

Data Consortium
Health Professions Workforce Data Workgroup
March 30, 2010

Nineteen persons representing 10 stakeholders (2 state agencies – KHPA, KDHE; 4 licensing boards – Dental, Health Occupations Credentialing, Healing Arts, and Nursing; and 4 other health organizations – KHI, Kansas Academy of Family Physicians, Kansas Association for the Medically Underserved, and Kansas Nurses Association) participated in the third meeting of this workgroup convened by KHPA in Topeka on March 30, 2010.

Purpose

Analysis and compilation of the materials presented at the first two meetings, discussion during those meetings and other input from stakeholders resulted in the development of a proposed minimum data set and four possible strategies for collecting that data from the health care professionals. The purpose of this meeting was to review those proposals and determine the recommendations to be made to the Data Consortium at the next meeting (April 7, 2010).

Presentation and Discussion

Dr. Mavoori presented the details of the four possible data collection strategies summarized in tabular format, which can be found at [Proposed Data Collection Model Draft](#). A summary of the strategies:

- 1) Each Licensure Board independently collects core data (Board defined), submits an extract for State reporting purposes, and other workforce data needed is collected by outside surveys (this is the method currently used in Kansas).
- 2) Each Board independently collects core and augmented data elements determined by a consensus of multiple stakeholders at state level, and submits an extract to the State for reporting purposes.
- 3) Each Board independently collects core elements (after data specifications have been standardized across the various Boards) and submits an extract to a third party vendor or State agency. That entity collects augmented data centrally and merges it with the extracts from Boards and other datasets (Medicaid, CAQH, NPI, etc.) for State reporting.
- 4) All core and augmented data is collected by an agency or third party vendor (state-level “clearing house”). Data needed by the Boards is made available to them; analysis and State reporting is conducted centrally.

The draft recommendations based on earlier workgroup discussions indicating a preliminary preference for Strategy 3 (with the option of pursuing Strategy 4 in the long term future), a schematic outlining the data flows for Strategy 3, and a draft of the minimum dataset based on all suggestions from the various workgroup members till date were also presented as a starting point for workgroup discussion.

Discussion Points:

- While some Boards indicated that they would not want their licensure data in one central system, another indicated that there is already a federal move toward a “clearing house” approach (MD and DO).
- While a central entity may offer the ability to pre-populate fields with data from other systems (saving professionals from having to enter data multiple times), there was an indication that some Boards felt they must collect the data directly from the professional and cannot accept input from an outside source.

- The Attorney General’s office is currently reviewing a question of how much information Boards can give to other agencies. This would be helpful in determining the feasible data collection strategy.
- Representatives of some Boards indicated that they have no need for, or interest in, data that they do not already collect. From this perspective, Strategy 3, which allows for such augmented data elements needed for state health workforce analyses to be collected centrally by a third party is desirable.
- With respect to “augmented data elements” – Dr. Allison (KHPA) indicated a need to remove the distinction between “required” and “optional” questions during the survey process in order to obtain more complete data. Board representatives pointed out that though they were open to this approach, the Licensure Boards will need to approve optional questions being asked of their professionals and make the determination whether to deny a license if a professional failed to complete such additional questions. Currently, licensure forms used by some Boards do have some optional questions, but no “hard stops” are built in so that professionals could proceed with their licensure process even if they choose not to answer these questions.
- Mr. Stiles (KDHE) emphasized the need to clearly explain to professionals why the “optional” data is needed and how it can be helpful to them and to the State as a whole (no additional surveys needed for HRSA/MUA data collection, added funding for the State, better distribution of services, etc.)
- The Board of Nursing has external entities that connect to their system in various fashions for data feeds; should there be a move to a centralized system, the RFP would need to account for such activity.
- An integral question for the Board of Healing Arts is how the data is to be transmitted, if different from the current system. This will need to be determined at the time of implementation of the proposed model with an effort made to minimize burden for the Boards.
- Some of the “core elements” indicated in the Proposed Minimum Dataset ([Overall Proposed Kansas Dataset](#)) are not currently being collected by all of the boards. So, some exceptions may need to be made on a profession-by-profession basis based on relevance.
- Data elements discussed at the meeting: NPI number; gender; hours worked at each site, as locum tenens or in telemedicine; residency information. It is understood that there are items on the list that do not apply to all professions.

Decisions – Recommendations – Next Steps

- Strategy 2 was not favored, as it would require the Boards to make significant changes to their current forms to add “augmented” data elements, and possibly frequent changes in the future, as outside needs arise.
- Strategy 3 was generally preferred by those present. A component of that (labeled in the meeting as “3a”) would be a standing option for a Board to enlist the central entity to assume collection of the core elements on their behalf.
- Strategy 4 was not favored in the short term, but may be an optional long-range plan, should the Boards desire to move in that direction at some point in the future.
- Dr. Allison expressed willingness to engage directly with the 8 Boards on this issue to express the increasing need for workforce data for policy planning and implementation of Health Care Reform.
- The draft list of core elements (posted online at http://www.khpa.ks.gov/data_consortium/WorkGroups/Health_Professions_Workforce/Dataset%20Recommendations_Draft2_033010.xls) needs to be finalized. Individual boards were asked to

review the list and respond to KHPA if there are items listed that they do not, or would not wish to collect.

- Specifications for the core elements will need to be standardized across the 8 Boards, hopefully by the end of 2010.
- A summary of the work of this group will be presented to the Data Consortium on April 7th, understanding that it is not in final form.
- KHPA will pursue funding for implementation of the proposal.

**Data Consortium
Health Professions Workforce Data Workgroup
January 15, 2010**

Twenty one persons representing 13 stakeholders (2 state agencies – KHPA, KDHE; 4 licensing boards – Healing Arts, Nursing, Dental, and Pharmacy; and 7 other health organizations – KHA, KHI, BCBS-KS, St. Francis Hospital, KU Medical Center-Wichita, Kansas Academy of Family Physicians, and Kansas Nurses Association) participated in the second meeting of this workgroup convened by KHPA in Topeka on January 15, 2010.

Purpose

The first meeting in November 2009 focused on compilation of analytical needs from different stakeholder perspectives (regulatory, access to care research, underserved area designations, workforce supply and demand analysis, etc) related to health professions workforce data collected in the State of Kansas. The purpose of this second meeting was to review the work accomplished since then to match those needs with data currently collected by the 8 Licensure Boards, KHPA, and KDHE to identify gaps and review these gaps to understand any data collection challenges. The input gathered from the workgroup members will guide the development of recommendations related to workforce data collection for presentation to the Data Consortium and the KHPA Board.

Presentation and Discussion

Dr. Hareesh Mavoori gave a brief overview of studies related to physician and oral health workforce in Kansas (discussed in more detail at the November 2009 meeting) as well as related initiatives in other states.

Tables were presented which summarize data that is currently collected by Kansas licensing boards and sent to KHPA and data which is included on licensing applications, renewals and reinstatement forms, in detailed and higher level formats. These can be viewed at

http://www.khpa.ks.gov/data_consortium/download/BoardDataFields_Comparison_Draft.pdf

http://www.khpa.ks.gov/data_consortium/download/LicenseBoardElementsSummary-Providers_Detailed.xls and

http://www.khpa.ks.gov/data_consortium/download/LicenseBoardElements_Providers_Grayscale%20map.pdf , respectively.

Rachel Lindbloom, KDHE Office of Health Assessment, presented a table showing elements currently in their dataset. It includes information received from the boards and collected by surveys. The list also included some new items which they need to begin collecting. These include demographics (race, ethnicity, languages spoken), patient access (percentage of patients who are on Medicaid and sliding fees, and wait time for new patients), and planning for the future (providers' plans to retire in the next 5 years). The document is posted at

http://www.khpa.ks.gov/data_consortium/download/KDHE%20Data%20Field%20Review.pdf

A Needs/Gap Assessment Worksheet, summarizing the documents named above, was presented and discussed point-by-point. It is available, along with notes from the discussion at

http://www.khpa.ks.gov/data_consortium/WorkGroups/Health_Professions_Workforce/Needs_Assessment_DC_Health_Professions_Workforce_Workgroup.xls

Additional discussion points include:

- How will the additional data be collected? By whom? Representatives of boards pointed out that some of the additional elements discussed would require revising their existing data systems.
- Does data need to be validated (such as NPI)? By whom? Since boards do not use this, any validation should be done by the state agencies who desire the data. (KHPA has access to the NPI database, but it doesn't include SSN).
- For identifying specialties, it is advisable to use national taxonomies/standardized coding.
- Determining % of time practicing at each site could be a challenge for certain professionals such as floating pharmacists with dynamically changing schedules, telemedicine providers, X-ray technicians who may be located in another state reading X-rays for patients across the nation, etc.)
- Board of Pharmacy and Board of Healing Arts indicated that they are considering starting a separate licensing process for telemedicine and locum tenens.
- How frequently does data need to be updated? If there is a need for ongoing updates, systems may need considerable modifications. Dr. Mavoori indicated that studies recommend refreshing every 2-4 years; therefore, updating at current renewal time frames of 1-2 years would likely be adequate.
- Some providers would not have access to information to correctly answer questions regarding % of patients on Medicaid (nurses, for example). Should seek other sources of data; one suggestion – obtain list of dentists from Dental Association and survey those providers (not as a part of licensing process).
- Because board-collected data falls under “open records,” there is concern about adding information to the databases which is not essential to the boards. Also, adding data elements to licensing forms would require approval of the individual boards. In general, the licensing Boards suggested that collection of non-mission-critical elements be handled via a link to another form containing a standardized set of such elements (created/maintained by a third party) rather than by changes to the licensing forms since such centralized administration will minimize maintenance costs and streamline the data collection. Boards would not receive this information.
- There is interest in knowing how other states do to obtain such information. Betty Wright offered to contact directors of North Carolina and Texas Dental Boards.
- Other possible sources of data – Dept. of Labor, associations (Hospital, Dental, Medical, Pharmacy, etc.) Examples – KHA collects voluntary and involuntary turnover rates (may relate to “job satisfaction” question) and may be able to track locum tenens.
- It was suggested that staff from Attorney General's office review questions which could potentially be construed as a basis for discrimination (gender, race, languages spoken). Again, if data is collected by an outside entity and not given to the boards, this will not be an issue.

Robert Stiles, KDHE Bureau of Rural and Local Health, presented a table showing those data elements which are required for HPSA/MUA designations and others which are recommended for other public health analyses. The table is posted at http://www.khpa.ks.gov/data_consortium/download/KDHE%20Needs%20Analysis.pdf. The data currently comes from the licensing boards and from surveys which are conducted by KDHE. The surveys are quite labor intensive; HRSA requirements are expected to increase that burden in July 2010. While this is not the responsibility of the boards, Mr. Stiles is seeking their help to educate the health professionals about the importance of this information and to standardize the questions to the extent possible.

Next steps:

Members are asked to send any further suggestions to Laverta.Greve@khp.ks.gov

KHPA will look into other data sources mentioned above as well as CAQH (suggested at November meeting)

Recommendations will be compiled for review by this workgroup in late February/early March to arrive at the final set of recommendations to be presented to the Data Consortium in April.

**Data Consortium
Health Professions Workforce Data Workgroup
November 6, 2009**

Twenty-two persons representing 13 organizations (2 state agencies – KHPA, KDHE, 5 licensing boards – Healing Arts, Nursing, Dental, Pharmacy, and Health Occupations Credentialing and 6 health organizations – KHA, KHI, BCBS-KS, St. Francis, KAMU, KAFP) were present for the first meeting of this workgroup convened by KHPA in Topeka on November 6, 2009.

Dr. Andy Allison opened the meeting by explaining the expectations for the group and the importance of its work to improving Kansans' access to health care. The goal is to review current licensure data, identify gaps, and determine how best to obtain the additional data necessary to support statewide workforce planning while minimizing the cost/burden to providers and associations for collecting it. The timeline includes a total of 3 meetings to develop a plan that can be presented to the KHPA Board and Data Consortium in March 2010.

Attendees introduced themselves, describing how they currently use health professions workforce data and/or how they would like to use it in the future.

Dr. Hareesh Mavoori explained the Kansas Health Policy Authority's (KHPA) statutory responsibilities to obtain data relative to health care in order to advance decision-making and coordinate data analysis with respect to health programs. He also presented an overview of the Professional Licensure Database maintained by KHPA which includes information collected monthly from 8 licensure boards representing 67 medical/health care professions. Deficiencies in this data were discussed, such as address variances (some boards collect address of main practice, but not satellites, some collect provider's home address, etc.), incomplete demographic data (gender, race, language fluency), and amount of time serving at each location (if practicing in more than one county).

Chris Tilden and Robert Stiles, Kansas Department of Health and Environment, demonstrated the financial benefits and additional health services made available to underserved areas of Kansas based on a Health Professions Shortage Area (HPSA) or Medically Underserved Area (MUA) designation. They explained the critical need for more complete information to document where health professionals practice, FTEs for each location of their practice, approximate number patients who are Medicaid beneficiaries, and other related factors that are required when applying for such Federal benefits. Additionally, it is expected that similar data will be needed for mid-level practitioners in the near future.

Dr. Mavoori shared the recommendations of two studies completed by KUMC professors (and associates) which examined workforce issues for physicians and oral health providers. These summaries along with links to the complete study reports and presentations made earlier to the Data Consortium on 10/6/2009 are shown on screens 40-42 of the KHPA PowerPoint presentation accompanying this summary.

In broad terms, the need is for standardization of data across the boards and a higher completion rate by the professionals, including data that is deemed "optional" for licensing purposes, but is essential for documenting access to care (or lack thereof) and workforce shortages. Although some states mandate such reporting, the hope is that this can be accomplished in Kansas through education of the workforce about the need and the many benefits, without a mandate and without adding significantly to the burden on the boards and providers.

Several members present asked for a specific list of the additional data needed and indicated a willingness to obtain/provide it. Other discussion points/suggestions included:

- Attempt to follow the model of a state that does this well without a mandate (North Carolina)
- Set up a site that asks the data elements currently missing from the licensure forms and have the boards include a link in their licensing surveys directly to that site.
- Should telemedicine services and locum tenens be included in workforce reports; if so, how?
- Data from PAs and ARNPs is needed, but not currently collected.
- Information is needed to show FTEs by practice location, not by home address or by main site (if one provider works at multiple sites).
- It is necessary to distinguish between professionals who are actually practicing and those who are simply keeping licenses active, but not in use.
- Office managers need to be included in the discussion, as they may be providing much of the information.
- Much of the needed data for a large number of providers is in the Council for Affordable Quality Healthcare (CAQH) Universal Provider Datasource. Boards could encourage more participation in a manner similar to Blue Cross Blue Shield – they do not require it, but those providers who use it do not have to complete additional enrollment forms; BC-BS can pull the necessary information from CAQH. It is endorsed by the Kansas Insurance Department. It is interactive – once a provider type is entered, only the appropriate questions for that person are displayed.
- Although their services differ from direct care providers, it is important to obtain data from pharmacists.
- Dr. Allison offered to help provide a mechanism for collecting the data; the boards welcomed it.

Next steps:

Before the next meeting (early 2010):

- Workgroup members will continue to communicate any further workforce data needs from their respective organizational perspectives by populating the Needs Assessment worksheet and sending to LaVerta.Greve@khp.ks.gov.
- A table (briefly displayed at this meeting) will be completed to show what information is currently provided by the boards.
- Based on the above, KHPA, in conjunction with KDHE, will develop a list of additional workforce data items needed.
- CAQH and other data collection mechanisms will be explored further.