"The Ebb and Flow of Health Workforce Planning at the National Level"

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1. **Transitions from the last conference:**

   One of the major factors that may affect National health workforce planning is the rollout of the insurance exchanges and that there wasn't any doomsday "surge" in demand on the system as was expected; thus the whole worry that we wouldn't have enough providers didn't necessarily come to fruition. The aging of the population, however, is still looming large and in 2011 (the time of the last IHWC meeting) was when the first baby boomers turned 65. So since the last meeting, our numbers of aging individuals are "officially" on the rise (given we define "old" as 65, the general age of eligibility for various US retirement benefits).

2. **The Basics**:

   The NCHWA, started in 2010 with the implementation of the ACA and the needed skill sets to maintain a national center include: statisticians, economists, social scientists and health services researchers. We have most of the skills in-house, but we do contract out the development of the microsimulation model, but the plan is to start running the model in-house and not rely so heavily on contractors.

3. **Sustainability**:

   NCHWA--one year funding cycles, but we are currently and have been for many years on a continuing resolution (CR) which has ruled the budget game. As for NCHWA's existence we're tied to political will, but perhaps more in terms of budget than existence. NCHWA did exist before ACA, but had a different name and function.

4. **Mission/Current Topics**:

   The larger picture work in NCHWA is determined by HRSA, HHS and thus the Administration that sit in the White House (we are executive branch of the WH). In many ways it determines who we partner with, what of our work garners interest, etc. However they--at least in our short existence--don't totally operate in a bubble and don't solely focus on what they are interested--there are some external-research world drivers. So for example, NCHWA's health workforce projections are driven internally by the federal government, but we fund HWRCs, who are external researchers that we support, who can focus on a wider variety of issues.

5. **Data**:

   NCHWA has data on several health professions (e.g., MD's, NP's, PA's, allied health professionals, etc.). We house the data on a secure drive where only select people have access. We receive data from professional organizations, federal and non-federal sources. NCHWA has public use files which do not present any data integrity issues. In addition, there are restricted data files that are carefully monitored and a rigorous review process is in place for any requests for data in the restricted files. Our data use agreements specifically state that any data released is not to be linked with another file to enable a person's identity to be determined.

6. **Analysis**:

   The Health Workforce Simulation Model (HWSM) is an integrated microsimulation model that estimates supply of and future demand for health care workers in multiple professions and care settings. It can provide state-level estimates and describe the effects of a policy option at any point in time within the projection period. The basic framework used with the HWSM consists of three components: 1) model for supply of health professions, 2) model for demand for health care services, and 3) staffing ratios that convert demand for services to demand for health care workers.

7. **Audience/Authority to Implement**:

NCHWA's audience is the U.S. public (taxpayers) because that is who funds us and who we serve. Beyond that, primary interested parties are policy stakeholders, academics/researchers in workforce, national and international organizations with an eye for health workforce, etc. The information provided is an excellent tool for workforce planning at the county, state and national levels. A Health Workforce Commission is authorized in the legislation, but to date there has not been any funding provided to set up the commission.

8. Dissemination:

The NCHWA info and other government agency information is disseminated through many channels including written reports/briefs/factsheets, internet (websites and listserves) and internally through federal government channels (e.g. GAO, etc).

9. Geography:

A number of factors influence the contemporary health care workforce's ability to meet emerging demands. Among these factors are population growth, the aging of the population, the growing burden of chronic diseases across all age groups, the adoption of new technologies in medical practice, the anticipated retirement of baby boom health care practitioners, and the expansion of insurance coverage to millions of Americans through the ACA. These factors play out against an existing workforce that is maldistributed geographically and across specialties and is sometimes in short supply. These challenges can be met with a multi-pronged policy agenda that promotes the effective delivery of high quality care while constraining costs. Some of the policy levers to address the composition of the health care workforce, its training and education, geographic distribution, and the ability to experiment with new payment and delivery system models. Federal influence over workforce policy includes: 1) Medicare and Medicaid payment policy, 2) Graduate Medical Education and other workforce training programs, 3) Loan and scholarship programs, and 4) Promotion of quality and efficiency through delivery system reform. **NOTE:** Some workforce functions are inherently non-federal. For example, states oversee the licensing and regulation of health professions, defining scope of practice of individual professions, and setting minimum standards for entry and licensure.

10. Collaborators:

This list can be endless, but the big ones are: sister agencies and other departments at the federal level, to states and their entities, to trade, professional, and other stakeholder organizations, to higher education and research & policy entities like think-tanks. The only sector we haven't explicitly partnered with yet is the philanthropic sector, but that is under consideration.

11. Competition:

HWRCs, the entire workforce investment system, Universities, States with workforce centers, etc.