

## PROJECT NARRATIVE

*Endnotes and a Glossary of Acronyms are in the Appendix immediately following this narrative.*

**1. PURPOSE: Need and Overall Goal**—This project will provide workforce data and analysis that is necessary to develop an effective response to the health workforce shortage threatening our most vulnerable communities. It focuses on forecasting the need for nursing and non-governmental public health workforce as well as maximizing access to federal resources through the mental health and dental Health Professional Shortage Areas (HPSA) designation process. Funding for a complementary project to address related capacity development in governmental public health and other occupations has been made to the Wisconsin Partnership Program at the University of Wisconsin. *An overview of the goals proposed to the UW is provided in the budget narrative under potential in-kind support.*

**A healthy Wisconsin requires a sufficient, diverse, competent and sustainable health workforce.** The public's health is dependent upon an adequate supply of personnel in all health settings: public health, hospitals, primary care practices, specialty care, long term care, home care, pharmacies, dental care facilities, mental health facilities, rehabilitation, and a variety of other support service settings. In a state with increasingly limited funds for education and training, effective planning is necessary to gain needed private and public sector support. Effective health workforce planning and development requires the ongoing collection and analysis of supply, demand and distribution data. This work necessitates a public-private partnership.

For several years, health care analysts and economists have been predicting massive and growing shortages of health workers in the United States. According to a new Institute of Medicine publication, *Retooling for an Aging America: Building the Health Care Workforce*,<sup>i</sup> the United States will need an additional 3.5 million health care providers by 2030 just to maintain the current ratio of providers to the total population. This is a 35% increase over current levels. "The mental health workforce shortage is expected to become more critical, since the Congressional Budget Office has estimated that about 113 million people in the U.S. are expected to benefit from the new mental health parity law (signed 10/3/08)."<sup>ii</sup>

An article on healthcare workforce by Daniel W. Rahn and Steven A. Wartman in the November, 2007 issue of the *Chronicle of Higher Education* further makes the case that we are facing a crisis:

The United States faces a looming shortage of many types of health-care professionals, including nurses, physicians, dentists, pharmacists, and allied-health and public-health workers. The results will be felt acutely within the next ten years. Colleges and health science programs will all be affected by demographic, technological, and bureaucratic trends driving the pending crisis... . The final crucial factor precipitating the health care workforce crisis is a lack of comprehensive workforce planning on the parts of academe, government, and the health care professions.<sup>iii</sup>

Some Federal data regarding the status of certain health professions is available. For example, the Health Resources and Services Administration (HRSA) has a workforce shortage forecasting tool. However, its estimates for future shortages in Wisconsin are based on relatively small sample sizes and have been mostly limited to the nursing profession. Wisconsin has not conducted comprehensive information-gathering regarding the status and future of the health occupations around the state. In addition, because of federal funding cuts, reports and analysis previously generated by the National Center for Health Workforce Information and Analysis in the HRSA Bureau of Health Professions have not been updated. As a result, states must be proactive in collecting their own data to project state health workforce needs. Current state resources, however efficiently deployed, are not sufficient to accomplish what needs to be done right now.

Health professions educational programs, employers, and public agencies in Wisconsin have been unable to obtain workforce data and labor market projections adequate to inform decisions regarding the preparation, retention, and distribution of a sufficient health workforce. Efforts to gather and analyze data on labor mar-

kets and distribution of health professionals are uneven and uncoordinated and we lack suitable models for forecasting supply and demand in the health sector on the state and local level. An update of the 2004 Report, “Who Will Care For Our Patients,” soon to be released by the Wisconsin Council on Medical Education and Workforce has as its first recommendation: “Develop an infrastructure to gather data sufficient to aid in understanding the current and future physician workforce.”<sup>iv</sup>

Consequently, educational programs training health occupations struggle to determine the number of prospective students to be admitted based on future projections of need in Wisconsin. Employers of the health workforce in Wisconsin struggle to obtain workforce data and labor market projections adequate to inform decisions about the number of health professionals who are entering and exiting the workforce. Prospective students struggle to determine the health occupation to select based on forecasted job availability.

In reviewing this application, there are two basic questions that should be explicitly addressed: (1) why can we not just address impending shortages without forecasting the supply and demand on the state and local levels and (2) why is this not the sole responsibility of state government?

**“Why can we not just address impending shortages without forecasting the supply and demand on the state and local levels?”** Because we need to “Mind the Gap”—the difference between the people trained to do the work and the jobs needing to be filled, both now and in the future. This is at the heart of assuring health services in our communities. Assuring an adequate workforce is an initiative with a very long lead time. Our health professionals typically require training of six to ten years after high school and that assumes we currently have an appropriate mix and adequate number of faculty in place, which we do not. We need to take action now to minimize the shortages of health professionals and workers that we know are needed for the upcoming baby boomer driven explosion of demand/need for services.

Statewide estimates aren’t enough. As said more than once about workforce shortages during the development of this project: “when it starts raining in the suburbs, expect a tsunami in Wisconsin’s rural and inner-city communities.” Two new Wisconsin initiatives designed to address the needs of underserved communities, the Wisconsin Academy of Rural Medicine (WARM) and the Academy of Center-city Medical Education (ACME) would not have been developed if we hadn’t considered the mal-distribution of physicians within our state’s boundaries. Our education and vocational programs in all of the disciplines need the data to “Mind the Gap” between supply and demand, not just in terms of state averages but also in terms of the local reality of our many diverse communities.

**“Why is this not the sole responsibility of state government?”** Government currently funds staff engaged in core health workforce activities in the Departments of Health Services, Workforce Development and Regulation and Licensing. This capacity has been preserved in the face of a steady erosion of federal and state funding and is ongoing work this proposal builds upon. Now, when major investments are critical, Wisconsin’s economic forecast is bleak, along with tax revenues and competing demands on scarce state dollars. The prospect for increasing funding in this area at this time has turned from bleak to non-existent.

The collaborative approach embedded in this application would be substantially less robust if government attempted to do it on its own. In addition, as noted above, there has been a failure to do comprehensive workforce planning on the part of three key sectors: academe, government, and the health professions. Government cannot and should not address this shortfall unilaterally. Workforce planning requires close collaboration amongst diverse interests and entities, the initiative of a single sector on its own is inadequate. Subsequent to this proposal being funded and completed, it is intended that the collaboration will be better able to better make the case for additional government funding being part of the sustainability plan.

The Healthier Wisconsin Partnership Program funded a Call to Action which resulted in the report, *Stepping Up to the Challenge*. Through a Summit and multiple other processes, organizations and individuals from

across the state built recommendations for the future public health workforce. The Wisconsin Health Workforce Data Collaborative's proposal for an Impact Award addresses a key objective in the *Call to Action Report* to: "Identify, define, and standardize workforce data systems to create new meaningful data and to make full use of the data that affects the public health workforce supply."<sup>v</sup>

**Relevance to the Health Improvement Model (HIM)**—This project focuses on the HIM approach, "Transform health improvement efforts through capacity-building and strengthening systems." It seeks to protect the health of all Wisconsin citizens by working to assure the availability of the health workforce needed in Wisconsin. Tying accurate and real time forecasting data tools to project the needs of the future allows for adequate and targeted increases to health workforce education and training programs.

The Collaborative addresses HIM's "Major areas of health risks." It offers a health data workforce plan which aligns well with the Healthiest Wisconsin 2010 state plan in the area of access to primary and preventive health services. This workforce crisis is expected to continue and grow, generating a "perfect storm" exacerbated by the aging baby boomers and the costs of chronic disease management, thereby creating an urgent need for data driven decision-making about provider preparation programs increasing their educational capacity. All of the Healthiest WI 2010 plan goals require a diverse, competent and sustainable workforce, and access will only be achieved if the workforce exists to provide the care.

The Collaborative addresses HIM's "Focus on specific populations affected." The Collaborative seeks to improve the disproportionate effects of health workforce shortages on specific populations by its analysis of the distribution of health providers as well as the forecast modeling scenario development. If health workforce stakeholders have a definitive tool that is accessible and transparent, decision-making can occur with all relevant data available for targeting the resources for specific populations. Diversity in the health care workforce has been demonstrated to improve the health results for diverse populations served with the collection of race, gender, ethnicity, age and other relevant data for the various health occupations, overlaid on certain health risk clusters (GIS mapping), the framework for targeted resources has more foundation.

The Collaborative addresses HIM's "Emphasize prevention of causes of death and disability." Prevention requires an appropriate health workforce. This project is intended to address the supply and the distribution of that workforce, both statewide and with a focus on our most vulnerable communities. The forecasting model with scenario capacity will show how the forecast will vary depending upon different scenarios affecting both supply and demand.

**2. PLAN:** The workplan format in this section states after each numbered activity the following: a description of the activity; the timeframe; and the Collaborative's lead person(s) and organizations. Additional activity details are provided in the Budget Narrative. Information about the lead person(s) is in the Partnership section and the Appendix. A Glossary of Acronyms used below immediately follows this narrative.

**Goal 1: Expand data collection and analysis of the supply and distribution of the Wisconsin registered nursing workforce with additional details on advanced practice nurses (APNs).** Outcome Measure 1: Comprehensive data for the supply and distribution of the registered nursing workforce will be collected and analyzed by July 2012.

**Objective 1.1: Review nursing workforce supply questions and methodologies from Wisconsin, other states, federal and national entities.**

**Activity 1.1.1:** Continue to contact Wisconsin and other state, national and federal entities that have completed supply data collection and analysis of the registered nursing workforce and request the methods used and a list of all questions; Jul '09; Lea Acord, WHA, WNA, DWD.

**Activity 1.1.2:** Request from DWD data elements necessary to include in an RN supply survey in order to predict supply and forecast demand for nurses in Wisconsin; Jul '09; Lea Acord, WCN, WHA, WNA, DWD.

**Activity 1.1.3:** Convene stakeholders to review supply questions and recommend survey questions and methodology for gathering the information; Aug '09; Lea Acord, WCN.

**Objective 1.2: Determine the methodology for gaining information from the nursing workforce in Wisconsin and survey registered nurses licensed in Wisconsin.**

**Activity 1.2.1:** Determine the most successful and cost effective mechanism for collecting survey data from registered nurses in Wisconsin; Sep '09; DWD, DRL.

**Activity 1.2.2:** Select survey questions; Oct '09; WCN, DWD.

**Activity 1.2.3:** Survey registered nurses who are licensed in Wisconsin; Jan '10; DWD, DRL, WCN.

**Objective 1.3: Analyze and distribute registered nursing workforce supply data.**

**Activity 1.3.1:** Analyze results from the Wisconsin RN surveys; Mar - Jun '10; Lea Acord, WCN, DWD.

**Activity 1.3.2:** Distribute supply survey results to interested parties; Jun '10; Lea Acord, WCN, DWD.

**Objective 1.4: Survey educational programs that prepare RNs for capacity data and share results.**

**Activity 1.4.1:** Collect data from registered nursing education programs about planned expansion of student/learner capacity; Jan '10; Lea, Acord, WCN, ANEW.

**Activity 1.4.2:** Collect data regarding barriers to increasing capacity; Jan '10; Lea Acord, WCN, ANEW.

**Activity 1.4.3:** Compare capacity possibilities of educational programs; Mar '10; Lea Acord/WCN, ANEW.

**Activity 1.4.4:** Convene a task force to address identified gaps and share information with educational programs; May '10; Lea, Acord, WCN, ANEW.

**Objective 1.5: Evaluate the RN survey instrument to determine appropriateness of its use in collecting data from other health occupations in Wisconsin in the future.**

**Activity 1.5.1:** Refine the data collection instrument by revisiting those activities in Objective 1.1 that are applicable; Jun - Nov '11; Lea Acord, WCN, WHA, WNA, WMS, DHS, DWD.

**Activity 1.5.2:** Create tools to be used to determine the supply of other health occupations; Jan'12; DWD.

**Objective 1.6: Recommend the state government's role for sustained data collection for Wisconsin health occupations that require state licensure.**

**Activity 1.6.1:** Identify and recommend workable options, including necessary resources for sustainable workforce data collection through the licensure process; Jul '09 - Jun'12; Lea Acord, WCN, WHA, WNA, WMS.

**Goal 2: Enumerate and analyze the non-governmental public health workforce (paid and volunteer) in private, non-profit agencies, voluntary associations and organizations, and community-based organizations, statewide and locally (via a pilot in one region), who address the core public health functions and essential services.** Outcome Measure 2: Enumeration and analysis of the non-governmental public health workforce for at least one region in Wisconsin will be completed and available to inform workforce planning and ensure emergency readiness by June of 2012.

**Objective 2.1: Describe the current and future composition, distribution, and trends of Wisconsin's non-governmental core public health workforce.**

**Activity 2.1.1:** Assure that occupation-specific data required for analysis of RNs in the core non-governmental public health workforce is available under Goal 1; Jul - Sep '09; Nancy McKenney.

**Activity 2.1.2:** Convene an expert panel to prioritize the scope (disciplines/workforce settings/region) and establish standardized methodology to enumerate, analyze, and determine provider to population, beginning with entities whose workforce provides essential public health services (including emergency readiness) through state and local health department contractual agreements; Jul - Dec '09; Nancy McKenney.

**Activity 2.1.3:** Identify non-governmental agencies through state and local public health agency contracting systems; Jul - Dec '09; Nancy McKenney.

**Activity 2.1.4:** Establish an inventory of current non-governmental public health agency workforce surveys, recommend additions or changes, and make recommendations for adding new data elements; Jul - Dec '09; Nancy McKenney.

**Activity 2.1.5:** Establish, implement, and analyze in at least one region a non-governmental public health workforce agency survey; Jan - Jun '10; collaboration between DPH and DWD.

**Objective 2.2: Develop and pilot methodology to forecast non-governmental public health nursing workforce needs.**

**Activity 2.2.1:** Estimate the provider to population ratio for the current non-governmental public health nursing workforce based on available data and the methodology developed by the expert panel; Jan - Dec '10; Nancy McKenney.

**Activity 2.2.2:** Examine available health status indicators by state, region, and county (particularly summary health outcomes and disparities measures developed by UWSMPH Population Health Institute) for those measures most related to public health nursing functions; Jul '10 - Jun '11; Nancy McKenney.

**Activity 2.2.3:** In conjunction with work completed under Goal 4, apply the methodology for forecasting the non-governmental public health workforce starting with the nursing profession; Jul '11 - Jun '12; Victoria Udalova and DWD, in cooperation with Nancy McKenney.

**Objective 2.3: Apply the forecast methodology to another non-governmental public health workforce discipline in Wisconsin.**

**Activity 2.3.1:** Identify the extent to which data exist and as appropriate, apply the year 2 analysis to another core non-governmental public health profession; Jul '11 - Jun '12; Nancy McKenney.

**Activity 2.3.2:** Review and consider emergency readiness core staffing level recommendations when providing estimates for the population to provider ratio; Jul '11 - Jun '12; Nancy McKenney.

**Activity 2.3.3:** Using forecasting tools developed by DWD for nursing in Goal 4, apply to other non-governmental public health disciplines; Jul '11 - Jun '12; Nancy McKenney with Victoria Udalova.

**Goal 3: Expand Wisconsin's capacity to designate as many eligible Health Professional Shortage Areas as possible to maximize access to HPSA-linked resources and help with workforce planning.**

Outcome Measure 3: Dental and mental health HPSA designations will be submitted for all new eligible areas by June 2012 to maximize provider eligibility for HPSA-linked resources, and statewide provider shortage data will be available for workforce analysis and planning.

**Objective 3.1: Compile and analyze mental health HPSA data for all non-designated areas.**

**Activity 3.1.1:** Complete sub-contract with WI Primary Health Care Association for mental health and dental HPSA data collection/analysis for undesignated areas; Jul - Sep '09; Anne Dopp.

**Activity 3.1.2:** Explore use of federal Medicaid match for Partnership funding for HPSA activities; Jul - Sep '09; Anne Dopp.

**Activity 3.1.3:** Enter psychiatrist data from 3 years of paper surveys into new HPSA provider database; Oct - Dec '09; WPHCA staff.

**Activity 3.1.4:** Determine definition and data source for "other mental health providers" with key partners; Oct - Dec '09; Anne Dopp & WPHCA staff.

**Activity 3.1.5:** Enter "other mental health provider" data into new provider database; Jan - Mar '10; WPHCA staff.

**Activity 3.1.6:** Add questions about mental health provider vacancies into new on-line HPSA survey; Jan - Mar '10; Anne Dopp & WPHCA staff.

**Activity 3.1.7:** Define mental health HPSA service areas throughout the state to maximize HPSAs and linked resources; Jul - Dec '10; Anne Dopp & WPHCA staff.

**Activity 3.1.8:** Enter psychiatrist and other mental health provider into new HPSA database for service areas not designated as HPSAs; Jan - Dec '11; WPHCA staff.

**Activity 3.1.9:** Contact and ask mental health clinics in non-HPSA areas to update provider data in secure HPSA database; Jan - Dec '11; WPHCA staff.

**Activity 3.1.10:** Analyze data for non-HPSAs and complete HPSA applications for state primary care office to submit to federal HRSA for eligible areas; Jul '11 - Jun '12; Anne Dopp & WPHCA staff.

**Objective 3.2: Compile and analyze dental HPSA data for all non-designated areas.**

**Activity 3.2.1:** Define dental HPSA service areas throughout the state to maximize HPSAs and linked resources; Jul - Dec '10; Anne Dopp & WPHCA staff; HPSA service areas identified.

**Activity 3.2.2:** Analyze Medicaid dental claims and population data for non-HPSAs and complete HPSA applications for state primary care office to submit to federal HRSA for eligible areas; Jan - Dec '11; Anne Dopp & WPHCA staff.

**Objective 3.3: Make dental and mental health workforce data available for statewide planning.**

**Activity 3.3.1:** Complete a data sharing MOU between WHWDC and DPH for sharing of data and reports but with protections for confidential and proprietary data; Jan - Mar '10; Anne Dopp.

**Activity 3.3.2:** Provide access to data and reports on dental provider shortages and mental health workforce for project partners and others per data sharing agreement; Jul '09 - Jun '12; Anne Dopp & WPHCA staff.

**Activity 3.3.3:** Provide web access to mental health and dental HPSA service area data to help support community development and health workforce development; Apr - Jun '12; Anne Dopp & WPHCA staff.

**Goal 4: Expand the existing nurse forecasting tool available in Wisconsin to incorporate various policy scenarios that may affect future supply and demand.** Outcome Measure 4: Forecasted supply and demand projections based on various policy scenarios are available.

**Objective 4.1: Adapt the existing projection tool to perform various scenario analyses.**

**Activity 4.1.1:** Consult with stakeholders to identify potential scenarios to run using the existing projection tool; Jul '10; Victoria Udalova and Jerry Wisnewski, DWD.

**Activity 4.1.2:** Select scenarios to analyze based on the importance and projection tool's capacity; Aug - Sep '10 ; Udalova and Wisnewski.

**Activity 4.1.3:** Expand the capability of the projection tool to run selected scenarios; Oct '10 - Jan '11; Udalova and Wisnewski.

**Objective 4.2: Perform scenario analyses for nursing workforce.**

**Activity 4.2.1:** Gather specific requests on scenarios from policymakers and stakeholders; Feb '11; Udalova and Wisnewski.

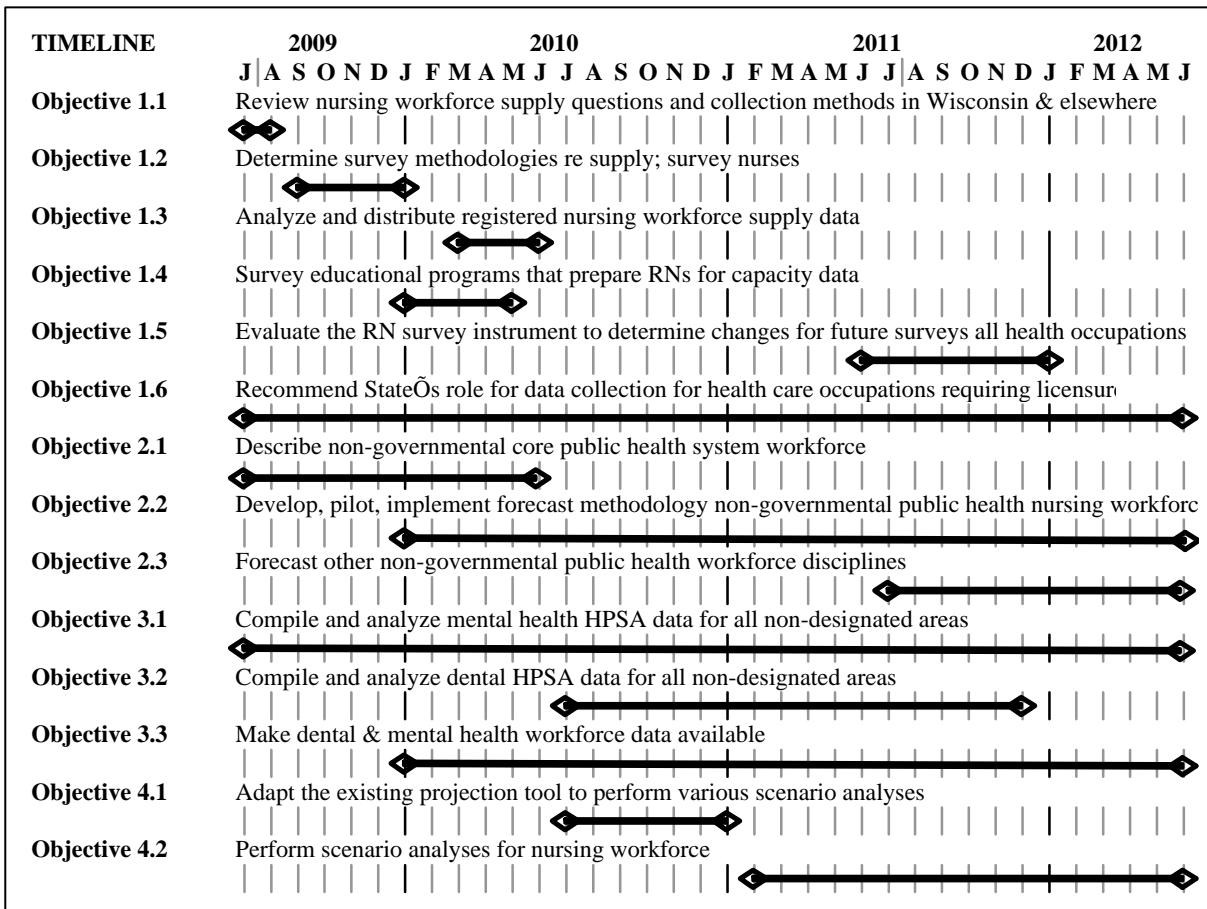
**Activity 4.2.2:** Prepare sensitivity analyses based on specific requests from policymakers and stakeholders; Mar '11 - Feb '12; Udalova and Wisnewski.

**Activity 4.2.3:** Prepare comparative analyses from run scenarios; Mar - Jun '12; Udalova and Wisnewski.

*Please see Timeline Schematic of Workplan Objectives on top of the following page.*

**3. PARTNERSHIP: Understanding the Environment for Partnerships**– The above workplan will be implemented through a carefully structured, collaborative approach. The applicant, the Wisconsin Health Workforce Data Collaborative (Collaborative), consists of 29 active participants who are senior staff from a diverse array of key regional and statewide organizations and agencies. Nine members of the Collaborative are also appointed members of the Wisconsin Department of Workforce Development Select Committee on Healthcare Workforce (Select Committee) from which the Collaborative's initiative developed. Rita Black-Radloff is staff to the Select Committee and the facilitator of the Collaborative meetings. *The "Biographical Sketches" in the Appendix also include complete Rosters of the Collaborative and the Select Committee.*

This proposal grew out of the Select Committee's Stronger Data Work Group dialogue initiated in late Summer of 2007. The Work Group, now known as the Collaborative, had an initial focus on better understanding the nature of the problem and then in the Spring of 2008 decided to write a proposal to each Partnership Fund. Every step of the way, more people have come to the table, which has been open to all interested parties. That many of the participants have worked with each other in a variety of other settings has



helped provide the necessary trust for this complex effort. Drafts of all key documents have been drafted by various individuals and small groups and then vetted by the whole Collaborative in person and by email.

**The Steering Committee consists of the Academic Partner: Peter Layde, MD, MSc** (Professor, Department of Population Health, Medical College of Wisconsin); **Collaborative Chair & Project Manager–Tim Size, BSE, MBA** (Executive Director, Rural Wisconsin Health Cooperative; RWHC is contributing his time to this project); **Collaborative Facilitator–Rita Black-Radloff, BS** (Senior Health Care Workforce Policy Analyst, Wisconsin Department of Workforce Development); **Fiscal Agent Representative to the Collaborative–Nancy Nankivil** (Senior Vice President; Quality & Efficiency, Wisconsin Medical Society; WMS is providing these services pro bono); **Goal 1 Coordinator–Lea Acord, RN, PhD** (Executive Director, Wisconsin Center for Nursing and Professor, College of Nursing, Marquette University); **Goal 2 Coordinator–Nancy McKenney, RDH, MS** (Director of Workforce Development, Division of Public Health, Wisconsin Department of Health Services); **Goal 3 Coordinator–Anne Dopp, RN, MSN** (Director, Primary Care Office, Division of Public Health, Wisconsin Department of Health Services); **Goal 4 Coordinator–Victoria Udalova, BA** (Economist, Employment Projections, Office of Economic Advisors, Wisconsin Department of Workforce Development).

The Collaborative has also submitted a complementary application to the Wisconsin Partnership Program at the University of Wisconsin (UW). Both proposals stand on their own merits but significantly faster progress for Wisconsin will be made if both are funded. The Collaborative will continue its spirit of transparency to assure that all funders are comfortable that this unprecedented public private partnership respects the principles of neither duplicating nor supplanting existing activities. Both proposals have worked hard to

identify activities that need to be accomplished in both public and private sectors but which have not yet occurred due to funding and prior organizational constraints. The Collaborative understands that fully addressing the threat of the workforce shortage will ultimately require additional resources.

Wisconsin's public and private sectors have been stalled or at best spinning their wheels on this issue. Partnership funding at this time is critically important to "jump start" us moving forward. Tim Size noted in a November 2007 editorial in *Eye on Health* (the newsletter of the Rural Wisconsin Health Cooperative):

Wisconsin's very own "inconvenient truth" is that we do not have a system to produce ongoing, statewide information that would allow us to make knowledgeable projections about health care workforce shortages. Due to limited resources and instances where collaboration needs to be substantially enhanced, our current approach to healthcare workforce planning falls far short because as regards to job vacancies, we don't know where we are or where we are going. As regards to the strategic investments and changes that need to be made in and by Wisconsin's universities, colleges and schools, we are playing a high stakes game of "blind man's bluff." The problem is that we have lots of data and not much information upon which to make knowledgeable workforce development decisions in or for either public or private sectors.<sup>vi</sup>

The Collaborative's partnership with the MCW Academic Partner, Dr. Peter Layde, builds naturally on a number of pre-existing relationships with key participants. The unusually diverse set of participants have come together due to a shared recognition that even rudimentary health workforce planning in our state has been hampered by inadequate systems for gathering health workforce data and a lack of suitable models for forecasting the labor market in terms of supply, demand, and distribution that can be applied on the local level. Amongst the statewide leadership and active participants there is a rich portfolio of experience with the development and management of collaborative initiatives as well as with the multiple aspects of health workforce development. While this application does not permit space for letters of support, letters have been received from the top leadership of the vast majority of participating organizations.

As evidenced throughout this application packet, **a central hallmark of the proposal is the open and collaborative development of a complex pair of proposals by an unusually diverse array of partners.** The process that led up to the development of a common purpose as well as the then substantial work of organizing and writing not one but two complementary "Partnership Fund" proposals demonstrates a strong commitment and capacity to achieve the three elements of the Community-Academic Partnership Model.

**Commitment to Partnership Principles**—The Collaborative emphasizes key partnership principles, in particular, trust, transparency and inclusiveness. Early on, participants recognized the need to agree on basic principles that would guide our work together; the following agreement is paraphrased from Collaborative Meeting Notes of March 27<sup>th</sup>, 2008: (1) that while most participants wore policy hats in other settings, the Collaborative would be neutral on all policy issues, allowing it to be the source of credible data and forecasts, (2) our focus would be on both supply and demand, (3) focus on clinical and selected technical occupations, (4) data would be available, transparent and accessible, (4) identify what exists and is useful, (5) not duplicate existing efforts, (6) use a structured/collaborative approach with formal outcomes, (7) seek sustainable and ongoing in real time trends and reproducible across all health care occupations with specificity to the occupation, and (8) engage academic and public/private partnerships across multiple sectors.

**Commitment to Partnership Development**—While the Collaborative has an impressive start, it recognizes the ongoing need to further a complex matrix of partnerships. The Collaborative Chair has an extended background managing and writing about collaboration. In a 1993 article entitled "Managing Partnerships" published in *Health Care Management Review*, Tim Size, the Collaborative Chair, wrote that collaboration requires the participants to respect these principles: (1) Respect the Need to Effect One's Own Future, (2) Involve the Community and Providers in the Planning Process, (3) Assure All Participants Know They Are

Needed, (4) Share Your Big Picture, (5) Agree on Methods of Accountability Up Front, (6) Assure that a Fair System of Arbitration is Available, (7) Design an Approach Where Participation Must Make Sense, and (8) Make Yourself a Partner Who Can Be Trusted.<sup>vii</sup> It is intended that the Collaborative will be managed according to these principles.

**4. EVALUATION:** Dr. Lea Acord, along with guidance from the Academic Partner, Dr. Peter Layde, and in conjunction with the rest of the Steering Committee, will be responsible for the overall evaluation. While there is not a specific goal for the Collaborative's development, that development is embedded in the successful completion of our outcome measures and will be an integral part of the ongoing evaluation. Dr. Acord is also the named lead for evaluation in the proposal submitted to the University of Wisconsin.

The evaluation plan for this project will have three elements. Progress evaluation will determine whether our collaborative is adhering to key deadlines according to our established timeline. The partners will utilize the timeline as an evaluation tool to determine when activities should occur and key milestones within each objective. Process evaluation will determine the strengths of our data collaborative, day to day operations and our ability to work within the project workplan. The success of our partnership lies in the ability of diverse partners to effectively communicate and coordinate specific activities within each goal. Outcome evaluation will determine if our data collaborative met its overall goal to develop an infrastructure that will support the ongoing collection and analysis of supply, demand, and distribution data of targeted health occupations in Wisconsin.

The comprehensive workplan, which has been developed for the project, will aid in evaluation. The primary evaluation activities will consist of tracking progress of activities to achieve the above-stated outcome measures. As such, there are already resources in place to conduct the evaluation (e.g., an existing workplan, timeline, and project partners to cross check activities with the workplan).

***Outcome Measure 1:*** *Comprehensive data for the supply and distribution of the registered nursing workforce will be collected and analyzed by July 2012.* Specifically, this Goal assesses the environment to determine appropriate supply survey questions and methodologies, develops and distributes the surveys, analyzes the results, shares the results with appropriate parties, reviews the methodologies, and makes recommendations about further health care workforce data collection and analysis to DWD and DRL. Overall evaluation will include tracking the progress including the timeline of each of the activities under the Goal 1 objectives and making adjustments as necessary in order to lead to the desired outcome.

***Outcome Measure 2:*** *Enumeration and analysis of the non-governmental public health workforce for at least one region in Wisconsin will be completed and available to inform workforce planning and ensure emergency readiness by June of 2012.* Evaluation activities will include: analysis of updated occupational data sets for the non-governmental public health workforces; prioritized list of disciplines and entities providing essential public health services to inform the scope of the project; standardized methodology determines provider to population ratio for the non-governmental public health workforce; non-governmental public health workforce surveys are analyzed, providing additional information for supply and demand analysis and subsequent workforce projections; analysis of refined forecast data is available for the non-governmental public health workforce; and evaluation of pilot methodology to forecast non-governmental public health nursing workforce needs, with consideration to health indicators and emergency readiness recommendations, assesses applicability to other non-governmental public health fields.

***Outcome Measure 3:*** *Dental and mental health HPSA designations will be submitted for all new eligible areas by June 2012 to maximize provider eligibility for HPSA-linked resources and statewide provider shortage data will be available for workforce analysis and planning.* Evaluation activities will include: documenting the process for completed subcontracts with Wisconsin Primary Health Care Association; reviewing and documenting the process for HPSA survey data entry, as well as mental health provider

data and Medicaid dental claims data; an ongoing review of updated HPSA provider database for non-HPSAs to determine its viability; tracking new HPSA applications for all areas not currently designated but that are eligible; tracking the development of workforce and vacancy data reports and datasets from the online mental health primary care provider database; and tracking requests for “HPSA profiles” available via the primary care office webpage.

**Outcome Measure 4:** *Forecasted supply and demand projections based on various policy scenarios are available.* Evaluation activities will include: evaluating potential scenarios to run using the existing projection tool after consultation with stakeholders and policymakers; tracking changes to the existing projection model to ensure it has the capacity to generate supply and demand projections based on selected scenarios; tracking results of sensitivity analyses based on specific requests from policymakers and stakeholders, and preparing and documenting comparative analyses of nursing workforce supply and demand projections for selected policy scenarios.

An overarching consideration for this evaluation will be to show that the data and analysis inherent in this project is being used to argue for and obtain private and public support for a health workforce available to and accessed by all of Wisconsin’s communities, especially our most vulnerable that already are facing chronic shortages.

**5. SUSTAINABILITY:** The primary organizations who need workforce data are the members of this Collaborative. We cannot meet our individual service missions without this collaborative work being sustained. An explicit outcome of this project is to develop a process for collecting and analyzing data that can be continued on a regular basis. An important strength of this project is that the key statewide organizations that you would need to support the sustainability of this project are an integral part of the Collaborative. Accordingly, the Collaborative will seek sustainability through three strategies:

- (1) Requesting the Wisconsin Departments of Health Services (DHS), Regulation and Licensing (DRL) and Workforce Development (DWD) to include in their Departments’ budgets a continuing appropriation designated to support workforce data collection and the related analysis activities. If the current level of funding doesn’t exist, the Departments will include a budget request in the next appropriate budget cycle for a continuing appropriation for data collection and analysis activities.
- (2) Continue to pursue grant and federal funding.
- (3) Develop a business plan that considers producing revenue from marketing the data, the reports and other products in a manner consistent with public access.

**6. DISSEMINATION:** Tim Size, the Collaborative Chair and Project Manager, along with guidance from the Academic Partner, Dr. Peter Layde and in conjunction with the rest of the Steering Committee, will be responsible for the overall dissemination. Mr. Size is also the named lead for dissemination in the proposal submitted to the University of Wisconsin.

Dissemination, the making available of relevant workforce data and forecasts, is at the very heart of this project. WHWDC will disseminate select information to the following stakeholders: educational institutions, health care agencies, policy makers both public and private, industries, and prospective students about future needs for the targeted health professions based on evidence. The expectation is that stakeholders will help the WHWDC to determine what data to gather and analyze and will support effective dissemination of this workforce data. At this point, it is anticipated that a series of reports will be developed. However, there may be other dissemination methods that explicitly target specific groups.

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## REFERENCES

### Endnotes

<sup>i</sup> Accessed July 10, 2008, at <http://www.iom.edu/?ID=53452>.

<sup>ii</sup> Kaiser Daily Health Policy Report, 10/06/08.

<sup>iii</sup> Daniel W. Rahn and Steven A. Wartman, "For the Health Care Work Force, A Critical Prognosis," *Chronicle of Higher Education*, 11/02/07.

<sup>iv</sup> Wisconsin Council on Medical Education and Workforce, "Who Will Care For Our Patients" an update expected to be released on 11/12/08.

<sup>v</sup> *Stepping Up to the Challenge: A Call to Action Report* (p 36) "**Goal Statement:** Sufficiency: Assure a sufficient public health workforce that is qualified to meet the demands of the population. **Objective 3:** Identify, define, and standardize workforce data systems to create new meaningful data and to make full use of the data that affects the public health workforce supply. **Rationale Statement:** Adequate data allows projections of current and future public health system workforce needs to assure population health needs are addressed. **Outcome Measure** (e.g., What will be different in 2010?): By 2010, significant baseline data will be available to (1) identify the current workforce demographics; (2) project future workforce needs; and (3) to provide better integration of data sets to calculate inputs (FTEs, funding) against outputs (health status, health outcomes)."

<sup>vi</sup> Editorial, "Health Workforce Planning Blindfolded," *Eye on Health*, 11/01/07

<sup>vii</sup> Tim Size, "Managing Partnerships," *Health Care Management Review*, Volume 18, Number 1, Winter 1993, pp. 31-41. Copyright © 1994, Aspen Publishers, Inc.

### Glossary of Acronyms

**ANew:** Association of Nursing Education in Wisconsin  
**Collaborative:** The Wisconsin Health Workforce Data Collaborative  
**DPH:** Division of Public Health, Department Health Services  
**DHS:** Department Health Services  
**DRL:** Wisconsin Department of Regulation & Licensing  
**DWD:** Wisconsin Department of Workforce Development  
**HIM:** Health Improvement Model  
**HPSA:** Health Professional Shortage Area  
**MCW:** Medical College of Wisconsin  
**MUP:** Medically Underserved Population  
**PCO:** Primary Care Office, Department Health Services  
**RWHC:** Rural Wisconsin Health Cooperative  
**SCHWD:** Select Committee on Health Care Workforce Development  
**UWSMPH:** University of Wisconsin School of Medicine and Public Health  
**WCN:** Wisconsin Center for Nursing  
**WHWDC:** Wisconsin Health Workforce Data Collaborative  
**WNA:** Wisconsin Nursing Association  
**WMS:** Wisconsin Medical Society  
**WPHCA:** Wisconsin Primary Health Care Association