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DEPARTMENT OF HEALTH AND HUMAN SERVICES

NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

Cody Phinney, MPH
Administrator

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Chief Medical Officer

The Health Care Workforce Working Group (HCWWG)

Meeting Agenda

October 16, 2025

1:00 P.M. To Adjournment

This meeting is being held virtually. The public is invited to attend.

Meeting Locations

Physical Location
No Physical Location
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Virtual Information
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1. The agenda items may be taken out of order.
2. Two or more items may be combined; and
3. Items may be removed from the agenda or delayed at any time.

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1. Call to Order and roll call

2. Public Comment

Public comment may be presented in-person, by computer, phone, or written comment. No action may be taken upon a matter raised under public comment unless the matter itself has been specifically included on an agenda as an action item. To provide public comment telephonically, dial 775-321-6111. When prompted to provide the Meeting ID, enter **755 212 454#** Due to time considerations, each individual offering public comment will be limited to not more than five (5) minutes. A person making comment will be asked to begin by stating their name for the record and to spell their last name. A person may also have comments added to the minutes of the meeting by submitting them in writing either in addition to testifying or in lieu of testifying. Written comments may be submitted electronically before, during, or after the meeting by emailing Mitch DeValliere at bdevalliere@health.nv.gov. You may also mail written documents to the Division of Public and Behavioral Health, 4150 Technology Way, 3rd. Floor, Carson City, NV 89706.

3. For Possible Action

Discussion and possible action for approval of July 24, 2025, Meeting Minutes

4. For Information Only

Discussion of workforce data currently collected by licensure boards at initial licensure and licensure renewal process

5. For Information Only

Model practices from other states that collect health workforce data at license renewal

6. For Information Only

Discussion to establish a health care provider database per NRS 439A.116

7. For Possible Action

Bureau of Child, Family and Community Wellness
4150 Technology Way, Suite 210 ● Carson City, NV 89706 ● (775) 684-4200 ● Fax (775) 687-7570 ● dpbh.nv.gov

Discussion and possible action to establish **meeting schedule** and **future agenda** items for November and January.

8. Public Comment

Public comment may be presented in-person, by computer, phone, or written comment. No action may be taken upon a matter raised under public comment unless the matter itself has been specifically included on an agenda as an action item. To provide public comment telephonically, dial 775-321-6111. When prompted to provide the Meeting ID, enter 147 938 14#. Due to time considerations, each individual offering public comment will be limited to not more than five (5) minutes. A person making comment will be asked to begin by stating their name for the record and to spell their last name. A person may also have comments added to the minutes of the meeting by submitting them in writing either in addition to testifying or in lieu of testifying. Written comments may be submitted electronically before, during, or after the meeting by emailing Mitch DeValliere at bdevalliere@health.nv.gov. You may also mail written documents to the Division of Public and Behavioral Health, 4150 Technology Way, 3rd. Floor, Carson City, NV 89706.

9. Adjournment

NOTICES OF PUBLIC MEETINGS HAVE BEEN POSTED AT THE FOLLOWING LOCATIONS:

Physical Posting Locations

- Division of Public and Behavioral Health – 4150 Technology Way, 1st Floor, Carson City

Internet Postings

- Division of Public and Behavioral Health website: https://dpbh.nv.gov/Boards/HCWWG/hcwwg-information/

This body will provide at least two (2) public comment periods in compliance with the minimum requirements of the Open Meeting Law prior to adjournment. No action may be taken on a matter raised under public comment unless the item has been specifically included on the agenda as an item upon which action may be taken. The Chair retains discretion to only provide for the Open Meeting Law's minimum public comment and not call for additional item-specific public comment when it is deemed necessary by the chair to the orderly conduct of the meeting.

This meeting is a public meeting, recorded and held in compliance with and pursuant to the Nevada Open Meeting Law, pursuant to NRS 241. By Participating, you consent to recording of your participation in this meeting. All voting members should leave their cameras on for the duration of the meeting and refrain from entering any information into the chat function of the video platform. Please understand the use of obscenities or other behavior which disrupts the meeting to the extent that its orderly conduct is made impractical may result in forfeiture of the opportunity to provide public comment or removal from the meeting.

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Mitch DeValliere in writing by email bdevalliere@health.nv.gov or by mail at 4150 Technology Way, 3d Floor, Carson City, NV 89706.

If at any time during the meeting, an individual who has been named on the agenda or has an item specifically regarding them, including on the agenda is unable to participate because of technical difficulties, please notify Mitch DeValliere (775) 431-7144 or by email at bdevalliere@health.nv.gov and note at what time the difficulty started to that matters pertaining specifically to their participation may be continued to a future agenda if needed or otherwise addressed.

Please be cautious and do not click on links in the chat area of the meeting unless you have verified that they are safe. If you ever have questions about a link in a document purporting to be from (Committee name here) please do not hesitate to contact Mitch DeValliere (775) 431-7144. Please refrain from commenting in the chat area of the meeting, unless requested to, because minutes are required to be taken of the meeting.

Supporting material for this meeting can be obtained at: Division of Public and Behavioral Health, 4150 Technology Way, Suite 210, Carson City, NV 89706, or by calling Mitch DeValliere (775)431-7144 or via email at bdevalliere@health.nv.gov.

Anyone who would like to be on the Health Care Workforce Working Group mailing list must submit a written request every six months to the Nevada Division of Public and Behavioral Health at the address listed below.

If you have difficulties with the hyperlink for the meeting provided above, please try copy and pasting the following address:

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HEALTH CARE WORKFORCE WORKING GROUP MINUTES
July 24, 2025
1:00 PM

The Health Care Workforce Working Group held a public meeting on 12/19/2024, beginning at 1:00 PM, held at the following location:

10375 Professional Circle
Third Floor – Walker Room
Reno, NV 89521

Working Group Members Present

Chair John Packham, Associate Dean, University of Nevada, Reno School of Medicine

Krisann Alvarez, Licensed Psychologist, Nevada Health Authority

Edward Cousineau, Executive Director, Nevada State Board of Medical Examiners

Tyree Davis, Chief Medical Officer for Ancillary Services, Nevada Health Center

Adam Higginbotham, Executive Director, Nevada State Dental Board

Joelle McNutt, Executive Director, State of Nevada Board of Examiners for Marriage and Family Therapists & Clinical Professional Counselors

Jose Melendrez, Executive Director, University of Nevada, Las Vegas, School of Public Health

Steve Messinger, Policy Director, Nevada Primary Care Association

Sarah Restori, Administrative Director, Nevada Board of Psychological Examiners

David Wuest, Executive Secretary, Nevada State Board of Pharmacy

Frank DiMaggio, Executive Director, Nevada State Board of Osteopathic Medicine

Victoria “Vikki” Erickson, Executive Director, Board of Examiners for Social Workers

Mitch DeValliere, Agency Manager, Division of Public and Behavioral Health

Working Group Members Not Present

Cathy Dinauer, Executive Director, Nevada State Board of Nursing

Joseph Fillipi, Jr., Executive Director, Patient Protection Commission, Nevada Health Authority

1. Call to Order and Roll Call

- Roll call was taken and determined a quorum of the Health Care Workforce Working Group (HCWWG) was present, per Nevada Revised Statute (NRS) 439.51
- Mitch DeValliere acknowledged that the meeting was being recorded to facilitate transcription.

2. Public Comment

- Chair John Packham read the public comment script.
- Chair Packham asked for public comment.
- None heard.

3. For Possible Action: Approval of Previous Meeting Minutes

- Motion to approve the December 19, 2024, meeting minutes.
- Motion: Vikki Erickson
- Second: José L. Melendrez
- Vote: All in favor, no opposition. Minutes approved.

4. For Information Only: Introduction of New Members

Chair Packham welcomed two new members:

- Adam Higginbotham, representing the State Dental Board, expressed interest in improving feedback loops between the board and this group.
- Chrisann Alvarez, a licensed psychologist with the Nevada Health Authority, shared her 18 years of experience with the Division of Child and Family Services.

5. For Information Only: Updates on DHHS and Nevada Health Authority

- Mitch DeValliere explained recent structural changes:
    - DHHS has been renamed the Department of Human Services.
    - The Nevada Health Authority was established through SB 494 to consolidate functions like Medicaid, compliance programs, and analytics.
    - Key goals include reducing healthcare costs, increasing provider capacity, and improving service coordination.
    - Environmental health functions have been reallocated across divisions.
- Dr. DeValliere committed to sharing slide materials after the meeting.

6. For Information Only: Overview of Health Workforce Data Collection

- Chair Packham provided a deep dive into the new workforce data collection requirements under NRS 439A.116 and AB 484:
    - Boards will need to collect 17 specific data elements during licensure renewal, including demographic details (race, ethnicity, gender identity), language proficiency, practice locations, telehealth use, and patient populations served.

    - He emphasized the complexity of collecting sensitive data (e.g., gender identity, languages spoken) and warned of potential challenges in standardizing definitions and protecting individual privacy.
- Jose Melendrez expressed concerns about how DEI-related data collection may be politicized, especially concerning vulnerable groups.
- Edward Cousineau asked for clarification on mandatory data collection timelines.
- Adam Higginbotham raised technical implementation challenges, questioning whether boards should integrate the questions into existing licensure systems or use external survey links.
- Sarah Restori asked whether licensees would be mandated to respond to these new data elements, with John noting that decision-making authority rests with the work group and future policy discussions.

7. For Information Only: Inventory of Workforce Data Collected by Boards

- John Packham proposed creating an inventory to understand:
    - What data boards currently collect during initial licensure and renewal.
    - Which data points are already publicly available.
    - Gaps that need to be addressed.
- Dr. DeValliere and Dr. Packham will distribute an inventory template to boards, and the findings will inform future strategies.

8. For Information Only: Leveraging State Practices – External Expertise Proposal

- Chair Packham recommended inviting representatives from the Indiana Bowen Health Workforce Research Center to present at a future meeting. He emphasized learning from states like Indiana, New York, New Mexico, and Arizona to avoid redundant efforts.
- The group supported the proposal.

9. For Information Only: Discussion to establish a health care provider database per NRS 439A.116

- Madison Lopey, Office of Analytics, highlighted key technical considerations:
    - Data collection must be standardized to ensure clean, reportable outputs.
    - Ms. Lopey suggested using Qualtrics or REDCap platforms. While Qualtrics offers built-in analytics, REDCap might be more cost-effective.
    - Ms. Lopey stressed the importance of minimizing free-text responses to maintain data integrity.
- Adam Higginbotham noted that integrating these data fields into each board's licensing software would be costly and time-consuming. He advocated for a centralized redirect link post-licensure renewal to collect data, which was met with general agreement.
- Ms. Lopey underscored the need for an initial inventory to avoid redundant data collection and to streamline the process across boards.

10. For Possible Action: Meeting Schedule & Action Items

- The group agreed to a bimonthly meeting schedule:

    - September 18, 2025
    - November 13, 2025 (moved from the third Thursday due to conflict)
    - January 15, 2026
- Motion to approve: Tyree Davis
- Seconded by: José Melendrez
- Approved unanimously.
- Chair Packham also announced an upcoming webinar on August 12, 2025, which will present:
    - The updated Nevada Health Workforce Chartbook.
    - A summary of 2025 legislative actions related to the health workforce.
    - Materials and registration links will be circulated.

11. Public Comment

No further public comments were received.

12. Adjournment

The meeting was adjourned.

Data Elements:	Nevada State Board of Dental Examiners	Nevada State Board of Examiners for Marriage and Family Therapists and Clinical Professional Counselors	Nevada State Board of Medical Examiners	Nevada State Board of Nursing
1) The type of license, certificate, or registration held by the applicant;	Yes	Yes	Yes	Yes
2) The race and ethnicity of the applicant;	No	No	No	Voluntary
3) The sex of the applicant;	Yes	No	Yes	Voluntary
4) The primary language spoken by the applicant;	No	Yes	No	"Required for applicants to speak English"
5) The specialty area in which the applicant practices;	Yes	No	Yes	Voluntary
6) Any other jurisdiction where the applicant holds, the same type of license, certificate, or registration that the applicant is currently renewing;	Yes	No	Yes	No
7) The county of this State in which the applicant spends the majority of his or her working hours;	No	Yes	No	Yes for APRNs; voluntary for nurses
8) The address of each location at which the applicant practices or intends to practice and the percentage of working hours spent by the applicant at each location;	Yes, for the location. No, for the percentage of working hours	Yes	No	Yes for APRNs
9) The type of practice in which the applicant practices in which the applicant engages, including, without limitation, individual private practice, group private practice, multispecialty group private practice, government or nonprofit;	No	No	No	Yes for APRNs; voluntary for nurses
10) The setting in which the applicant practices, including, without limitation, hospitals, clinics, and academic settings;	No	No	No	Yes for APRNs; voluntary for nurses
11) Whether the applicant utilizes telehealth, as defined in NRS 629.515, in his or her practice	No	No	No; Unless they hold a telehealth license. However they may practice telehealth with an unrestricted license, and this data is not gathered in that circumstance.	No
12) The education and primary and secondary specialties of the applicant;	Yes	Yes	Yes	Yes

13) The average number of hours worked per week by the applicant during the immediately preceding calendar year;	No	Yes	No	Voluntary
14) The percentages of working hours during which the applicant engages in patient care and other activities, including, without limitation, teaching, research, and administration;	No	No	No	No
15) The types of patients whom the applicant serves, without limitation, newborns, children, adolescents, adults, senior citizens, pregnant persons, veterans, incarcerated persons, persons without disabilities, persons who speak a language other than English, persons who are recipients of Medicaid or Medicare and persons who pay on a sliding fee schedule;	No	No	No	APRNs must identify their population focus
16) Any planned major changes to the practice of the applicant within the immediately following 5 years, including, without limitation, retirement, relocation or significant changes in working hours;	No	No	No	No
Other comments:	"Ideally an external link collecting the applicable data is implemented. Requesting additional data fields to the existing licensing software system with out licensing software vendor is an additional cost to the Board."		The responses submitted by the licensees are strictly voluntary	"We can add or modify voluntary questions if needed"
Occupations Licensed:	Dental Hygienists; Dental Therapists; Dentists	Clinical Professional Counselors; Marriage and Family Therapists	Allopathic Physicain Assistants (PA); Allopathic Physicians (MD); Practitioners of Respiratory Care; Genetic Counselors; Anesthesiology Assistants	Licensed Practical Nurses (LPN); Registered Nurses (RN); Advanced Nurse Practitioners (APRN);

Data Elements	Nevada State Board of Osteopathic Medicine	Nevada State Board of Pharmacy	Nevada State Board of Psychological Examiners	State of Nevada Board of Examiners for Social Workers
1) The type of license, certificate, or registration held by the applicant;	Yes	Yes	Yes	Yes
2) The race and ethnicity of the applicant;	Yes	No	Yes	Yes
3) The sex of the applicant;	Yes	No	Yes	Yes
4) The primary language spoken by the applicant;	No		No	Yes
5) The specialty area in which the applicant practices;	Yes	No	Yes	No
6) Any other jurisdiction where the applicant holds, the same type of license, certificate, or registration that the applicant is currently renewing;	Yes	No	Yes	Yes
7) The county of this State in which the applicant spends the majority of his or her working hours;	No	No	No	Yes
8) The address of each location at which the applicant practices or intends to practice and the percentage of working hours spent by the applicant at each location;	Yes; "We ask if they intend to practice in NV and where"	No	No	Yes; "Not percentage"
9) The type of practice in which the applicant practices in which the applicant engages, including, without limitation, individual private practice, group private practice, multispecialty group private practice, government or nonprofit;	No	No	Yes	Yes
10) The setting in which the applicant practices, including, without limitation, hospitals, clinics, and academic settings;	No	Yes; Name of Primary Practice	No	Yes
11) Whether the applicant utilizes telehealth, as defined in NRS 629.515, in his or her practice	No	No	No	No
12) The education and primary and secondary specialties of the applicant;	Yes	Yes; Education	Yes	Yes; "The education only"

13) The average number of hours worked per week by the applicant during the immediately preceding calendar year;	No	No	No	No
14) The percentages of working hours during which the applicant engages in patient care and other activities, including, without limitation, teaching, research, and administration;	No	No	No	No
15) The types of patients whom the applicant serves, without limitation, newborns, children, adolescents, adults, senior citizens, pregnant persons, veterans, incarcerated persons, persons without disabilities, persons who speak a language other than English, persons who are recipients of Medicaid or Medicare and persons who pay on a sliding fee schedule;	No	No	Yes	No
16) Any planned major changes to the practice of the applicant within the immediately following 5 years, including, without limitation, retirement, relocation or significant changes in working hours;	No	No	No	No
Other comments:		We collect the data points that are mandated by the Statute	"Ease of collecting the data by Boards that are very small (have limited resources/staff)"	
Occupations Licensed:	Osteopathic Physician Assistants (PA); Osteopathic Physicians (DO); Anesthesiology Assistants	Pharmaceutical Technicians; Pharmacists	Psychologists	Licensed Clinical Social Workers (LCSW); Social Workers (LSW); Licensed Masters Social Workers (LMSW); Licensed Independent Social Workers (LISW)

HWTAC
Health Workforce Technical Assistance Center

RESOURCE BRIEF
May 2016

Collaborating With Licensing Bodies in Support of Health Workforce Data Collection: Issues and Strategies

Background

The health care delivery system in the United States is undergoing rapid transformation. Health reform initiatives are underway in many states, supporting transitions to value-based payment and encouraging the development of innovative team-based delivery models focused on population health.[1] These changes have had a substantial effect on demand for health workers.

Increasingly, states are recognizing the value of health workforce monitoring systems that can give them access to relevant and timely information on the supply and distribution of health workers in their states. This information is critical for the development of evidence-based policies and programs to meet current and future workforce needs. The National Center for Health Workforce Analysis at the Health Resources and Services Administration (HRSA) developed a standard set of basic questions that can be used to collect data on the supply of health workers. Known as the Minimum Data Set (MDS), it consists of a small number of questions focused on key demographic, educational, and practice characteristics of health professionals, information that can be used to support effective health workforce planning.*

A recent Health Workforce Technical Assistance Center study found that health workforce supply data are collected in more than half of states, and most states report doing so at the time of licensure/relicensure.[2] In some instances, MDS questions are incorporated directly into licensure forms that health professionals are required to complete or update. In other instances, a separate survey containing the MDS questions is included with licensure materials, and its completion is either mandatory or voluntary as part of the licensure process. An advantage of collecting workforce supply data as part of the licensure process is that it affords an opportunity to routinely collect information on all members of a profession. Ideally, states would collect this information at the time of initial application for licensure and update it routinely (eg, with changes in practice location, setting, or clinical hours) at each subsequent license renewal. The success of this approach requires cooperation and collaboration with state licensing bodies.

This brief is designed to help stakeholders interested in developing a state health workforce monitoring system to better understand the issues involved and to identify potential strategies to engage licensing bodies in collecting health workforce data.

Potential Collaborators

A number of key stakeholders are likely to be involved in developing a state-specific strategy to collect data on health professionals in the state. Stakeholders may include:

- State licensing bodies
- State provider associations
- State professional associations
- State health professions education associations
- Universities and community colleges
- Health policy makers, policy analysts, and planners from state and local government and the employment sector
- Area Health Education Centers (AHECs)
- Researchers

* For more information on the MDS, please see: http://www.healthworkforceta.org/wp-content/uploads/2015/03/MDS_Resource_Brief.pdf; http://bhpr.hrsa.gov/healthworkforce/data/minimumdataset/index.html; and http://www.nursingworkforcecenters.org/minimumdatasets.aspx. Accessed April 27, 2016.

Data Ownership, Security, and Confidentiality

Licensing bodies collect sufficiently detailed information on individuals to verify identity and to confirm qualifications and credentials to practice. Licensees, in turn, expect that their personal information will be safeguarded. Ensuring data security and confidentiality is critical to the effective functioning of licensing bodies.[7] Consequently, any effort to collect MDS data on licensed health professionals must include a plan that describes data ownership, data sharing, and protection of shared data. Because some states have strict privacy laws, changes in legislation may be required to allow for data sharing.*

The process of collecting and sharing data comes with risks to stakeholders, licensing bodies, and licensees. Mitigating these risks requires strong and trusting relationships between stakeholders to minimize the potential for damage from misuse or unauthorized access to the data. As stakeholders work together to build a data system, they need to:

- Understand state privacy laws as they relate to data collection, storage, and reporting†
- Establish a plan for securely storing and accessing data
- Develop procedures for data sharing

In Conclusion

Health reform initiatives are transforming health service delivery and the workforce needed to provide care. New models of care, value-based payment, and team-based approaches to care are changing the numbers and types of health care workers needed. The demand for accurate, timely, and comprehensive workforce data has never been greater as state and federal policy makers seek to understand the size, skill mix, and competencies of today's health workforce relative to anticipated future workforce needs. Budget constraints create challenges for stakeholders looking for ways to build on existing data sources and foster new collaborations to create the data systems needed to inform health workforce policy. Data collected through the licensure process are a potentially rich source of information, and licensing agencies and boards have become key partners in health workforce data systems around the country. This brief has offered some insight into the questions and concerns that boards may have when they are approached to collaborate. With this information, stakeholders attempting to work with licensure boards will be better able to understand the boards' perspectives and to engage boards early and often in the process of planning a health workforce data system.

* Montana is one example of a state that would require a change in legislation to allow its licensing boards to collect and share additional data.

† For example, please see: http://www.hhs.gov/ocio/securityprivacy/awarenesstraining/privacyawarenesstraining.pdf. Accessed April 27, 2016.

Acknowledgments

The authors wish to thank Kathy O'Dwyer Arney, PT, MA, Deputy Director, North Carolina Board of Physical Therapy; Charles Brown, Executive Director, State of Arizona Board of Physical Therapy; Julie George, RN, MSN, Executive Director, North Carolina Board of Nursing; and David Benton, RGN, RMN, BSc, M Phil, PhD, FFNF, FRCN, CEO, and Nur Rajwany, CIO, Information Resources Division, National Council of State Boards of Nursing for their generous time and insightful feedback on licensure board perspectives on the MDS.

References

1. Fraher EP. The workforce needed to staff value-based models of care. Talk presented at: National Health Policy Forum; February 20, 2015; Washington, DC. https://www.youtube.com/watch?v=JP79uSNt1-A. Accessed April 27, 2016.

2. Armstrong DP, Forte GJ, Moore J. *Inventory of State Health Workforce Data Collection*. Rensselaer, NY: Health Workforce Technical Assistance Center, Center for Health Workforce Studies, School of Public Health, SUNY Albany; September 2015. http://www.healthworkforceta.org/wp-content/uploads/2015/11/HWTAC_Data_Collection_Inventory_Report_2015.pdf. Accessed April 27, 2016.

3. Federation of State Boards of Physical Therapy. *The Minimum Data Set*. Federation Forum, Winter 2015. https://www.fsbpt.org/Portals/0/documents/free-resources/Forum_Winter2015_MinimumDataSet.pdf. Accessed April 27, 2016.

4. Spector N. Evidence-based nursing regulation: a challenge for regulators. *J Nurs Regul*. 2010;1(1):30-36. https://www.ncsbn.org/EB_Regulation_article_final.pdf. Accessed April 27, 2016.

5. Personal communication with Kathy Arney, Deputy Director, North Carolina Board of Physical Therapy; October 26, 2015.

6. Personal communication with David Benton, CEO, and Nur Rajwany, CIO, National Council of State Boards of Nursing; March 10, 2016.

7. Fraher E, Gaul K, Spero J. How states can develop better nursing workforce data systems. Robert Wood Johnson Foundation (RWJF) Nursing Research Network, September 2013. http://www.shepscenter.unc.edu/wp-content/uploads/2014/01/TWO-RWJ_Organization_-September-2013-Final.pdf. Accessed April 27, 2016.

This resource brief was prepared by the Health Workforce Technical Assistance Center (HWTAC) staff, Katherine Gaul, Jean Moore, and Erin Fraher. HWTAC is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U81HP26492.

Established to support the efforts of HRSA's National Center for Health Workforce Analysis (NCHWA), HWTAC provides technical assistance to states and organizations that engage in health workforce planning. HWTAC conducts a number of initiatives each year designed to provide expert assistance with health workforce data collection, analysis, and dissemination. HWTAC is based at the Center for Health Workforce Studies (CHWS) at the School of Public Health, University at Albany, State University of New York, and was formed as a partnership between CHWS and the Cecil G. Sheps Center for Health Services Research at the University of North Carolina.

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Concerns of Licensing Bodies

Most of the potential stakeholders are likely to appreciate the importance of developing a health workforce monitoring system for their state. However, state licensing agencies and affiliated boards may have unique concerns, particularly if the strategy involves data collection tied to the licensing/relicensing process. Among the issues and questions that may arise are[3]:

- The value of these data to the licensing bodies
- Funding to support the costs associated with implementing a data collection system
- Whether the board has statutory authority to add or change questions on the licensure forms or would require legislative action to do so
- Data ownership, data confidentiality, and data sharing

The purpose of professional licensing is to protect public safety. While licensing bodies must collect sufficient information to verify credentials, ensure competency, and discipline members, they typically do not collect data for health planning purposes. Licensing bodies may not understand the purpose and value of adding questions for workforce planning and policy. Furthermore, modifications to the licensing process require additional resources (staff time, technology). Most licensing bodies do not have sufficient resources to cover these additional costs and will be wary of requests or mandates that are made without financial support. Changes in legislation or administrative code also may be needed to allow licensure bodies to collect additional information from their licensees. Another key concern relates to data ownership and data sharing: Licensing bodies must comply with state rules related to the protection of the personal data that they collect, and these rules complicate efforts to share data with collaborators for workforce planning purposes.

The Value of the Data to Stakeholders, Including Licensing Bodies

There is growing recognition of the value of data to support effective health workforce planning.[4] MDS data could also be useful to licensing bodies as they relate to issues of supply and distribution (active vs licensed), gender and racial/ethnic diversity, and changing practice characteristics, such as the provision of telehealth services.

Specifically, MDS data can help stakeholders[5]:

- Understand whether the public has access to needed health care services
- Identify that the right professionals have the right training and work in the right areas to serve the public
- Understand and inform new delivery and payment models as they relate to health professional regulation (eg, telehealth and interstate licensure compacts)

Understanding the supply and distribution of health care providers also can allow stakeholders to identify current or potential gaps in access and move to ensure that safe care is available to all citizens.[3]

Funding

Finding sustainable resources to create and maintain a health professions data collection system is critical. States have used a variety of options, including annual state appropriations, grant funding, funding from private foundations, and revenue generated through requests for the data being collected. Some states have considered increasing health professional licensing fees to offset the associated additional costs. In some instances, participating stakeholders contribute resources, either direct or in-kind (eg, staff time, technology, funding), on an ongoing basis. Outside resources also may be available to help augment a state's efforts. For example, the National Council of State Boards of Nursing (NCSBN; www.ncsbn.org) has a 3-pronged strategy to encourage and support state nursing boards to collect better data.[6] Collaborating stakeholders are in the best position to identify the most viable strategy for securing the funding needed to develop and maintain a health professions data collection system.

Resources from State Health Workforce Research Centers that collect health workforce data through the licensure renewal process

A. Examples of Profession-specific Survey Instruments

Behavioral Health Counseling

(Marriage and Family Therapist, Clinical Professional Counselor)

Surveys by State:

- **Indiana** – IN Behavioral Health Survey – *Bowen Center for Health Workforce Research & Policy*
- **Utah** – UT Behavioral Health Survey – *Utah Department of Health & Human Services*

Dentistry

(Dentist, Dental Hygienist)

Dentist Surveys by State:

- **Indiana** – IN Dentist Survey – *Bowen Center for Health Workforce Research & Policy*
- **Utah** – UT Dentist Survey – *Utah Department of Health & Human Services*
- **Vermont** – VT Dentist Survey – *Vermont Department of Health*

Dental Hygienist Surveys by State:

- **Indiana** – IN Dental Hygienist Survey – *Bowen Center for Health Workforce Research & Policy*
- **Utah** – UT Dental Hygienist Survey – *Utah Department of Health & Human Services*
- **Vermont** – VT Dental Hygienist Survey – *Vermont Department of Health*

Medicine and Allied Health

(MD, PA, Respiratory Care)

MD Surveys by State:

- **Indiana** – IN Physician Survey – *Bowen Center for Health Workforce Research & Policy*
- **New Hampshire** – NH Physician Survey – *NH Division of Public Health Services*
- **Utah** – UT Physician Survey – *Utah Department of Health & Human Services*

PA Surveys by State:

- **Indiana** – IN Physician Assistant Survey – *Bowen Center for Health Workforce Research & Policy*
- **Pennsylvania** – PA Physician Assistant Survey – *Pennsylvania Department of Health*
- **Utah** – UT Physician Assistant Survey – *Utah Department of Health & Human Services*

Respiratory Care Surveys by State:

- **Indiana** – IN Respiratory Care Practitioner Survey – *Bowen Center for Health Workforce Research & Policy*
- **Utah** – UT Respiratory Therapist Survey – *Utah Department of Health & Human Services*

Nursing

(CNA, LPN, RN, APRN)

Surveys by State:

- **Indiana** – IN RN, APRN Survey – *Bowen Center for Health Workforce Research & Policy*
- **Nebraska** – NE RN Survey – *Nebraska Center for Nursing*
- **Utah** – UT APRN Survey – *Utah Department of Health & Human Services*

- **Utah** – UT RN, LPRN, Apprentice Survey – *Utah Department of Health & Human Services*

Osteopathic Medicine

(DO, PA)

DO Surveys by State:

- **Indiana** – IN Physician Survey – *Bowen Center for Health Workforce Research & Policy*
- **New Hampshire** – NH Physician Survey – *NH Division of Public Health Services*
- **Utah** – UT Physician Survey – *Utah Department of Health & Human Services*

PA Surveys by State:

- **Indiana** – IN Physician Assistant Survey – *Bowen Center for Health Workforce Research & Policy*
- **Pennsylvania** – PA Physician Assistant Survey – *Pennsylvania Department of Health*
- **Utah** – UT Physician Assistant Survey – *Utah Department of Health & Human Services*

Pharmacy

(Pharmacist, Pharmacy Technician)

Surveys by State:

- **Indiana** – IN Pharmacist Survey – *Bowen Center for Health Workforce Research & Policy*
- **Massachusetts** – MA Pharmacist Survey – *Massachusetts Department of Public Health*

Psychology

(Psychologist, Intern/Assistant)

Surveys by State:

- **Indiana** – IN Psychologist Survey – *Bowen Center for Health Workforce Research & Policy*
- **Utah** – UT Behavioral Health Survey – *Utah Department of Health & Human Services*

Social Work

(LSW, LCSW, LISW)

Surveys by State:

- **Indiana** – IN Behavioral Health Survey – *Bowen Center for Health Workforce Research & Policy*
- **Utah** – UT Behavioral Health Survey – *Utah Department of Health & Human Services*
- **Vermont** – VT Social Worker Survey – *Vermont Department of Health*

General Healthcare Workforce

Surveys by State:

- **California** – CA Health Workforce Survey – *California Department of Health Care Access and Information*
- **Minnesota** – MN Healthcare Workforce Survey – *Minnesota Department of Health*

B. Health Workforce Research Centers

AZ University of Arizona College of Public Health Center for Rural Health, Health Workforce Data and Analysis

CA University of California at San Francisco, Health Workforce Research Center on Long-Term Care
Focus: Preparing the health workforce to meet the nation's long-term care needs

DC George Washington University, Institute for Health Workforce Equity, Health Practice Workforce Research Center
Focus: Studying emerging health workforce issues

DC George Washington University, Institute for Health Workforce Equity, Health Workforce Education Research Center
Focus: Studying equity in health workforce education and training

IN University of Indiana Bowen Center for Health Workforce Research and Policy

MI University of Michigan, Behavioral Health Workforce Research Center
Focus: Promoting a skilled behavioral health care workforce

MN University of Minnesota, Public Health Workforce Research Center
Focus: Creating an effective public health workforce for the future

NC University of North Carolina at Chapel Hill, Program on Health Workforce Research and Policy
Focus: Developing the health workforce

NC University of North Carolina at Chapel Hill, Behavioral Health Workforce Research Center
Focus: Strengthening the current and future behavioral health workforces

NM University of New Mexico Health Sciences Office of Research, Economic Development and Workforce

NY State University of New York (SUNY) at Albany, Center for Health Workforce Studies, Health Workforce Technical Assistance Center (HWTAC)
Focus: Supporting informed workforce planning and development

NY State University of New York (SUNY) at Albany, Center for Health Workforce Studies, Oral Health Workforce Research Center (OHWRC)
Focus: Improving the nation's oral health services

SC South Carolina AHEC Consortium

WA University of Washington, Center for Health Workforce Studies – Allied Health
Focus: Building the health workforce through allied health professions

WA University of Washington, Center for Health Workforce Studies – Health Equity
Focus: Addressing health equity and health workforce diversity