those who accept private insurance, Medicaid, or the uninsured and bilingual professionals. Other limitations include APRNs not being able to prescribe suboxone and methadone. Respondents noted that the result can be long wait times, poor patient/staff ratios, and provider burnout.
- Insurance issues, including inadequate insurance reimbursement to doctors for psychiatric and psychotherapy services. (See Box B, below.) Sample quotes include:
    - *"Insurance reimbursements are too low and too complicated to collect, i.e., treatment authorizations and reports with retrospective review."*
    - *"Medicare pays $150 when I charge $300."*
    - *"This population is crisis oriented and the paperwork for providers and higher standards and regulations for behavioral health is discouraging providers to enter the field."*
- Cost, including high co-pays and deductibles for clients who have insurance.
    - *"A patient with a high value (well reimbursing) POS BCBS plan told me today that Abilify for one month would cost $950 with insurance and $1050 without."*
    - "*Many times, seeing a clinician only would not meet a client's deduction in a year."*
- Limited services, specifically in the areas of residential care, substance use, and autism spectrum disorders.
- Coordination of care with the therapist and other providers.
    - *"Medication management is part of the bigger issue of mental health treatment. Care is too fragmented already. If a patient is that stable that all he/she needs is medication management then they should get it from their primary doctors."*
- Personal barriers, such as denial, stigma, compliance, side effects of medication, substance abuse; family challenges such as parents working multiple jobs, transportation, daycare, caregiver mental health, and resources for indigent and undocumented patients.

Box B. Prescriber Perceptions of Insurance

A vocal group of respondents felt strongly that insurance companies affect doctors' ability to provide quality care, while at the same time recognizing that psychiatrist services are too expensive for most people to afford without insurance reimbursement:

- *"Too few psychiatrists willing to accept a system designed to denigrate their knowledge and expertise, a system that would turn us into prescription writers, med managers and med backup providers. … I'd rather make less money and treat people, see patients as collaborators in the work we do together as we try to reach their goals – not unscientific, but "measurable" standard set by some FOR PROFIT insurance company."*
- "*Doctors have all the responsibility and no power; the insurance companies have all the power and no responsibilities."*

Respondents' concerns with insurance companies included the requirement for prior authorizations, reimbursing for generic drugs rather than brand names, and not covering certain medications. In response, most choose not to accept insurance. One suggested increasing the use of Medical Spending Accounts (MSAs) "*so patients as counseled by their doctors rather than as dictated by insurers, can exercise independent*

decision-making about what services or products to spend their health insurance money on." Another respondent suggested creating a physicians' union.

Respondents who do accept insurance commented on the challenges of billing, noting:

- *"At times I do not get the fee promised. I have no way of knowing what patient is supposed to pay when they have a deductible. This makes me want to just do private pay."*
- *"…Work extra hours to meet the documentation demands, disability applications, DTRs, SOAP forms, etc. We have to do our own coding… Many of us underbill for fear of some official finding that we failed to document only 3 items from one category or other. Again this is undervaluing of our own work and over-scrutiny by various agencies.*"

1. Solutions Proposed by Prescribers

Psychiatrists and APRNs suggested the following solutions for attracting and retaining more doctors into psychiatry, expanding access, and encouraging providers to accept insurance:

- Increase compensation and reimbursement rates to providers, to reflect their extensive training, eliminate the two-tiered mental health system, and attract more providers.
- Use incentives such as sign-up bonuses, educational opportunities, tuition breaks in medical school, and credits toward their student loans for those who practice in community psychiatric centers.
    - A particular request was to "*Give APRNs the ability to do loan repayment programs in CT that are <u>not</u> affiliated with federal programs."*
    - One respondent noted the importance of public recognition: *"How about when one of those magazines does a 'Best in Connecticut' survey they include the public sector? There are some extraordinary clinicians working in the state system who get little recognition."*
- Expand the role of APRNs to prescribe suboxone and methadone.
- Provide Spanish-language classes to prescribers to increase cultural competence.
- Simplify insurance, including streamlining paperwork, creating one website for all the formularies, reconsidering standards for Prior Authorizations for Behavioral Health Treatment plan updates every 90 days, and decreasing copays and deductibles. Consider broader reforms such as a single-payer system or tort reform: "*Because of their illness and/or personality psychiatric patients' judgment is by its very nature often compromised, yet psychiatrists are held responsible… if you tell the patient to take a medicine as prescribed and the patient doesn't do so you are held accountable for the poor outcome."*

Other prescriber suggestions included:

- Create a service ladder for children with chronic mental health conditions and developmental disabilities, so they can "*step up and down the ladder and parents don't have to wait months to reapply and change programs*."
- Use a team approach. Make use of Visiting Nurse services. "*Grouping patients' counselors or therapists with a certain prescriber will shorten the time needed for evaluations and medical appointments.*"

- Provide long-term care coordination to the most vulnerable: *"Care Coordinator should be assigned to high-risk families and stay with family for life. This sounds expensive but would significantly cut down on wasted resources, missed appointments, and duplicating work for provides. Plus families would have a consistent relationship with someone who knows the child and family well."*
- Eliminate consumer drug advertising.

2. Prescriber Views on Telepsychiatry

Technology can offer virtual solutions to shortages of providers by routing some office visits to telemedicine, with clients being examined online or primary care providers consulting with a clinician via an online portal. One key to expanding the use of these models will be the development of a technology infrastructure and new payment models to ensure that providers are incentivized and reimbursed to use these capabilities.

Our prescriber survey asked respondents to provide feedback regarding the potential value of telepsychiatry, such as the Access Mental Health CT hub available to pediatricians in Connecticut. Table 3 summarizes prescribers' feedback.

Table 3. Prescribers' Perceptions of Telepsychiatry

Possible Role for Telepsychiatry	% Responding Prescribers*
Primary Care Providers consult with prescribers for help with medication management	50%
Prescribers provide care to existing clients remotely	52%
Prescribers provide care to new clients remotely	25%
None	9%
Could Telepsychiatry play a role in your practice?	**% Responding Prescribers***
Definitely Yes	32%
Probably Yes	27%
Probably Not	30%
Definitely Not	7%

**Based on 44 prescriber responses, representing 17% of prescribers in region*

➔ **The majority of responding prescribers "definitely" or "probably" see a future role for telepsychiatry in their practice.**

➔ **Respondents were most interested in using telepsychiatry to work with their existing clients remotely or to provide consultation to primary care providers.**

Connecticut's existing telepsychiatry program, Access Mental Health CT, recently released an evaluation of its first year. The program was very successful in enrolling pediatric practices across the state and providing them with a phone consultation with a psychiatrist within a half-hour of calls. Far more calls were received from pediatricians than expected. This model was quite successful and responds to an important need, yet its funding was almost cut in the recent budget rescissions. **It will be important to sustain the Access Mental Health CT program and in fact to expand this or similar models beyond pediatrics.**

II. RECOMMENDATIONS

Based on these findings, the Southwest Regional Mental Health Board and its members recommend the following:

1. Proactively address the impending shortage of psychiatrists:

    a. Protect funding for Access Mental Health CT, and expand the program from pediatrics in order to make it available to a wider range of providers. Assist interested psychiatrists to learn more about telepsychiatry.
    b. Expand the scope of work of APRNs to enable them to prescribe suboxone for addiction.
    c. Consider expanding the scope of work of other providers, including both clinical staff and peers. For example, three states currently allow psychologists who have undergone further training to prescribe medication.
    d. Create incentive systems such as student loan repayment, tuition breaks, educational opportunities, etc. to expand the pool of doctors entering psychiatry.
    e. Provide opportunities and incentives to providers to learn Spanish and to fill other gaps such as hoarding.

    SWRMHB is delighted that State Representatives Terrie Wood and Cristin McCarthy-Vahey are collaborating on this topic and have co-introduced legislation to begin to address the workforce issue.

2. Address procedural difficulties in using insurance so that more providers will participate:

    a. Streamline systems and reduce paperwork to the extent possible.
    b. Consider placing all insurance formularies on a single website.
    c. Seek ways to address prescribers' sense that they have "responsibility but no power" and of being undercompensated.
    d. Better promote the benefits of participating with insurance companies. (At a Catchment Area Council meeting, a couple of providers noted that reimbursements from HUSKY were not only easy but also quicker and better paid than private insurance.)
    e. Investigate other system reforms, such as tort reform.

3. Identify ways to reduce the financial burden on consumers, for example, by reducing their co-pays and deductibles or by requiring providers to participate in insurance and/or provide a sliding fee scale.

The Association of American Medical Colleges estimates that without an increased use of non-physician clinicians and staff, by 2025 the United States will have a shortage of 46,000-90,000 prescribing physicians. The Bureau of Labor Statistics' Employment Projections 2012-2022 projects 1.05 million job openings for registered nurses by 2022. Despite expected problems with physician understaffing, practices continue to under-utilize non-physician clinicians and other staff to their full capacity. Such current workforce models will not be sufficient to meet future health care demands without other practice transformations.