State Strategies for Health Workforce Assessments

Pipeline Assessments

What:

The health workforce pipeline includes training programs, both career and technical education and higher education, and other strategies (such as Health Occupation Students of America, Area Health Education Centers, Centers of Excellences, and Health Careers Opportunity Programs) that prepare people with the skills to enter the health workforce. Because many jobs in health care require specialized training and skills, the number of people in the health workforce pipeline has a direct impact on the number of workers who will be available. As such, states have a vested interest in monitoring the size of their health workforce pipeline (how many students are in training) and evaluating associated outcomes (how many students stay in the state and become part of the health workforce). This type of information is helpful to inform state policy and programming related to the health workforce pipeline. The following is a state strategy for assessing the health workforce pipeline.

Strategy:

Work with state career and technical, higher education or state longitudinal data systems to obtain information on pipeline size. This can be done by mapping Classification of Institutional Programming (CIP) codes to standard occupation codes (SOC) to determine the current pipeline size and/or distribution through the state. When this data is coupled with demand data (ex: Bureau of Labor Statistics or real-time posting data sources such as Burning Glass), it can be powerful to identify potential pipeline insufficiencies.

- State Example: Tennessee recently published a report, *Improving the Pipeline for Tennessee's Workforce Academic Supply for Occupational Demand Report*, which includes an analysis of graduates from programs (CIP), mapped to corresponding occupations (SOC), and examines demand in context of Bureau of Labor Statistics job opening data. This report demonstrates how this could be done in many industries, including health and human services occupations (p. 47-56).

Supply Assessments

What:

Assessing the supply of health workers within a state is critical to determining workforce capacity and identifying shortages. This tool examines state strategies for health workforce supply assessment.

Strategies:

- **Strategy 1: Health Professional Shortage Areas and Medically Underserved Areas/Populations Designations**
  - Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas/Populations Designations are geographic areas/communities federally designated as having a shortage of certain health workers. HPSAs and MUA/P identified through partnership between federal and state governments. The state role involves collecting individual level data (name, profession/specialty, hours in direct patient care, practice address, etc.) on health professionals, and then using this data to either validate or update information in a federal platform used to calculate population to provider ratios and identify shortage areas. States collect individual provider data through multiple mechanisms. Some states have put strategies to collect this information from professionals at the time of their state license renewal [link to tool with information on supplemental data collection].
    - State example: Indiana has statutory authority to collect information required for updating provider data associated with HPSAs and MUA/Ps designations at the time of license renewal for selected health professions. This strategy significantly enhances the efficiency with which Indiana can collect workforce data and identify communities with shortages of certain professionals.
- **Strategy 2: Population to professional/provider ratios and beyond**
  - In order to assess health workforce supply across the state and within certain geographies, some states collect supplemental information [link to supplemental data description], including labor market/employment characteristics, practice location, specialty/roles and average weekly hours worked from licensed health professionals at the time of their license renewal.
    - **Population to provider ratio**: Practice location information can be used to calculate population to provider ratios at the state level and within certain geographic regions (e.g., counties or catchment areas). This provides enhanced information on workforce capacity across a state but does not account for variations in hours worked or other factors that contribute to workforce capacity.

    - **Population to full-time equivalent (FTE) of provider ratio**: Average weekly hours worked can be aggregated to a geographic unit of interest and used to estimate the full-time equivalents within a geographic area. This data can be used to calculate population to provider FTE, which may be a better indicator of workforce capacity to service the population. Population to provider FTE may provide a more accurate picture of workforce capacity.
        - Note: In some instances, states collect supplemental information on the practice setting (e.g., hospital, nursing home, etc.); services (e.g., Medication Assisted Treatment, labor and delivery, etc.) and populations served (e.g. 12-15 yrs, 65+ yrs), by a healthcare professional. When combined with the appropriate population data, this additional workforce information can support customized assessments.

- **Strategy 3: Medicaid provider capacity**
    - Assuring provider capacity for enrollees is an important part of state Medicaid programming. States are required to complete a Access Review Monitoring Plan (ARMP) every three years which includes an analysis of state Medicaid provider capacity for certain services: primary care; specialty care; behavioral health, including mental health and substance use disorder; pre- and post-natal obstetric services, including labor and delivery and home health services. Provider enrollment and provider level claims may be used to assess utilization and historical capacity; however, workforce data on providers not currently enrolled in Medicaid are needed to identify and target recruitment initiatives in communities with insufficient workforce capacity for certain services (e.g., recruiting obstetric providers to enroll in Medicaid in region with shortage of obstetric service for Medicaid recipients). In addition to serving as a supply assessment, Medicaid population benchmarks (as provided by the Health Resources and Services Administration as a part of special population designations) can be used to enumerate the number of Medicaid providers necessary to satisfy unmet demand.

Demand Assessments

Strategy 1: Workforce Development Data

- Monitoring workforce demand is an important function of state-level executive branch agencies for workforce development or labor. These agencies frequently collect, analyze and report data on job postings, using applications such as burning glass, to monitor trends in demand by industry and within job classifications.
    - State examples: Colorado, Indiana, Maine, Missouri

Strategy 2: Health Sector Approach to Monitoring Demand

- Demand for health workers changes based on the healthcare needs of the population. The COVID-19 pandemic demonstrated that, in some instances, demand can change within a period of days/weeks. In some instances, common workforce demand monitoring tools may not provide all of the information that a state may want/need to "keep a finger on the pulse" of health workforce demand. Routinely collecting demand information from employers through structured surveys or reporting mechanisms is one way states can collect timely information on workforce demand.
    - State example: The Sentinel Network in Washington is a collaborative initiative between the Health Workforce Council of the Washington State Workforce Board and the University of Washington Center for Health Workforce Studies. This network includes a group of health sector employers that communicate their workforce needs with decision makers. The information they provide is used by the state to understand demand signals, identify skill needs and inform health workforce policy and programming.