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A Workforce Minimum Data Set for Social Workers

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BACKGROUND

Social workers play a central role in the provision of behavioral health services in the United States. According to the U.S. Bureau of Labor Statistics (BLS), social workers comprise more than 40% (n=402,060) of the behavioral health occupations included in Occupational Employment Statistics.[1] Much of our information about social workers is limited to raw numbers (as evidenced by the BLS data) and with increased demand for behavioral health services[2,3] and a workforce in crisis,[4] a more nuanced understanding practice settings, education, and background of the largest segment of the behavioral health workforce is necessary.

The Behavioral Health Workforce Research Center (BHWRC) developed a workforce Minimum Data Set (MDS)[5] in 2016 for several behavioral health occupations[6,7,8] to standardize workforce variables and data collection methods. In 2017, the MDS was customized to focus on social workers. Responsibility for regulating practices and education for social workers occurs at the state level, resulting in fifty different entities with information on licensed social workers across the United States.

The purposes of this pilot project are to: 1) test the elements of a Social Work MDS to assess the utility of the instrument; 2) determine the feasibility of collecting workforce data through a diffuse network of state social work licensing boards; and 3) collect workforce data from social workers, including demographics, practice settings, licensure, and education. This brief focuses on the first two project aims.

METHODS

The data themes and elements from the behavioral health workforce MDS were adapted to meet the specific data collection needs of social workers. Members of the BHWRC research team worked with partners from the field of social work as well state licensure boards

CONCLUSIONS AND POLICY IMPLICATIONS

Results from this MDS study indicate that social workers who responded to the survey were generally willing to disclose information about their job settings, daily functions, education, training, and licensure/certification background. There was some concern about disclosing demographic information for fear of respondents' privacy not being protected, and due to a lack of clarity about how the data would be used. More direct privacy reassurance and information about study purpose may help allay these concerns in future MDS use.

Study dissemination methods showed that although state licensing boards are an important source of workforce data, data elements are not currently aligned across states and are often determined by state statute. Changes made by individual state legislatures would permit licensing boards to adopt common MDS elements and expand workforce data collection. Challenges associated with collecting data by partnering with state licensing boards, including response rates from the boards themselves and practitioners, limits the overall effectiveness of this approach for dissemination and implementation of an MDS.

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[1] United States Department of Labor Bureau of Labor Statistics. Occupational Employment Statistics. 2017; https://www.bls.gov/oes/. Accessed July 24, 2017.
[2] Olfson M, Blanco C, Wang S, Laje G, Correll CU. National trends in the mental health care of children, adolescents, and adults by office-based physicians. *JAMA psychiatry.* 2014;71(1):81-90.
[3] Olfson M, Druss BG, Marcus SC. Trends in mental health care among children and adolescents. *New England Journal of Medicine.* 2015;372(21):2029-2038.
[4] Hoge M, Morris J, Daniels A, Stuart G, Huey L, Adams N. An action plan for behavioral health workforce development. *Cincinatti, OH: Annapolis Coalition on Behavioral Health Workforce*
[5] Health Resources and Services Administration. Health Professions Minimum Data Set. 2017; http://bhw.hrsa.gov/healthworkforce/data/minimumdataset/index.html. Accessed February 18, 2016.
[6] Ryan P, Delaney C. Nursing minimum data set. *Annual review of nursing research.* 1995;13:169-194.
[7] Landi F, Tua E, Onder G, et al. Minimum data set for home care: a valid instrument to assess frail older people living in the community. *Medical care.* 2000;38(12):1184-1190.
[8] Irwin P, Rudd A. Casemix and process indicators of outcome in stroke. The Royal College of Physicians minimum data set for stroke. *Journal of the Royal College of Physicians of London.* 1998;32(5):442-444.

to identify data themes and elements for elimination which were inappropriate or illogical for social workers to answer.

The Association of Social Work Boards (ASWB), a membership organization comprised of the "social work regulatory boards and colleges of all 50 U.S. states",[9] provided contact information for each state's licensing board. The BHWRC sent short recruitment emails to each state's licensing board contact to invite them to participate in the study. Three states, Arkansas, North Carolina, and Oklahoma, agreed to participate in the study and provided the BHWRC with contact information for all state-licensed social workers (n= 14,655). An email invitation to complete an online survey was sent to each social worker in the sample in July 2017; the survey closed in September 2017. Participants were offered the opportunity to enter a random drawing for one of five, $25 MasterCard gift cards as an incentive. Descriptive statistics were used to assess item non-response and general characteristics of survey respondents.

Table 1. Summary of Minimum Data Set Data Elements for Social Workers

MDS Theme	Data Elements	
Occupation and Area of Practice	• Provision of behavioral health services • Area of practice	
Education and Training	• Degrees obtained and years of completion • Degree-granting organization information • Field of study/specialty	• Completion of other educational programs (e.g. internships) • Current enrollment in degree program
Licensure and Certification	• Type of job-related licenses held • Type of job-related certificates held • Year origination and Expiration of license	• National Provider Identification number • State identification/registration number
Practice Characteristics and Settings	• Employment status • Employment location • Number of current employment positions • Number of hours and weeks worked per year	• Use of telehealth • Employer practice setting • Hours per week spent on job activities • Employment plans • Employment arrangement • Patient populations served
Demographics	• Name • Age • Race/ethnicity • Sex/gender	• Sexual orientation • Place of birth and residence • Language skills • Location

KEY FINDINGS

Professional Overview

A total of 1,256 social workers responded to the survey (9% response rate). Respondents reported a variety of different titles and specialties, including Clinical Social Work (801/3,412; 23%), Mental Health Social Work (664/3,412; 19%), and Child, Adolescent, and Family Social Work (425/3,412; 12%). The majority of respondents (991/1,141; 87%) indicated that they provide behavioral health care services as part of their daily occupational tasks.

Educational attainment was heavily skewed towards the Master's Degree in Social Work, with 97% (1,110/1,143) of respondents indicating that it was their highest earned degree. Only 3% (30/1,132) of respondents indicated that they were currently enrolled in a formal education program. Of those currently enrolled in an education program,

[9] Association of Social Work Boards. Association of Social Work Boards. 2017; https://www.aswb.org/. Accessed March 18, 2017.

40% (12/30) were pursuing a degree in social work, followed by psychology and law. Nearly 70% (12/29) of respondents were pursuing a doctoral degree.

Most respondents (778/960; 81%) reported their employment status as actively working in a social work position that requires a social work license, with the remainder working in a social work position that does *not* require a social work license (172/960; 18%) or working in a field other than social work or retired (3/960; 0.3% for both responses). Respondents reported working in a variety of practice settings, with the highest segment of respondents reporting working in an ambulatory care facility or clinic (173/839; 21%), hospital or in-patient facility (161/839; 19%), or private practice (134/839; 16%). Most respondents reported that they were permanent salaried staff employed directly by an organization (567/841; 67%), followed by permanent hourly staff (111/841; 13%), and self-employed (97/841; 12%). When asked to report hours allotted to daily job tasks, respondents reported being engaged in activities related to treatment (11 hours per week, on average, 850 responses), followed by case management (6 hours per week, 846 responses), and administration (6 hours per week, 845 responses).

Minimum Data Set Feedback

The survey asked respondents to reflect on their level of comfort with reporting data collected by the workforce MDS to a variety of entities, including employers, state licensing boards, national discipline-specific organizations, federal government, and researchers. Respondents indicated that they would be willing to share information with any of the entities listed above. On average, 2% of all respondents (In total across all MDS Themes, 321/15,260) indicated that they did not feel comfortable reporting information. Demographic information, in particular, stimulated the most concern over sharing information (104/2,851; 4%). Respondents felt the most comfortable sharing their information with state licensing boards, the National Association of Social Workers, and university researchers.

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