ready to work WELEARN

Solving The Allied Health Pipeline Problem

How healthcare organizations are building a workforce that stays.

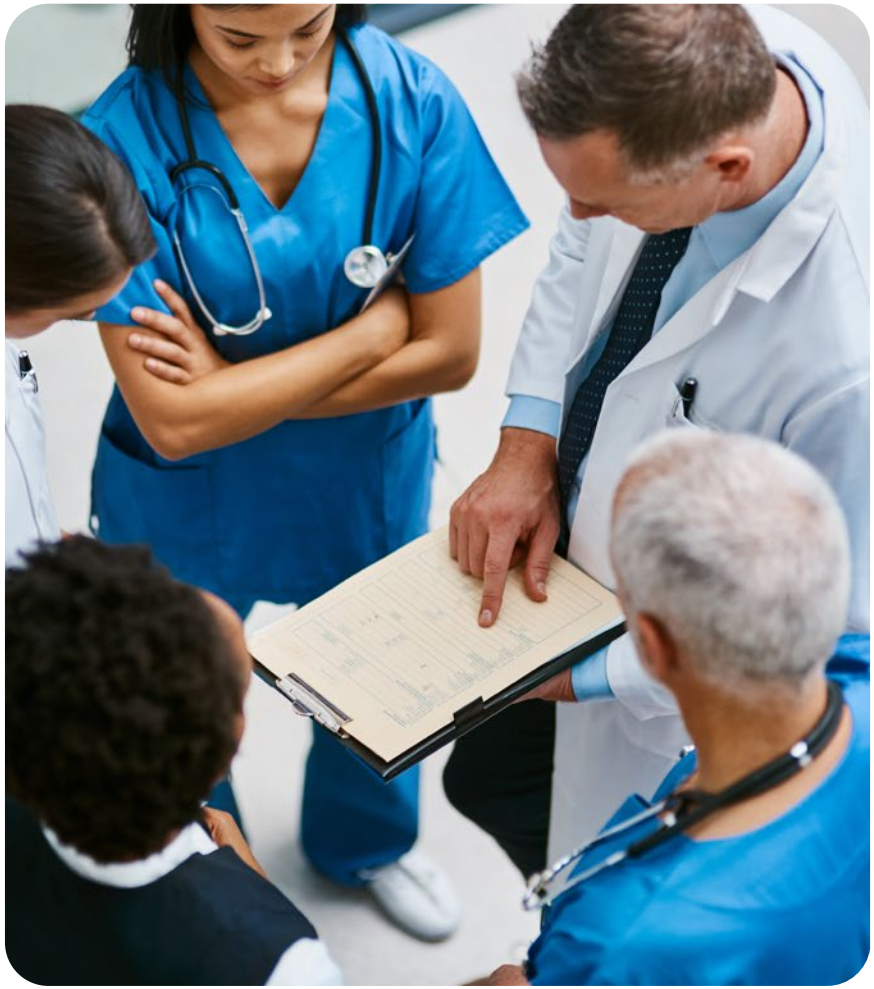
A Ready to Work / WeLearn paper for healthcare leaders

The roles holding healthcare together

As you walk through any hospital — before the next shift starts — you'll see the people involved in opening it: the medical assistants stocking exam rooms, patient care technicians taking vitals on their rounds, phlebotomists on their second draw, and pharmacy, radiologic, surgical and respiratory techs all setting up for their upcoming shift. Most patients will never learn their names. Their work is what makes everything that comes next possible.

These are the allied health roles. If your work touches talent acquisition, HR, L&D or clinical operations, you've been living the consequences of how hard these roles have become to fill.

In this paper we will cover how — and why — most hospitals responding to these personnel shortages are actually partly responsible for reproducing them, and we offer an alternative way of addressing the problem.



"Most patients will never learn their names. Their work is what makes everything that comes next possible."

The numbers everyone is feeling

The data confirms what the floor is already telling you.

Hospital turnover sits at 18.3%, down from the 25.9% pandemic peak but still well above pre-pandemic norms. Every RN departure now costs hospitals around $61,000, a figure that has climbed 17% in just two years. Each one-point reduction in RN turnover saves a hospital roughly $289,000 a year (NSI 2025).

The bigger story, though, is happening below the RN line. CNA turnover in hospital settings runs between 36 and 42%, which works out to complete staff replacement every three years. Phlebotomists and medical assistants are turning over above 20%. Imaging vacancies have hit all-time highs, with CT at 17%, MRI at 14%, and a sonography pipeline that has contracted 22% (NSI 2025; ASRT 2025; IPEDS 2024).

The supply side cannot keep up. HRSA projects a 245,950 LPN FTE deficit by 2038, representing a 30% shortage. More than 37 states are heading toward CNA shortfalls by 2028. Lab tech program completions are down 11.4% (HRSA Dec 2025; IPEDS 2024).

Meanwhile, demand keeps climbing. BLS expects nearly 1.9 million new healthcare jobs by 2034, with medical assistant employment alone growing 12.5% over the next decade and producing more than 112,000 annual openings (BLS 2024–2034 Projections).

There's no ambiguity in the math. The traditional staffing and pipeline playbook will not close this gap.

$61,000 per RN turnover event

$289,000 saved per 1-point reduction in RN turnover

CNA turnover **36 - 42%**

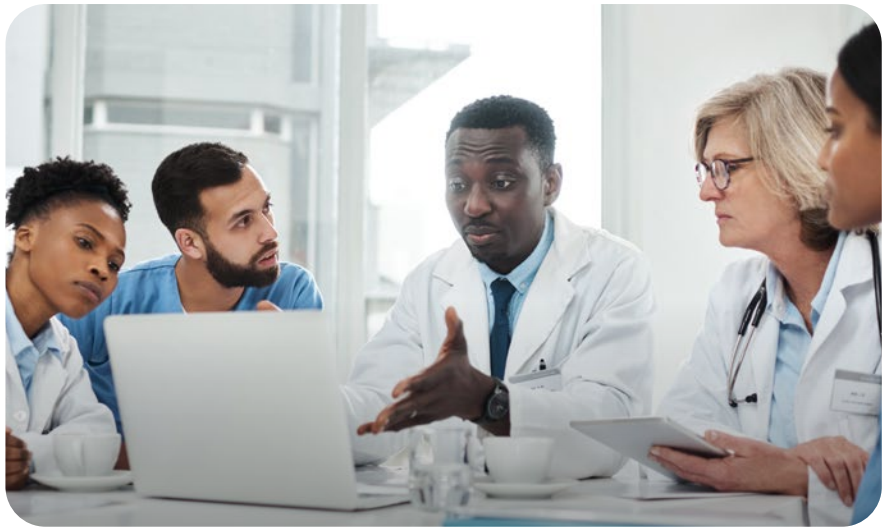
Imaging vacancies: CT **17%**, MRI **14%**, sonography pipeline down **22%**

245,950 LPN FTE deficit projected by 2038

1.9 million new healthcare jobs projected by 2034

Why hiring harder isn't enough

By now, most hospitals have tried the obvious responses. They've raised wages, expanded recruiting teams, leaned harder on travel and contract labor, and partnered with local colleges to sponsor cohorts of students. Every one of those moves has clear limits, and most leaders already know it.



"You can't out-recruit a supply problem."

Compensation increases buy goodwill for six to twelve months before they fade, especially when they aren't paired with visible career growth (PLOS ONE meta-analysis, September 2024).

Recruiting harder doesn't help if the pipeline itself isn't producing enough qualified candidates; you can't out-recruit a supply problem.

Travel and contract labor solved a real crisis in 2022 and 2023, but the model is structurally unsustainable, and 73% of hospitals are now planning to cut agency usage (NSI 2025).

College partnerships, while genuinely well-intentioned, tend to disappoint on conversion. One major Northeast academic medical center had been sponsoring cohorts of 20 students at local colleges and was ultimately hiring 10 to 20% of graduates. Cost per hire climbed exponentially while staffing gaps held open.

What ties these responses together is a shared assumption: that allied health is fundamentally a hiring problem in need of better hiring. The shortages tell a different story. This is a pipeline problem, and pipeline problems don't yield to recruiter headcount or signon bonuses. They yield only to investment in the supply itself.

A different approach: build, don't chase

Ready to Work is WeLearn's response to the pipeline problem. It's a workforce development program that trains, credentials, and places candidates into the allied health roles your hospital is struggling to fill from outside, and that develops the people already on your payroll into the roles you can't recruit for at all. It is neither a staffing agency nor a job board. It's a workforce-building partnership.

The premise is straightforward. Most of the allied health workforce a hospital needs is already nearby. Some of these people are in your local community and want a way into healthcare but can't take on the cost or time commitment of a traditional degree. Others already work in your building, in adjacent roles, and are ready to grow into more if a real pathway existed. Ready to Work builds both.

That distinction matters because it's the difference between staffing thinking and pipeline thinking.

Staffing thinking asks who can be hired to fill an opening today.

Pipeline thinking asks who can be developed to fill that opening, the one behind it, and the one after that.

Most hospitals we work with need both motions running in parallel.

Bringing people in: external pipeline

The first motion brings new people into healthcare from your local community. Candidates train at no cost to themselves through a hybrid model that combines self-paced online coursework with hands-on labs and dedicated career support. They earn nationally recognized certifications and build the workplace-readiness skills hiring managers actually need to see, including professionalism, infection control, customer service, and patient care. By the time these candidates reach your hiring process, they have already been screened, trained, and prepared.

New this year is the Ready to Work employer dashboard, which gives hospitals searchable access to a national pool of credentialed, vetted candidates and lets you connect with them directly. For many of the employers we work with, the dashboard functions as the pipeline
they had been trying to construct on their own, already in place.

Programs are currently available in:

- Acute Nursing Assistant
- Assisted Living Assistant
- Clinical Medical Assistant
- Dialysis Technician
- EKG Technician
- Health System Medical Assistant
- Medical Billing and Coding
- Patient Care Technician
- Personal Care Assistant
- Pharmacy Sterile Compounding
- Pharmacy Technician
- Phlebotomy Technician
- Sterile Processing Technician
- Surgical Technician

Moving people up: internal upskilling

The second motion focuses on the people already on your staff. Almost every hospital has employees who could grow into harder-to-recruit roles if the path existed. CNAs who could step into LPN work. Medical assistants who could take on more clinical responsibility. Patient care technicians who want a credential and a future worth working toward. The talent is in the building. What's usually missing is the program to develop it.

Ready to Work builds that program with you. The structure mirrors the external pipeline, with industry-aligned curriculum, hands-on practice, certification support, and ongoing coaching. The difference is the population. These are people who already know your culture, your systems, and your patients. Credentialing them costs a small fraction of what it takes to recruit and replace them.

> "The people most likely to grow into your hardest-to-fill roles are sitting in your easier-to-fill ones, waiting for a path that doesn't yet exist."

Most upskilling programs we build focus on:

- ✓ Medical assistant advancement into specialized clinical roles
- ✓ Pharmacy and lab technician credentialing
- ✓ Cross-training for imaging, surgical, and respiratory support roles
- ✓ Customized pathways built around your specific staffing gaps

The case for internal upskilling is reinforced by what employees themselves report. In recent workforce data, only 66% of healthcare workers said their career goals are achievable at their current organization, a number that has dropped 7 points below the broader workforce average. Only 48% said they're being compensated for the new skills they bring to the job, compared to 60% across other industries (Mercer IEM 2026).

Read that as an engagement issue and a retention issue at the same time, but also as a workforce issue hiding in plain sight: the people most likely to grow into your hardest-to-fill roles are sitting in your easier-to-fill ones, waiting for a path that doesn't yet exist.

What upskilling looks like in practice

In a large East Texas health system, a physicians group in Tyler had a problem familiar to most of our partners. A handful of administrative professionals in the practice knew the patients, knew the workflows, and were ready to take on more responsibility. What they didn't have was a way into the medical assistant role the group was struggling to recruit for externally. We built one with them.

The program runs over 12 weeks online, with each learner working through a custom designed schedule. Every week, learners join an instructor-led cohort session, which gives them a consistent place to ask questions, work through challenges, and reinforce what they've covered in self-paced modules. Sessions are recorded for anyone who can't attend live.

The program culminates in a two-day in-person lab where learners practice the clinical skills they've built, including a patient rooming simulation customized to the physician group's own rooming procedure. After the lab, candidates go through a dedicated NHA certification review session led by their instructor and receive a fully sponsored exam voucher to sit for the credential.

The retention math on this kind of program is hard to beat. These weren't external hires who needed onboarding into an unfamiliar culture. They were already part of one. The investment came in the form of a credential, a clinical skill set, and a real path forward. The group filled roles it couldn't fill externally, and the employees ended up with careers they couldn't have built on their own.

Results so far:

5 cohorts	**31** enrolled	**3** drops
11 of 12 certified	**91.7%** pass rate	

What external pipeline looks like at scale

Consider one leading academic medical center we partnered with, a major teaching hospital and one of the largest employers in its state. The system was facing the situation most readers will recognize immediately: severe shortages in medical assistant and patient care technician roles, a local population aging quickly and projected to grow nearly 30% by 2030, and college partnerships converting only 10 to 20% of graduates while cost per hire kept climbing. Underneath everything was a capacity problem that no recruiting strategy could solve on its own.

Together with WeLearn and a higher-education partner, the medical center launched Ready to Work with a clear goal: place 1,000 individuals into allied health roles within three years.

Three design choices made the model work.

First, **performance-based funding.** WeLearn and the education partner were paid only when candidates were hired and stayed in role for at least 30 days. No placements meant no payment, which lined everyone's incentives up around candidate success rather than enrollment volume.

Second, **scale from day one.** Rather than running small cohorts, the team opened the program wide. Job postings on Indeed created a massive intake funnel, and more than 50,000 community members responded.

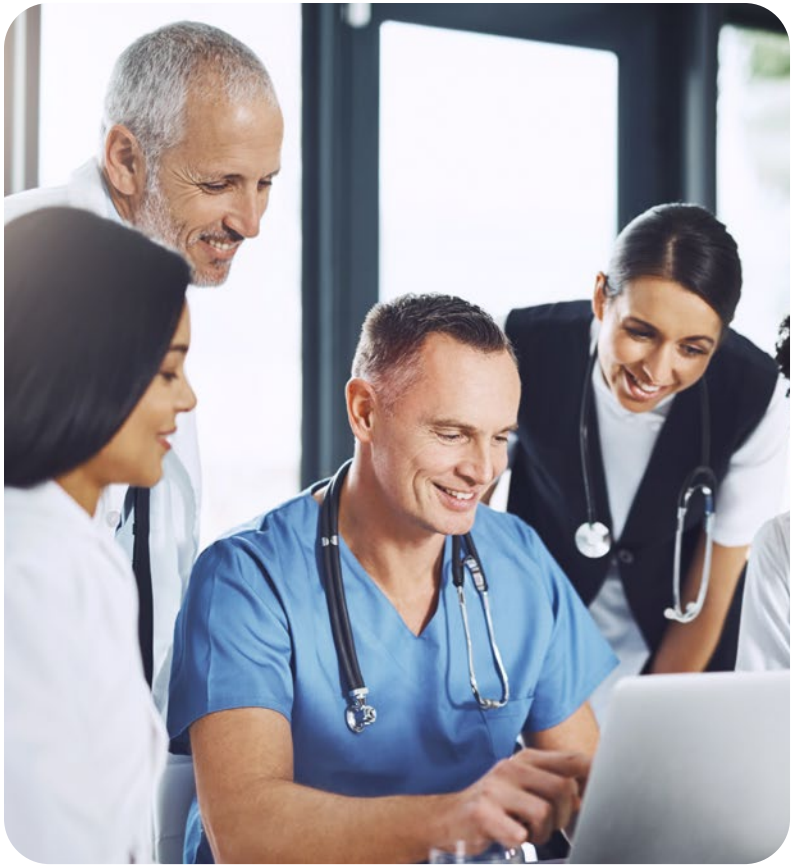
Third, **no financial barriers for candidates.** Training was delivered at no cost, with no tuition and no hidden fees. Healthcare careers became reachable for people who had previously been priced out of them.

After launch, the team didn't walk away. They listened to candidates, watched the progression data, and refined the model continuously. Virtual instructor sessions were added to build trust. A tracking system was built to flag candidates closest to job-ready. Career Services Days and interview prep workshops were rolled into the model. A pilot job fair produced 20 hires from a single event.

Three years in, the results:

- ✓ **23,000+** enrollments
- ✓ **800+** placements at the partner system
- ✓ **300+** placements at other regional employers
- ✓ **79%** six-month retention, well above industry averages

The program met its placement goal. The grant supporting it was extended. And the workforce in that region now includes hundreds of people who entered healthcare through a path that didn't previously exist.



Workforce strategy is community strategy

What makes this approach work goes beyond the program design. The deeper move is recognizing that the allied health workforce is a community to develop rather than a market to harvest, and that this is true on both sides of the wall between your hospital and the neighborhood it serves.

Every external Ready to Work placement creates two outcomes at the same time. A hospital fills a role with a candidate who is prepared, credentialed, and likely to stay. A person from the local community gets a career path they couldn't have built alone.

The internal version produces the same dual win. A hospital fills a hard-to-recruit role with someone who already knows the culture. An employee who might otherwise have left in search of growth stays and builds a career instead.

That dual outcome is the design of the model, not a side effect of it, and it's what makes the work durable for everyone involved.

Healthcare leaders are increasingly recognizing that workforce strategy and community strategy aren't separate efforts; they're the same effort. Magnet hospitals have understood this for years, and the systems that have measurably reduced contract labor and turnover are coming to see it too. Patients see it most clearly of all, in care teams that reflect the communities they live in and that include people who have already been part of them.

There's a window here. Hospitals that move on this now will build a real, durable advantage. The cost of waiting will keep showing up where it always has: in turnover dollars, in patient experience, and on the shoulders of the staff who carry every unfilled role into their next shift.

> "Workforce strategy and community strategy aren't separate efforts. They're the same effort."

Where this leaves you

ready to work

If you've made it this far, you probably arrived already convinced that what you've been doing isn't enough. The honest question is what to build next.

Ready to Work isn't the only possible answer, but it's a proven one, and it's available now. The model flexes to where you are.

- Some hospitals need a fully managed external pipeline.
- Others need internal upskilling pathways for the staff already on payroll.
- Many use the new employer dashboard to access a national pool of credentialed candidates directly.

Most of our partners eventually combine all three.

We'd welcome the conversation. Start with what your hospital is wrestling with right now, and we'll walk through what a workforce partnership could realistically look like for you.

Reach us at **employer@ready-2work.com**.

WELEARN

WeLearn is a learning services, consulting, and custom content partner. We work alongside you to create solutions grounded in strategy, shaped by culture, and designed for real behavior change.

Ready to Work is WeLearn's allied health workforce development program, building pipelines for hospitals and health systems across the country.

Learn more at ***welearnls.com***