

# Steps Toward Implementing a National Behavioral Health Workforce Minimum Data Set

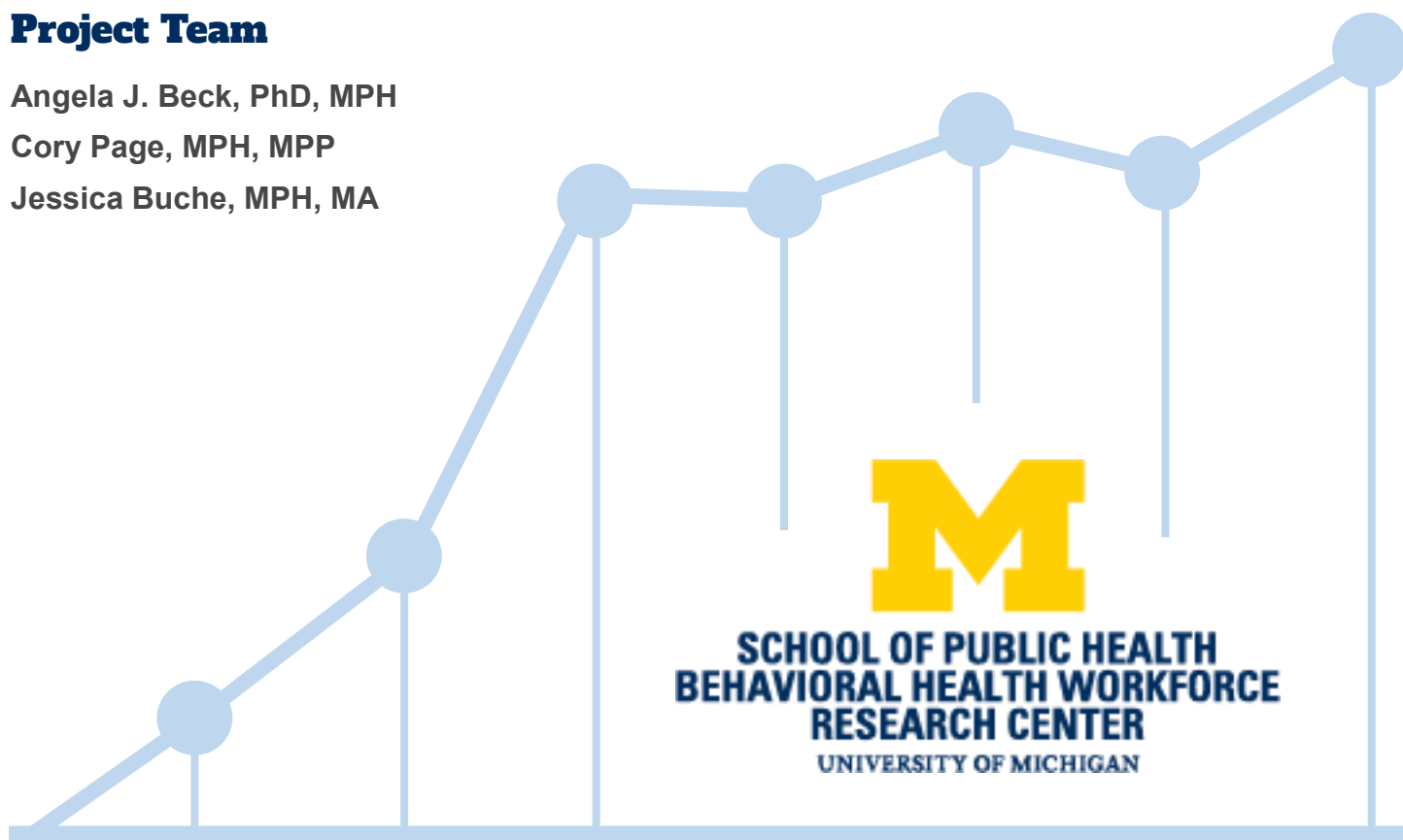
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## Key Findings

Enumerating the supply of the myriad occupations that comprise the behavioral health workforce is an important step in workforce planning. Understanding each occupation's distribution, work status, education, experience, specialties, practice setting, services provided, payment forms, and demographics would allow policy makers to craft precision interventions to remedy behavioral health care access issues. Collecting such granular data is difficult, particularly when those data are to be nationally-representative, current, and publicly available. Adoption of a uniform set of data elements for purposes of improved data quality and comparability is referred to as a Minimum Data Set (MDS). The purpose of this study is to determine whether the behavioral health workforce MDS developed in 2016 is feasible for licensing boards, professional organizations, and employers to utilize in practice. Findings can inform a strategy for collecting comprehensive, standardized data on the workforce across the country to achieve the goal of efficient workforce planning.

Sixteen key informant interviews were conducted during the summer of 2018 to elicit the challenges and opportunities associated with implementing a standardized MDS for the behavioral health workforce nationwide. Question themes included: 1) prior use of a workforce MDS; 2) usefulness of the five MDS topical themes; 3) barriers to MDS implementation; and 4) recommendations for the Behavioral Health Workforce Research Center (BHWRC) and federal partners for national implementation of the MDS.

Study findings show that the BHWRC should work to develop the following:

- An web-based platform that houses an MDS question bank to permit users to organize and filter variables of most relevance to their discipline and data collection needs.
- A statement that better summarizes how the data will be of value to workers who provide the information and organizations that utilize the tool.
- A recommendation to federal partners that more technical assistance and resources are needed for state partners and professional organizations to implement the MDS and create a uniform data collection system.

## Background

Enumerating the supply of the myriad occupations that comprise the behavioral health workforce is an important step in workforce planning. A 2011 Institute of Medicine report noted that “effective workforce planning and policy making require better data collection and an improved information infrastructure.”<sup>1</sup> Understanding each occupation's supply, distribution, work status, education, experience, specialties, practice setting, services provided, payment forms, and demographics would allow policy makers to craft precision interventions to remedy behavioral health care access issues. Collecting such granular data is difficult, however - especially if those data are to be nationally-representative, current, and publicly available.

### Overview of Workforce Data Sources

State-level efforts, particularly data from state licensing boards, have the potential to yield the most accurate data.<sup>2</sup> State behavioral health licensing boards obtain documentation of applicants' education and work history prior to issuing a license, and often require proof of continuing education and practice before renewing a license. If licensing boards were to track these data and make them publicly available, researchers, policymakers, and employers alike would be better able to make beneficial adjustments. Some states that track this licensure information for workforce analysis purposes include North Carolina, South Carolina, and Virginia.<sup>3</sup> Furthermore, if these licensing boards used licensing issuance and renewal as opportunities to present applicants with a more nuanced, mandatory survey, then the board would effectively be able to track the state's active behavioral health workforce in its entirety. Such a mandatory survey was implemented in New Mexico in 2011.<sup>4</sup> Other states that issue supplementary surveys to track their health workforce include New York and Wisconsin.<sup>3</sup>

One limitation of these state-level efforts is that licensing boards do not cover all facets of the behavioral health workforce. Addiction counselors, peer recovery support specialists, prevention specialists, community

health workers, psychiatric aides, and other behavioral health professionals could be certified, registered, or work without any credential.<sup>2</sup> Another limitation is that any data collection efforts attempted by a state would require statutory backing. In New Mexico, lawmakers passed the Health Care Work Force Data Collection, Analysis and Policy Act in 2011 a full 4 years before releasing their first findings on the state's behavioral health workforce.<sup>4</sup> And financial barriers serve as the final limitation. Collecting, storing, maintaining, analyzing, and disseminating these data require funding for personnel and infrastructure.<sup>5</sup> Such funding would likely be allocated either from state taxes, or come as an award/grant from a federal body.

National enumeration efforts like the National Provider Identifier (NPI) database,<sup>6</sup> the American Community Survey (ACS),<sup>7</sup> and the Bureau of Labor Statistics (BLS) Occupational Employment Statistics<sup>8</sup> collect and publicly report supply for a number of occupations, but none of them perfectly represent the entire health workforce. NPI entries are updated regularly and cover the name, specialty, and practice location for many healthcare professionals, but some professionals may not use their own identifier if they are billing under the authority of an organization or supervising physician, and others may not have a number at all if they do not work with Medicaid or Medicare populations.<sup>5</sup> The ACS is administered to 3.5 million residents annually and represents one of the largest samples of national workforce data with detailed demographic information, however it lacks specificity around occupation titles.<sup>5,9</sup> And BLS data, while providing detailed occupational data both quantitatively and qualitatively, do not cover self-employed individuals - excluding large amounts of private practice healthcare professionals (e.g. private practice physicians.)<sup>10</sup>

A fourth national database, the Area Health Resources File (AHRF), offers county-level workforce data across many occupations.<sup>11</sup> However, it utilizes data from over 50 different sources, including the BLS, and is subject to the limitations of each of those sources.<sup>5</sup> This methodological shortfall prevents the AHRF, and comprehensive tools like it, from assembling a complete picture of the health workforce using various state and national sources.

Finally, national professional associations, such as the American Psychological Association, the National Association of Social Workers, and others, collect information on their membership. However, the information collected may not be as comprehensive as some other workforce data sources, and some workers choose not to join a discipline-specific association. Further, these data typically are not publicly available so accessibility for purposes of workforce planning is limited.

Each of these data sources provide important information to contribute to the full picture of workforce supply and distribution, but they still have gaps and comparability across sources is limited. If all data collection instruments tracked the same set of variables, with the same language, and utilized standardized occupational taxonomies, then compiling data across sources would become more viable. Such a data standard is referred to as a Minimum Data Set (MDS).<sup>2</sup>

## Developing a Plan for a National System of Data Collection

Constructing an MDS requires feedback from numerous stakeholders. Not only does the taxonomy of the MDS need to include relevant occupational titles, but the MDS variables must also be occupation-specific. The Health Resources and Services Administration (HRSA) collaborated with a number of national boards, councils, and associations to create MDSs for licensed professional counselors, psychologists, substance abuse/addiction counselors, and other occupations that make up the health care workforce.<sup>12</sup> After reviewing these MDSs and consulting with more interest groups, in 2016, the Behavioral Health Workforce Research Center (BHWRC), along with a Consortium of partners, refined what data sets were already available, added more occupational categories, and assembled a uniform MDS for the entire behavioral health workforce.<sup>13</sup>

The purpose of this qualitative study was to determine whether the current behavioral health MDS was feasible for licensing boards, professional organizations, and employers to utilize in practice. Findings inform a strategy for collecting comprehensive, standardized data on the workforce across the country to achieve the goal of efficient workforce planning.

## Methods

The BHWRC conducted a study during the summer of 2018 to elicit the challenges and opportunities associated with implementing a standardized MDS for the behavioral health workforce nationwide. A snowball sampling method was used to recruit study participants to engage in key informant interviews and focus groups. Consortium members and other research partners identified interviewees from the following groups:

- State licensing boards
- National and state professional organizations collecting membership data
- State and federal government agencies with workforce data collection responsibility
- Behavioral health workforce researchers
- Behavioral health workforce employers

The key informant interview and focus group guide included an introduction to the BHWRC, background of the behavioral health MDS instrument, and overview of the existing challenges in implementing a common data collection system on a national level. Question themes included: 1) familiarity with and current use of a workforce MDS; 2) usefulness of the five MDS topical themes; 3) barriers to MDS implementation; and 4) recommendations for the BHWRC and federal partners for national implementation of the MDS.

## Findings

Sixteen key informants were interviewed over the course of the study, who primarily represented disciplines of psychology, social work, and counseling. Most interviewees had personally used an MDS, often one of the MDS instruments available on HRSA's website.<sup>14</sup> All respondents had experience collecting data on some or all of the five key MDS themes. Based on their experience with data collection, all respondents indicated that improving data quality through an MDS is important for the field. Each MDS theme received different feedback from respondents:

- **Demographics:** Respondents appreciated the amount of demographic detail the MDS includes. However, some respondents felt that the subpopulations referenced in the MDS were incomplete, and that incorporating all such vulnerable subpopulations might make the tool too cumbersome. Respondents also felt that certain questions, particularly those about citizenship, were particularly sensitive, and should be removed.
- **Licensure and Certification:** Respondents acknowledged that licensing and certification boards would have the most accurate data for this theme. However, such a method would only be accurate if all states require licensees to renew their licenses; according to one respondent, some states have voluntary re-registration and/or exceptions that allow some professionals to forgo renewing their credential with any state body. Further, licensing and certification boards do not have the infrastructure to collect these data for research purposes, so the feasibility of collecting data through common methods across all licensing boards is quite low.
- **Education and Training:** This theme was viewed as among the most useful of all 5 themes, according to respondents, because it revealed which competencies workers were likely to have and may help predict which types of services they were likely to provide.
- **Occupation and Area of Practice:** This theme spoke directly to how workers specialized their practice after graduation and was especially useful for psychologist and social worker categorization, as these occupations do not have specialty certifications, and therefore cannot track specialists through certification data.
- **Practice Characteristics and Settings:** Respondents were surprised that the MDS contained this level of granularity, as most tools they used prior did not ask about practice settings. While they generally agreed that this theme was useful for understanding the workforce, respondents questioned whether answers to this theme may vary widely by profession and the resulting data would be "noisy."

Respondents requested that the MDS be more customizable, as some questions are not relevant to all of the organizations that would be using the tool across professions and states. They also suggested adding the following questions: whether providers offer specific services; whether providers work in an integrated care setting; and whether board certification was required for the provider's current position.

The top three barriers to implementing the MDS brought up by respondents were:

- Obtaining appropriate buy-in from both data-collecting organizations and workers
- Ensuring data collection was uniform across states and professions, and
- Having the statutory backing necessary to allow state licensing boards to collect data.

To address buy-in, respondents recommended federal grants be given to state licensing boards in order to finance data collection, as is done in Virginia, or to national professional organizations to better structure and formalize data collection for research purposes. Regarding feasibility of uniform data collection, respondents suggested that the value of the MDS be better explained to participating organizations beforehand, and that technical support be available as they begin data collection. When asked what entity should be primarily responsible for the data collection, answers were varied. Some respondents thought HRSA would be the appropriate entity to collect and house the data for public use; some felt that national professional organizations should be funded to collect comprehensive data for their discipline and subsequently coordinate the housing and use of those data across disciplines. Finally, some respondents felt that a third party research group, such as the BHWRC, should be charged with data collection, cleaning, and making data publicly available. Regarding statutory backing, respondents recommended crafting laws mandating survey participation for licensees renewing their credential - similar to how New Mexico and Virginia collect data.

When asked what federal partners could do improve data collection efforts, besides providing the necessary grant funding, respondents requested HRSA more widely share the lessons it has learned about workforce data collection from key states. When asked what the BHWRC could do to support data collection efforts, respondents requested that the Center provide online trainings to introduce the elements of the MDS and help popularize the MDS through marketing and informational campaigns. In addition, federal partners could consider developing a public-private consortium to support infrastructure for an MDS.

## Next Steps

To further implementation of the behavioral health workforce MDS across the field, the BHWRC should work to develop the following:

- A web-based platform that houses an MDS question bank to customize questionnaires. This will permit users to organize and filter variables of most relevance to their discipline and data collection needs.
- A value proposition statement that better summarizes how the data will be of value to workers who provide the information and organizations that utilize the tool. The BHWRC's Consortium will provide input on this statement.
- A recommendation to federal partners that more technical assistance and resources, including financial, are needed for state partners and professional organizations to implement the MDS and create a uniform data collection system.

The adoption of a national system for data collection has the potential to vastly improve the quality of the data that policy makers use for workforce planning decisions to ensure appropriate access to behavioral health services. However, such a system for implementation will take time, resources, coordination, and support from stakeholders across the field. If investment in an MDS is made, the findings of this study indicate that the resulting data would be valuable to the many disciplines comprising the behavioral health workforce.

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