



Stress

By definition, stress is a state of mental or emotional strain or suspense.

What causes stress?

Stress is very common and may be brought on by a situation, mental state, or the actions of others.

What are the signs and symptoms of stress?

To name only a few...

- Problems with memory
- Confusion
- Poor judgment
- Repetitive of continual thoughts
- Fatigue
- Hair loss
- Weight gain or loss
- High blood pressure
- Chest pain, irregular heartbeat

How do you manage stress?

The most important thing to remember when you are under stress is to breath. Taking deep breaths can put you at ease and allow you to deal with with the situation at hand.

You can also...

- *Exercise regularly*
- *Get enough sleep*
- *Maintain a balanced diet*
- *Talk to others about your feelings*
- *Reduce caffeine and sugar*

You can even take up yoga!



Diabetic Neuropathy

Diabetic Neuropathy is a peripheral nerve disorder caused by diabetes. Diabetic Neuropathy symptoms are the following numbness, pain, or tingling in the feet, or legs. Symptoms may go unnoticed for a long time, and flare up suddenly and affect specific nerves so that an affected individual will develop double vision or dropping eyelids or weakness of muscles. The main focus in treating Diabetic Neuropathy is to relieve discomfort and prevent future tissue damage. Part of the treatment is controlling blood sugar levels by diet and medication. It is usually helpful to patient to walk, take warm baths, or using elastic stockings to relieve leg pain. There is research being done by the NINDS.



...the stealth health care workforce crisis

The nursing workforce crisis dominates the imagination of both institutional leaders and policymakers in health professional education and service delivery. The well-documented projected shortfall of over 800,000 nurses by the year 2020 focuses the mind of many and has brought real attention to the chasm of care that too few health professionals will breed. But, as dramatic as this situation will be, it pales in comparison to similarly driven shortfalls in other health professional groups. And, as important as shortages in pharmacy, medicine, and even dentistry might become, they will also fail to reach the depths of the **looming crisis in the allied health professions.**

More than twice the size of nursing, the over 200 allied health professions together represent the other core of the health care workforce that not only run the machines of our high-tech health care system, but also provide much of the face-to-face care and specialized services that make the health system work. These health professionals range from entry-level positions which require short training periods and relatively low wage rates to some doctorate prepared professionals who can generate private practice incomes that rival physicians.

The shortage of workers in the allied health professions is driven by many of the same dynamics that are shaping the nursing shortfall:

- aging workforce,
- increased demand for care and services,
- greater opportunities for women,
- a shrinking or inadequate number of educational programs, and
- faculty shortages

But, unlike nursing, workforce issues in the allied health professions remain hidden because they are understood in the context of one professional group

at a time, not as a crisis for an entire professional community. In practice settings such segmentation is in some ways even more treacherous for care delivery organizations than the one presented by nursing. Because the numbers of radiological technicians or clinical laboratory scientists are so small when compared to the overall number of nurses employed, they might be missed as a critical area for concern. But, in such small service lines three or four retirements, or a decision to move to higher paying jobs as a group, can mean severely limiting or perhaps even temporarily shutting down the services provided by the laboratory.

Allied health varies from nursing in some other ways as well. Because allied health programs are more likely to be located in public education settings and, like most health professional educational programs, are expensive to operate, they are susceptible to budget shortfalls at the state or institutional level. This has put pressure on allied health programs; when issues arise it may be easier to close these programs than their nursing counterparts. Nearly 25 hospital-based medical technologist programs closed each year from 1995 to 1997. Our largest state, California, has only 9 programs and about 50 graduates per year to fill hundreds of job openings. Because graduates make lower salaries than many other health professionals it is not as feasible to supplement the educational budgets by charging higher tuitions or moving entire programs to private institutions.

One flip side of this development is that the growing shortage of workers in these critical areas represents much, if not most, of the employment opportunity for entry-level workers over the next few years.

According to the U.S. Department of Labor's Bureau of Labor Statistics listing in 2004, of the 30 fastest growing occupations in the entire labor market, about half are jobs in the allied health fields (iv). As the population ages and demands more care, while more allied workers retire, the level of the opportunity will only rise, as will salaries.





There are several things now underway that will begin to address the issue. The Allied Health Reinvestment Act is making its way through Congress and merits the attention and support of the care delivery community, particularly the leadership of the hospital community.

It provides much needed funds to support and hopefully enlarge these programs. Just as essential, it brings needed attention to the issue.

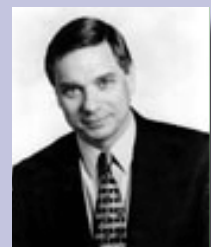
The proprietary educational sector has begun to recognize the growing need in this area. They see allied professions as more attractive for entry than nursing because of lower entry barriers and a shorter training time for entry-level positions. Many of these providers have developed significant distance learning or e-learning platforms that will be attractive to students and employing institutions alike as sponsors of such efforts.

New or rediscovered arrangements in traditional educational offerings are also cropping up. Hospitals in some regions are beginning to see the availability of an adequate workforce as a public good, not just a competitive advantage. In turn, they are exploring much deeper engagement with education, an engagement that goes beyond short-term financial support. Collectively and individual, hospitals are once again reconsidering owning the capacity to educate and grant degrees internally. This not only gives them ready access to graduates, but allows for more effective education and clinical practice ladders to emerge. For example, Kaiser Permanente, in partnership SEIU, developed career ladder maps for 60 job classifications in order to encourage career advancement for incumbent workers. Hospital Councils manage to put competitive issues aside in order to strategically address workforce needs that impact all members across the board. **As a part of such innovations deeper integrations into high school vocational educational programs are also being reconsidered.**

There are other things that the professions themselves can do:

- reconsider approaches to multi-skilling,
- improve, streamline or eliminate the current accreditation system of new programs,
- partner strategically with nursing and more completely
- capture the contributions of all of allied health and the cost in terms of expense, patient safety and lost quality.

Because of its inherent invisibility, allied health is the sleeper workforce crisis. It needs attention now.



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