HWTAC
Health Workforce Technical Assistance Center

RESOURCE BRIEF
August 2016

Health Workforce Data Collection FAQs

As implementation of health reform initiatives accelerate, states are increasingly aware of the need to collect state-level health workforce data to determine adequacy of the current health workforce to meet the expected increase in demand for health services. This brief is intended to assist states and organizations who are engaged in health workforce planning by answering some frequently asked questions about health workforce data collection.

Q: What are some different ways to collect health workforce data?

A: There are generally 4 methods to collect health workforce data:

1. Licensure Process. Data are collected as part of the licensure process when health professionals apply for their initial license and when they renew, capturing 100% of the workforce. This is one of the most efficient and cost-effective methods to collect data. Some questions on the licensure forms may be mandatory, while others are optional. The organizational structure of the licensing boards will present different opportunities and barriers to data collection. (Examples: North Carolina, South Carolina, Virginia)

2. Surveys. Data are collected through surveys, either in conjunction with the licensure process or as a separate effort. This method requires more staff time and money. Response rates may vary, but this is a good option if health workforce questions cannot be included directly on the licensure forms. (Examples: New York, Wisconsin)

3. Continuous Monitoring. Data collection begins with a list of all licensees in one or more professions. From there, states track individuals through surveys, news clipping services, and other methods to determine practice status, practice setting, and other characteristics. This method can be costly, but it may provide more up-to-date information. (Examples: Iowa, Nebraska)

4. Secondary Data Sources. Secondary data sources can also be used to enumerate the workforce in a specific state. These data sources include the National Provider Identification (NPI) file, the American Medical Association (AMA) Physician Masterfile, the US Bureau of Labor Statistics, and the Census Bureau's American Community Survey, as well as state professional associations. Additionally, all-payer claims databases can be used to enumerate the health workforce in select states, but there are significant limitations.

Q: What is the MDS?

A: The Minimum Data Set (MDS) provides basic, consistent guidelines for fundamental health workforce questionnaires. These questions can be used by anyone who wants to collect data on the supply of health workers, whether through the licensure process or surveys, and can be adapted for additional professions. MDS questions focus on essential demographic, education, and practice characteristics.

For more information, visit http://www.healthworkforceta.org/wp-content/uploads/2015/03/MDS_Resource_Brief.pdf.

Q: What states have implemented the MDS?

A: Many states are already collecting health workforce data, with a customized MDS in place to collect any additional data they need for health workforce planning. Some examples of states that are already collecting an MDS include North Carolina, Virginia, New York, Indiana, and Minnesota.

For more information on which states are collecting data, visit http://www.healthworkforceta.org/resources/state-health-workforce-data-collection-inventory/, or contact HWTAC.

Q: How do you work with licensure boards to collect and share data?

A: Relationships are key. Licensure boards are important partners in health workforce data collection, but their main priority is regulation to protect patient safety. They often don't have resources (ie, funding, staff, time) to collect additional data, and in some states, current legislation restricts their ability to share data.

Show the boards the value of collecting additional workforce data as it relates to evidence-based regulation, and look for ways to minimize their burden, especially during the initial development period. Treat them as a valued partner and bring them into the conversation very early to build trust.

Q: How easy is it to get licensure boards to add or change questions?

A: This will vary from state to state. It is important to remain cognizant of a) the financial cost to the board to change online renewal questions; b) the time that it takes respondents to complete their licensure renewal form; and c) the need for comparability across time. Only request changes or additions when absolutely necessary.

Some states mandate the collection of data through legislation, which affects how easy it is to add or change questions. For example, Florida's data collection is legislated, and any question must go through a lengthy public comment period to be added or changed. This process has the potential to subject questions to bias from the public and special interest groups.

Q: Do you have examples of questions that we could ask?

A: Yes. The National Forum of State Nursing Workforce Centers, and the Federation of State Boards of Physical Therapy (FSBPT) have developed suggested Minimum Data Sets. Additionally, HRSA has developed MDS standards, and the WWAMI Center for Health Workforce Studies at the University of Washington has a questionnaire library containing data collection instruments volunteered by several states. The HWTAC is also planning to post selected instruments from states in 2016.

http://bhpr.hrsa.gov/healthworkforce/data/minimumdataset/

http://www.nursingworkforcecenters.org/minimum-dataset-surveys/

http://www.fsbpt.org/FreeResources/RegulatoryResources/MinimumDataSet.aspx

http://depts.washington.edu/uwchws/chws-questionnaire-library.php

---

Q: I'm interested in allied health and administrative support workers. They're not always licensed. How do you count them?

A: For those professions, it may be necessary to conduct surveys, or rely on other data sources such as professional associations or the BLS, noting limitations as appropriate.

Q: What staff and resources are needed to undertake health workforce data collection and analysis?

A: This depends on many different factors, such as how many health professionals you want to track, the method used to collect data (licensure, survey, continuous monitoring, secondary data), the types of deliverables for which you're accountable, and organization structure. If the data system is embedded within a larger organization, such as a university or state government office, it is likely that some administration, finance, and infrastructure resources are already available for basic operation. If the data system is a stand-alone organization, you will need to secure funding.

In terms of staff, you may consider having a director to guide the work, make decisions, present results and acquire funding; one or more project managers/researchers to analyze data, write reports and present results; and a data manager to collect, clean and analyze data. Other positions may include communications specialist, visualization specialist, research assistant, administrative assistant, grants manager, and financial manager.

Additional resources needed include computer hardware and software for data management, statistical analysis, GIS, and graphic design.

Q: How do you fund health workforce data collection and analysis?

A: Data systems can be funded through state appropriations, private foundations, grants and contracts, and on a cost-recovery basis. Each funding mechanism has its challenges. State appropriations are tenuous; administrations and priorities change, and budgets get cut. Foundations are often geared to fund initiatives that show more tangible results. Grants are often time-limited. Cost-recovery is subject to demand for data and services, and limits the type of analyses and reports that you can do. Stakeholders who require data may be persuaded to fund the analysis costs to meet their specific needs, but they frequently are not willing or able to fund the fixed infrastructure costs. Consider the appropriate funding source for the specifics of your data collection effort, given the meaning and value of the project.

This resource brief was prepared by the Health Workforce Technical Assistance Center (HWTAC) staff , Katherine Gaul and David Armstrong. HWTAC is supported by the Health Resources and Services Administration (HRSA) of the US Department of Health and Human Services (HHS) under grant number U81HP26492.

Established to support the eff orts of HRSA's National Center for Health Workforce Analysis (NCHWA), HWTAC provides technical assistance to states and organizations that engage in health workforce planning. HWTAC conducts a number of initiatives each year designed to provide expert assistance with health workforce data collection, analysis, and dissemination. HWTAC is based at the Center for Health Workforce Studies (CHWS) at the School of Public Health, University at Albany, State University of New York, and was formed as a partnership between CHWS and the Cecil G. Sheps Center for Health Services Research at the University of North Carolina.