federation forum
Winter 2018

This article is based on a presentation by Kathy O. Arney, PT, MA, Executive Director, North Carolina Board of Physical Therapy Examiners; Thomas Mohr, PT, PhD, FAPTA, Chester Fritz Distinguished Professor and Associate Dean for Health Sciences, University of North Dakota; and David Relling, PT, PhD, Board Member, North Dakota Board of Physical Therapy, at the 2018 FSBPT Annual Meeting.

Opportunities for Regulatory Effectiveness: Instituting Workforce Data Collection and Reporting

Participation in the Physical Therapy Minimum Data Set (PTMDS) effort – collecting and using workforce data — is an opportunity for regulatory effectiveness. Two states, North Carolina and North Dakota, shared a presentation consisting of an explanation of the PTMDS, an exploration of the data collected in their jurisdictions, and a summary of the important information learned as a result.

The PTMDS was developed several years ago when the American Physical Therapy Association (APTA), the Health Resources and Service Administration (HRSA), and FSBPT determined what would need to be included in a minimum data set that effectively describes the physical therapy profession. The working definition for the PTMDS is a consistent set of data elements to be collected on all licensees at regular intervals, in order to understand workforce needs related to health care access. Some states report they are collecting workforce data, but a complete data set does not exist for all states. Another challenge is states are not collecting the same data sets and have not shared the data with fellow boards. FSBPT is pursuing information concerning which states are collecting data, and what is being collected, to build on the PTMDS effort.

The PTMDS serves both policy and regulatory needs. Recognizing workforce needs and informing public policy and educational institutions is necessary to identify and address shortages and distribution gaps for physical therapy professionals and understand why they exist. The PTMDS helps policymakers and regulators understand trends —such as whether licensees stay and practice where they've gone to school — and identify reasons for certain practitioner distribution patterns. The PTMDS can help answer questions such as are there access gaps to the types of care that are needed in a geographical area and the types of licensees practicing there. The PTMDS can also collect data to show how many licensees are leaving the profession and for what reason. It isn’t possible to know how many licensees and licensees with practice specialties are needed in a specific area if we don't know who's in the workforce to begin with.

North Carolina
Workforce data collection has been a voluntary effort of all North Carolina health care occupational licensing boards for a number of years. The data is currently collected through the online license renewal

process, aggregated, and then submitted to the Cecil G. Sheps Center for Health Services Research ("Sheps Center") at the University of North Carolina. The Sheps Center reports the data on their website in various ways — including through interactive maps — which is useful to employers, schools, and policymakers, among others. Recently the North Carolina data was studied to better understand stroke populations, rehabilitation settings, and outcomes.

The North Carolina board receives frequent requests for workforce data, as is likely the case in other states. The PTMDS collects demographic information; current work settings; and types of patients that are seen in primary, secondary, and tertiary locations. The PTMDS then asks the individual's future plans involving their profession. It is a minimal question set and doesn't require much time for respondents to complete.

North Dakota

Boards should be aware of developments within their jurisdictions that could lead to changes in health care demand and a need for information about the health care workforce. A recent event in North Dakota — advancements in oil drilling technology — led to dramatic population growth in a rural part of the state that triggered concerns about a health workforce shortage. This situation created strong interest from the legislature on how to develop more health care workers in the state. The North Dakota Legislature appropriated funding to increase the number of health care program graduates to increase that workforce.

One-fifth of North Dakota's population is over sixty-five and some counties have a very high percentage of individuals over the age of eighty-five. There is a definite need for physical therapy services for these individuals to stay active and at home — another example of how health workforce data is valuable to address the need for physical therapists and physical therapist assistants in specific areas or counties. The workforce is changing in that the millennial generation now has the greatest number of individuals within the workforce. A Gallup poll in 2016 found millennials are more likely to be mobile and to change jobs. Without health data tracking, understanding this dynamic to address gaps in physical therapy services is guesswork.

A previous effort through the University of North Dakota to survey physical therapists and physical therapist assistants in the state to collect workforce data yielded too low of a response rate to be useful, but it led to the realization that the North Dakota Board of Physical Therapy is best positioned to capture all the information needed. The board determined that it had statutory authority to collect workforce data, and it worked with FSBPT to initiate the PTMDS effort. North Dakota is required to collect names, contact information, places of work, and license type. As the statutory language did not place limits on what could be collected, the board determined there were no barriers. Because the data was collected through the licensure renewal process it was seamless and just another step in the process.

Boards embarking on this kind of effort may want to do as North Dakota did with the University of North Dakota Center for Rural Health — partner with an entity that possesses the expertise to analyze and report data. The North Dakota data supported much of what was expected with respect to demographic information of the licensees. It also indicated that specific to educational attainment, the bachelors and certificate degree earning practitioners are declining. As expected, the number of Doctor of Physical Therapy entry-level degrees is increasing. The majority of PTs are working in outpatient settings, either in a hospital or outside of a hospital. Interestingly, the majority of PTAs are working in skilled nursing facilities, which is appropriate as we have established North Dakota's population is a rather aged one relative to many other states. Finally, the data clearly displays the urban/rural distribution divide in that most of the PTs in North Dakota are located in the four largest population centers. Rural communities have a hard time recruiting licensees, and interestingly telehealth isn't being utilized.

So what is the impact of one physical therapist in North Dakota leaving practice? It may seem like no big

deal, but when mapped the data shows that one physical therapist retiring or moving could represent a loss for an entire county. It would not be unusual in North Dakota to drive a minimum of thirty minutes to as much as three hours to see a health care provider. Having this kind of data really gives a clear and complete picture of access — or lack thereof — to care.

Next Steps for the PTMDS

States should begin by determining whether data is being collected, and if so, by whom. Sometimes it's the jurisdictional board, but it could be another state agency or department or an external organization performing this work. If the data is being collected by an entity other than the board, board representatives should obtain the collection instrument and share it with FSBPT's Professional Standards team to prepare a crosswalk comparison; this crosswalk determines whether any data collection gaps exist so they can be addressed. If the data collected does not include physical therapists and physical therapist assistants, board representatives should encourage the inclusion of those health care providers on the data collection instrument. This process will ultimately lead toward a robust set of data that will build a national PTMDS database.

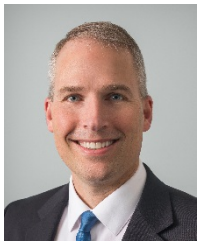
If the data is not being collected and the board wishes to do so, first determine there are no statutory barriers. Board members should review and liberally interpret their Practice Acts in favor of public protection. The Model Practice Act, sixth version, has specific language authorizing the board to collect PTMDS data. Those boards should also build collaborations, perhaps with schools and other stakeholders, to secure a data analysis and reporting partner. Reach out for other stakeholders such as the professional association as they are interested in this information and are likely willing to collaborate to share the information — especially with policymakers. Boards should also work with partners to inform stakeholders on why the data is being collected, how it can be used in the future, and how it can benefit patients, the public, the regulatory board, and other stakeholders within the state.

With an increasingly mobile society, and highly mobile millennials now comprising the largest number of individuals in the workforce, a complete PTMDS is critical to identifying how to address gaps in physical therapy distribution and practice and also where and what type of patients need to obtain that care. Having workforce data in a PTMDS will inform data-driven decisions around where PT and PTA schools need to be located, whether they should expand, and what type of patient population their graduates need to treat.

The Case for Regulatory Effectiveness

With heightened scrutiny on regulatory boards and their effectiveness, the PTMDS is one strategy to demonstrate how boards provide value in the form of data reporting to legislators, educational programs, and the public that indicates where physical therapists or physical therapist assistants are needed. No state can stand alone in this process; all boards need to collect and share data across the jurisdictions and maintain it in a national database to inform our decisions.

Kathy Arney, PT, MA is the current Executive Director of the North Carolina Board of Physical Therapy Examiners (NCBPTE). Kathy has worked with NCBPTE for ten years holding a variety of positions and has regulatory experience with developing and implementing programs related to continuing competence requirements, Rulemaking, Investigations and Disciplinary Actions and Scope of Practice issues. She is serving as the Vice Chair of the PT Compact Commission and the Chair of the Commission's Rules and Bylaws Committee. She has served on FSBPT committees and task forces, including Continuing Competence and Minimum Data Set (MDS) and most recently the Board Assessment Task Force.



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