Regulation Matters:
a CLEAR conversation

Episode 6: The Role of Regulators in Health Workforce Data Collection

August 14, 2018

Line Dempsey: Once again, welcome to our podcast, Regulation Matters: a CLEAR conversation. I'm your host, Line Dempsey with the North Carolina Dental Board. I'm the senior investigator there, and I'm the current chair of the National Certified Investigator Training Committee with CLEAR.

For those that are not familiar with CLEAR, CLEAR is the Council on Licensure, Enforcement and Regulation, and it's an association of individuals, agencies and organizations that comprise the international community of professional and occupational regulation. Our podcast is a chance for you to hear the latest and greatest in our community.

I'm very excited about this episode as it is a lead up to a conference session that's being presented in the Administration, Legislation and Policy track at CLEAR's 2018 annual educational conference in Philadelphia this September. Today, I'm joined by an expert panel representing the US and Canada to discuss the role of regulators and health workforce data collection.

First, I have Dr. Jean Moore, who is the director of the New York Center for Health Workforce Studies and serves as principal investigator for two corporate agreements funded by the Health Resources and Services Administration, the Oral Health Workforce Research Center and the Health Workforce Technical Assistance Center. Also David Armstrong, Dr. David Armstrong is the director of the Health Workforce Technical Assistance Center at the New York Center for Health Workforce Studies. Dr Elizabeth A. Carter, she is the Director of the Virginia Department of Health Professions, Healthcare Workforce Data Center and Executive Director for the Virginia Board of Health Professions. And finally, Dr. Ivy Lynn Bourgeault, a professor at the Telfer School of Management at the University of Ottawa and the Canadian Institutes of Health Research Chair in Gender, Work and Health Human Resources. [Laughing] There's a lot of workforce and a lot of work in human stuff in all the introductions, so welcome everybody.

Guest speakers: Hello!

Line: Great; well, thanks for joining me. We certainly do look forward to this. So the topic is regulators

role in health workforce and data collection. Policymakers and planners in all jurisdictions face complex challenges in assuring access to needed health care services. Evidence-based decisions require objective and comparable provider supply and distribution data; licensing boards are in a unique position to help. Let me start by posing, I guess, a question for each of you individually, but we'll go one at the time. Jean, starting with you, can you tell us why states are increasingly interested in health workforce data and why they look to collaborate with licensing boards on developing data collection strategies?

Jean Moore: Sure, happy to answer that. So, for starters, I think it's important to recognize that there are a limited number of national data sources on the health workforce, and unfortunately these sources can be fairly problematic for a lot of different reasons. They're not always up to date, they can be incomplete, they can cost money, and probably most importantly, they typically aren't able to support small area analysis. So that kind of raises the question, Why should states be concerned about the availability of health workforce data and the issue of being able to conduct small area analysis? I think it's generally recognized that states need data that can support health workforce planning. And so what do they need to know? We need to be able to describe the supply and distribution of health workers, and I think there's a wide array of professions and occupations for which there is an awful lot of interest: primary care providers, behavioral health professionals, oral health providers, obstetrical providers. I think that the issues may vary by state, but I think there is recognition that the need for understanding the workforce in a state is really critical, and supply and distribution really is the starting point.

So then what? Once you know about supply and distribution, what can you do? Probably one of the most important things is to identify areas of need. And again I think that in trying to ascertain where are the areas that perhaps have the greatest need for certain providers, it doesn't lend itself to looking at a county level or a state level, 'cause a lot of times, what you find is a great deal of mal-distribution. So a state like New York, say, looks to have an awful lot of providers in a lot of different professions, but unfortunately, they're pretty poorly distributed so that we may have large concentrations in some areas and shortages in others. So again, it really does require small area analysis. And then what do you do with that information once you get it? The real key is developing programs and policies to address the workforce needs in underserved communities.

So, why are state planners inclined to collaborate with licensing boards on the collection of health workforce supply data? Frankly, it's a pretty logical choice. License renewal processes create a great opportunity for collecting data needed for workforce planning purposes. And clearly, state licensing boards in partnership with key stakeholders within a state can help support the collection of data needed to inform state-level workforce development efforts.

Line: That's very interesting. I guess it would be helpful, like for example, coming from my background in dentistry, if we have underserved populations, that maybe an area doesn't have oral surgeons in that particular county or the neighboring county, that would be information that you guys can take. And then what would you do with that?

Jean: Well, I think one of the interesting aspects to that is that maybe in certain areas, and probably the best example is rural areas where perhaps there isn't a sufficient population base to actually develop an oral surgery practice, but what you could do is build some strategies for getting people to the services they need, sometimes through telehealth.

So I think that it's not an issue of 'oh, we need more of this' or 'we need more of that'. I think it starts with what do we know about the population, what do we know about the needs and what are the most efficient ways to get services to them? Another area in oral health just relates to lack of access to *general* dental services, and in some states they've introduced dental therapists as a way to create access to basic restorative oral health services for underserved populations. So again, I think it's important to recognize it's a multi-prong strategy, but it really starts with good data to understand what the issues are.

Line: Excellent, well, let me move over to David then. David, the HWTAC, or the Health Workforce Technical Assistance Center, has been tracking state health workforce data, doing this collection for the last three years. Can you tell us what you're seeing? Are more states engaging in health workforce data collection? Are licensing boards more actively engaged in these efforts? What seems to be going on?

David Armstrong: Well, first, let me go ahead and tell you a little bit about ourselves. HWTAC was formed as a corporate agreement between the New York Center for Health Workforce Studies and the Health Resources and Services Administration (that is, HRSA). And we were created as a partnership between the New York Center and the University of North Carolina, and our primary mission is to provide technical assistance to states and organizations engaged in health workforce planning. And we have three areas of focus: health workforce data collection, analysis, and dissemination. You can find out more about us on our website at healthworkforceta.org. On our website, you will find an ever-expanding webinar library and our health workforce data collection inventory, which we use to track state data collection efforts.

And as of right now, 49 organizations in 36 states report collecting health workforce supply data, and the vast majority of those states collect data with the cooperation of their state licensing boards. Indeed more than half of the licensing boards in the country collect health workforce supply data, and in many of those states, the data collection is mandatory.

Now, in regards to the data question itself, a lot of states follow HRSA's Minimum Data Set guidelines, which describe the basic questions you need to ask in order to have enough information to conduct basic health workforce analysis. That is, states aren't collecting mountains of data on individuals, but instead they are trying to collect just what they need to answer those basic policy questions. Now actually back to your original question, yes, since the onset of our tracking system there has been an increasing interest in collecting health workforce data with the cooperation of state licensing boards. And as Jean noted, this has largely been driven by the understanding that you need good data to make

informed policy decisions.

Line: That makes good sense. Well, let me then see what we're doing up north. Ivy, what are the Canadian best practices in health workforce data collection, and how are these efforts helping inform and develop health policy and decision making?

Ivy Bourgeault: Super; well, thank you for that question. What we prefer to use, the term we prefer to use in Canada are sort of promising practices. We have 13 jurisdictions plus the federal government, and so we experiment in one jurisdiction and hopefully translate that to others. I think that health workforce regulators play a really critical role in data collection, and it just kind of reiterates what Jean commented on that the licensing renewal process is a really great opportunity to collect data. One of the data sets that we used to have for physicians was the National Physician Survey, and it was a survey of all physicians - a census of physicians - and the response rate was getting to be 17 percent. And there's really great difficulty being able to say anything robust with that type of response rate. So again, when you're getting exact information from the licensing renewal process, that's a real promising practice.

So I'll draw on the example of the province of Ontario where I am situated, and it is a province that has umbrella legislation for all health professional regulatory bodies. We call them colleges here, and the colleges have a mandate in the legislation that they are to provide to the Ontario Ministry of Health 59 data elements. That is similar to the HRSA's minimum data set guidelines. So all health professions that are regulated - and there are over twenty that are regulated, some are not such as personal support workers, but many of them are, so we have over 20 - and for a number of years now, we have some robust data elements.

And it's important that we look at data elements that are not just about head count, but looking at activity and participation rates because we know that there have been changing practice patterns. That doesn't only exist within nursing or medicine; it exists across the board. So it's not like a nurse is a nurse is a nurse. So we need to have data elements that capture more than just headcount.

So I'll draw upon three examples there. The first is nursing and midwifery. Midwifery is a very small profession in our country. We have a direct entry midwifery exclusively, so we don't have nurse-midwifery as you do in the United States, and because it's a small profession and has developed more recently, there's a small number of providers. And we are able to have standardized data across the country for them, 'cause it's a bit easier to do that. Nursing is the largest profession, but it has been making extensive efforts at the different regulatory levels - registered nurses, practical nurses, nurse practitioners - to get some very exact information about them. And so, although we have in the province of Ontario 59 data elements that all regulatory bodies must contribute, that is not the case across Canada. So nursing has been working really hard to have some standardized data across the 13 jurisdictions plus the federal government. In the case of medicine, as I mentioned before, they were having difficulty in terms of the response rate for the National Physician Survey. And building on the processes in Ontario to have those 59 data elements that are provided by the regulatory body, there

has been a process spearheaded by the Royal College of Physicians and Surgeons of Canada, our national regulatory college, to kind of coordinate amongst jurisdictions the collection of a minimum data set. Now it's fewer than the 59 data elements, but at least there's movement to collecting that. So I think that they have four or five jurisdictions now, and then the other jurisdictions are going to follow through to make sure that there is a standardized data set.

Other professions have been looking towards having more coordination of the regulatory body. So we've been working with dietetic profession, and so we're very hopeful that they will come on board for that. And by we, I mean not just my chair in gender, work and health human resources, but I coordinate the Canadian Health Human Resources Network. And we work in partnership with the Canadian Institute of Health Information, and they have been coordinating a national data collection, and so they are working with tools provided by the World Health Organization, most recently the National Health Workforce Accounts, to really try to have very standardized data across the jurisdictions. It's a difficult task. And regulatory bodies can play a really crucial role in being involved in this process, again because of that primary opportunity at licensure renewal.

Now, in terms of how these efforts have helped health policy decision-making, as both David and Jean have mentioned, this is very important knowing what your health workforce is, and how that needs to be adjusted to meet changing population needs is critically important. And we have, I would say, we don't have a concentrated table where we have those discussions. The federal provincial territorial assistant deputy ministers on health workforce do gather together on the Committee of Health Workforce. And both the Canadian Institute of Health Information and the Canadian Health Human Resources Network - we coordinate a biennial, so every two years, Canadian Health Workforce Conference, and that is where we present some of the latest data, some of the latest research on health workforce issues. Our next conference is this fall, and we do have a healthy participation by health policy decision-makers at that conference. And then in between conferences, we have different conversations where we try to address the different health workforce needs of different jurisdictions.

And so I'll close off with one very specific example. The jurisdiction that we've been working on (and it gets into the issue that Jean commented on in terms of small area analysis), we have been working with a small team at the Canadian Health Human Resources Network with the Toronto Central Local Health Integration Network (so it's like the regional health authority for the city of Toronto) and they've been very interested in doing interprofessional primary care workforce analysis. And so, the dataset that they collect in Ontario is one of the datasets that we draw upon 'cause we want to cover off a number of primary care providers, not just primary care physicians, but nurse practitioners and others who contribute to primary care and bringing in a variety of different data sets. And one that has been really very helpful is the Canadian Institute of Health Information has created a tool called Pop Grouper that gives you a very close sense of what your population health needs are. And so, what we've worked with the Toronto Central Local Health Integration Network is to create a model where we meet the population level data and the health workforce data to do workforce planning on an ongoing basis in that local region, but then we're hoping to work with other regional health authorities to really build on that. So those are some examples from the far north.

Line: Great, awesome. Well, then let me go a little closer to my home and Virginia. Liz, can you describe your state health workforce data management system and your strategy for translating data and information that are needed by your stakeholders.

Elizabeth Carter: Yeah, thank you so much. I think I've got a little bit of a different perspective because in Virginia, we have our Department of Health Professions. It houses our 13 health professions licensing boards. It also has the Board of Health Professions; it has research staff there. Now, about ten years ago it became a mandate from our governor through his Health Reform Commission to create the Healthcare Workforce Data Center within our agency. We have licensing data that dated back to the 1980s for over 60 professions already, and everybody was sort of used to providing information to us.

And today, we are surveying 28 of those professions along with our nursing education for LPN and RN program. The question that you've got here, so I wanna turn it around a little bit. You said, when our strategies for translating data into information that's needed by stakeholders - Our stakeholders told us the information they wanted. We brought together members of our general assembly, the governor's cabinet, academicians, the professions themselves, of course, the licensing boards. Over a hundred stakeholders told us the key policy-relevant questions, which ended up being our minimum data set that Jean and others have alluded to earlier. So the demographic characteristics, the age, retirement plans, where are you practicing, what are the patient characteristics that are there, what are your plans for retirement, how much educational debt do you carry, how much income - those key questions not only for research purposes for our own governmental policy and planning, but for chambers of commerce, information that is interesting to students and career counselors, you name it, the questions that they wanted answered can be addressed by what they wanted to have (and hopefully we have this now) - census quality data. So we've incorporated our surveys into our licensing renewal system which is online, and we get on average 85 percent response rates. I've gotten as high as 97 percent response rate.

Line: Wow!

Elizabeth: Yeah, and you know what, it's in our law. We have legislation passed in 2009 that we have the right to collect that data in the first place - 'cause you have to have that; you can't just be Big Brother and collect a lot of this stuff without statutes that permit it. But it's something we've found that our stakeholders up in the beginning, the professions themselves, want to know a lot of the answers to these questions. And every time we get our results back, we do a report to the respective licensing board, we post it on our website, and we also do break-outs by geographic regions that have policy relevance. It may be Workforce Investment Act or it might be Area Health Education Center, Health Planning Districts - we do a lot of just geographic breakouts. We try to make it as close as we can to what a census would be. And so we do a lot of data visualizations and what we instituted back in 2013 was a very consistent methodology across professions. We found before that some professions may not work a 40-hour week; their typical work week may be 32 hours or it might be 55,

but we came up with a standard full-time equivalency measure of 2000 hours, so you can compare and contrast multiple professions on that full-time equivalency variable as well as the demographics that we mirror what's in the US Census to the degree we can. So we can tell you lots of the ethnicity and age and all those kinds of things. So it's been a wonderful last 10 years. Members of our general assembly reference our information. We're often called upon to include information about where people are working and what their specialties are and all those sorts of things which we now have at our fingertips because we have the ten years' worth of data across these multiple professions. So we are speaking to the regional information that has been referred to earlier. We do provide the data for our health professional shortage area designations that reported to HRSA and that brings money to that locality. That brings a lot of resources that wouldn't be there otherwise. So we're getting a return on investment from this data. It's not only from a governmental perspective, but it's also for those communities. It's very apparent and it's very useful. The value is just there for them.

We have also been involved quite a bit in the opioid crisis. We need to know where our prescribers are. We've been working with multiple other state agencies to look at (I'm getting into the weeds here, but) morphine prescribing - who can do that within certain areas. We work with the Department of Criminal Justice Services to look again at the opioid issue. We've also been involved in helping students and guidance counselors to just have a one-pager. Not everybody is gonna be a dentist or a physician or a nurse, but you might be very much interested in being a respiratory therapist or a rad tech or a lot of other professions that you don't think about. And part of the things that we're looking at is we're looking at team delivery for the future, so we really need to understand more than just the larger professions. And what we're able to now do is give you insight into that you get pretty good money being a dental hygienist, for example, for two years of education. So what we did was look at the pipeline from that perspective, make sure that students are aware just for a couple of years past high school, what you can do if you get that math when you start out early. But that is then distributed to our guidance counselors and our career counselors in the community college system.

So there's a lot of stakeholders out there, and we try to address as many as we can, and we do respond to individual questions from researchers. We have been sharing our minimal data set and our approach with lots of other states. Thank you, Jean and your folks and Dave and all those for pointing people in our direction, and we love to work with others. The key we try to make sure that we're working on here is being able to cross-reference back and forth across all these data collection efforts. Our data are cross-walkable with the Federation of State Medical Boards, the surveys that they've been working on, the National Council of State Boards of Nursing, the Federation of State Boards of Physical Therapy. And also we're working with the psychologist counterpart. So we try to make sure that - you're not gonna get it word-for-word - we try to make sure that we're all able to do apples to apples comparison because that helps us all.

Line: Very good. Well, I think my appetite is quite whet to hear your presentation in September. I think it's gonna be very interesting. I do wanna thank all of you, Jean, David, Ivy and Liz, for your time and being a part of this CLEAR podcast. It really is wonderful to have the opportunity share and learn from each other. And I really like the idea of getting a preview to a presentation that's gonna be happening

at our annual conference in September, so I look forward to hearing you guys then.

And I also wanna thank our listeners. We'll be back with another episode of Regulation Matters: a CLEAR conversation very soon. Please subscribe to our podcast if you haven't already on Podbean, iTunes, on Apple Podcast, Google Podcasts, Google Play, Stitcher, Spotify or TuneIn - we're available pretty much everywhere - and you can also find out more information about us at www.clearhq.org for additional resources and the calendar of upcoming training programs and events. Also on the apps that I mentioned earlier, you can leave feedback and comments, which are always helpful to us as we bring this program to you. Finally, thanks to CLEAR staff, specifically Stephanie Thompson, our content coordinator and editor for this program. I'm Line Dempsey, and I hope to be speaking to you again soon.

The audio version of this podcast episode is available at https://podcast.clearhq.org/e/the-role-of-regulators-in-health-workforce-data-collection.