The Licensing Board's Role in Collecting Workforce Data

This article is based on a presentation by Kathy Arney, PT, MA, Executive Director, North Carolina Board of Physical Therapy Examiners, and Katie Gaul, Program on Health Workforce Research and Policy, Cecil G. Sheps Center for Health Services Research, University of North Carolina and the Health Workforce Technical Assistance Center, at the 2016 FSBPT Annual Meeting.

North Carolina has been a pioneer in implementing a system to collect workforce data. This session highlighted speakers from the North Carolina Board of Physical Therapy Examiners (NCBPTE) and the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill discussing the importance of, and the challenges and opportunities associated with, collecting this data.

North Carolina (NC) has had a health workforce data system since the 1970s. At the time, there were fewer barriers to begin collecting this data. There wasn't as much concern about licensee or patient privacy or data security. The NC system is often considered the gold standard in workforce data collection and synthesis.

What worked for creating a system then, however, does not necessarily work now.

Minimum Data Sets
Guidelines for the Minimum Data Set (MDS) were developed by the Health Resources and Service Administration (HRSA) and other experts to collect basic, minimum, consistent, and comparable data on the supply and distribution of health professionals. The MDS varies in order to collect information of most value to each profession, however typically the questions look at demographics, educational background, and practice settings. The HRSA has detailed information on its website,
http://bhpr.hrsa.gov/healthworkforce/data/minimumdataset/index.html.

An MDS can be implemented and promoted in multiple ways and through collaboration between organizations. For example, the Federation of State Boards of Physical Therapy (FSBPT) and American Physical Therapy Association (APTA) can work together to promote the MDS and to collect data. The state regulatory board can collect data through surveys and during the licensure process. Educating individual health professionals about the advantages of collecting this data can also help get them to spread the word.

Creating a Physical Therapy (PT) Minimum Data Set
In 2013, HRSA approached FSBPT and APTA about creating a PT MDS. A task force was formed, which struggled over a weekend to determine the type of data to capture and the

appropriate questions to ask. (i.e. Were individuals working in a particular specialty? How many hours are licensees working?). It's one thing to know the actual number of licensees; it's another to know how many hours of clinical care people are providing and where they're working. Asking the questions that drill down further allows a better understanding of the provider panel to which residents of the state actually have access.

From that weekend task force meeting came a draft document that was then circulated for stakeholder review to ensure the data to be collected was the data that should be collected. Modifications were made to questions to be asked about practice adding primary, secondary, and tertiary employment and the characteristics of that work.

The questions were then tested with a number of PT and PTA licensees working in a variety of settings. Cognitive interviewing was undertaken to determine if the questions were understandable and could be answered easily without additional interpretation. After making some clarifying corrections, the final MDS product was published in 2014.

The PT MDS is a standard set of questions that looks at the demographics, the educational background, and the practice settings, including types and length of time of work, for PTs and PTAs in the United States. The MDS looks like a lot of questions, but most are actually subsets of the particular practice setting to be more informative. Every effort was made to get the MDS to the actual minimum of the data needed to draw meaningful conclusions about the physical therapy workforce.

Implementation
Now that the PT MDS has been created, the goal is for all jurisdictions to implement it. Some states had already been collecting some data, but not necessarily the MDS data. Some states are considering implementing it. But it won't be an effective tool until the vast majority of jurisdictions have adopted and implemented it and the data can be aggregated. The survey can be found on the Federation's website at
https://www.fsbpt.org/portals/0/documents/free-resources/mdssurvey2016.pdf.

Because the regulatory boards are unique in having direct communication with each licensee, the easiest way to collect the MDS information is during the renewal process. The benefits of collecting data through licensure includes that boards have the opportunity to capture data on 100% of the workforce. It also builds in the existing data collection infrastructure and is cost-effective compared to periodic surveys. However, it is not always as simple as it sounds. Educating stakeholders that may also wish to use the workforce information to understand how to help the boards is the key to success.

North Carolina's process
North Carolina has an online renewal process and the data is collected electronically. Other jurisdictions send out printed or electronic surveys. Some require a response, while others make it voluntary. Often boards may find that they need a partner to synthesize the data collected and make it more meaningful. In North Carolina, the Cecil G. Sheps Center for Health Services Research is that partner.

In 1975, Sheps received federal funding to develop state health professions data systems. But three or four years into it the funding was cut and states were left to figure out how to fund it. North Carolina and a few other states were able to continue without the federal funds. Sheps approached the boards and on a handshake deal the boards agreed to allow

Sheps access to the data, which they crunched and gave back to the boards.

It is all voluntary. There is no legislative mandate and no appropriation. Sheps receives some governmental funding and also survives on grants and contracts. The boards also receive no funding to gather and release the data to Sheps, although the costs are considered to be minimal. Since 1979, NCBPTE staff have extracted data and sent it to Sheps annually for analysis. The plan is to soon replace the current North Carolina MDS with the new FSBPT/APTA version of the PT MDS. The two versions are similar, so it should be a relatively smooth transition.

Barriers to MDS Data Collection
Barriers to getting started include having the technology, the legal authority to do it, the staff and funding. A jurisdiction also needs to determine how to securely collect and store the data and who has access to it. Sheps is a good resource to get help to start answering those questions.

The number one barrier to states collecting and using data to inform policy is convincing funders, data collectors, board members, and others who can support the effort that this is a good idea. They have to be persuaded workforce data is as important to make decisions as the other areas of their lives in which they use data to make decisions.

The data has many uses.
- The data can be used to inform the education pipeline. It can track the number of graduates and indicate if new schools should be opened to graduate more licensees in a particular area.
- Combined with the National Physical Therapy Exam (NPTE) pass rates and scores, it can be used to evaluate program performance.
- It can be used to develop educational tools for specific workforces, e.g. re-entry, FEPT/FEPTA, and aging licensees.
- Looking outside of physical therapy, other MDS data can be used to determine if a second dental school should be built in the state.
- Students use the data to write their theses and dissertations.
- In a world of evidence-based policy making, this is part of that foundation too.

Justifying the need to collect data is pretty straight forward. Data helps states answer legislative and other inquiries. It helps track the educational pipeline and programs for PTs and PTAs. Gauging where shortages of care are located gives a pretty good idea what areas will suffer adverse health outcomes. It also can help push legislation, such as the Licensure Compact. For example, due to data collection, the NCBPTE knows there are areas of the state that are underserved — and they happen to be along the border of a neighboring state, which can be visually represented to a legislator or other stakeholders.

There are also organizational barriers, analytical challenges, and financial barriers. A state needs to decide who will collect the data — the boards, a university, research institution, or a professional organization. Decisions also need to be made on what data should be collected, if collection should be mandatory, and what should be reported and how. Data security and usage also would fall under organizational barriers. Analytical challenges include locating providers. If a licensee puts down the company's home address but actually works in a remote location, the data is skewed. Financial barriers include finding funding to

develop the database, implement it, and keep it running.

The best way to get around the barriers is to work together in developing and sharing resources. Jurisdictions with best practices should share them with other states as a model to begin the process. Share data use agreements, security protocols, and model legislation.

Examples of the value of data
Using the data, Sheps is able to chart trends. For example, the number of active PTs practicing in North Carolina has grown from 677 in 1979 to 6,631 in 2016, with active PTAs growing from 208 to 3,106 over the same time period. Sheps and the NCBPTE are able to chart where in the state PTs and PTAs practice. The caveat on location, however, is the current NC MDS data only shows licensees' primary practice address. It does not take into account additional practice locations; when the FSBPT/APTA MDS is implemented, additional practice locations will be tracked.

Age distribution is another important data set. For example, North Carolina data from 2014 shows the number of younger PTs and PTAs far outweigh the number close to retirement, indicating there is no need for an aggressive recruitment program to replace them. An important component of the data set asks about a licensee's future plans in patient care, helping to plan for anticipated future workforce needs.

Additional Requirements of Data Collection
North Carolina is required to release any information asked for, with the notable exception of Social Security numbers and exam scores. Requests may be from a company compiling a list of licensees and email addresses so the company can pitch them. In the past year, those requests have increased substantially. LexisNexis is among the companies that collects data and then resells it. It wants everything about the workforce, including licensure status, disciplinary actions, right down to year of birth. It's a lot of information and a lot of work to collect for the modest fee allowed to collect it.

Large commercial databases are not the only ones seeking data. For example, a licensee from the Raleigh Veterans Affairs office was seeking information on PT specialists — their roles, job description, and compensation. Again, the NCBPTE had the information, but it wasn't all aggregated and easy to compile. Because of that, it's important to have the data aggregated in a centralized location for easy retrieval.

Current and Future MDS usage
Few states are looking at an MDS for PTs at this time. Most states typically start with physicians and nurses, then go to pharmacists and dentists. However, as we move into more integrated care, PTs will play a big role and this data becomes important.

The physical therapy regulatory community is ready to implement the MDS. FSBPT has both the completed MDS and model legislative language allowing for the MDS to be collected. FSBPT could potentially develop software to help states collect, store, and share data and license the software to cover costs and provide technical assistance to the states. States should work with stakeholders to fund data collection, analysis, and dissemination.

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