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The value of workforce data in shaping nursing workforce policy: A case study from North Carolina

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ABSTRACT

Background: In 2015, the Institute of Medicine's Committee for Assessing Progress on Implementing the Future of Nursing recommendations noted that little progress has been made in building the data infrastructure needed to support nursing workforce policy.
Purpose: This article outlines a case study from North Carolina to demonstrate the value of collecting, analyzing, and disseminating state-level workforce data.
Methods: Data were derived from licensure renewal information gathered by the North Carolina Board of Nursing and housed at the North Carolina Health Professions Data System at the University of North Carolina at Chapel Hill.
Discussion: State-level licensure data can be used to inform discussions about access to care, evaluate progress on increasing the number of baccalaureate nurses, monitor how well the ethnic and racial diversity in the nursing workforce match the population, and investigate the educational and career trajectories of licensed practical nurses and registered nurses.
Conclusion: At the core of the IOM's recommendations is an assumption that we will be able to measure progress toward a "Future of Nursing" in which 80% of the nursing workforce has a BSN or higher, the racial and ethnic diversity of the workforce matches that of the population, and nurses currently employed in the workforce are increasing their education levels through lifelong learning. Without data, we will not know how fast we are reaching these goals or even when we have attained them. This article provides concrete examples of how a state can use licensure data to inform nursing workforce policy.

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Introduction

In 2011, the National Institute of Medicine's (IOM) Future of Nursing report highlighted the need to develop better nursing data systems to support workforce planning and policy as one of four national priorities (IOM 2011). In 2015, the IOM's Committee for Assessing Progress on Implementing the Future of Nursing recommendations found that "little progress has been made on building a national infrastructure that could integrate the diverse sources of health workforce data; identify gaps; and improve and expand usable data not just on the nursing workforce but also on the entire health care workforce." (IOM, 2015) As the Committee noted, the lack of adequate workforce data

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is not limited to nursing. One of the enduring themes of workforce reports published by the IOM is the absence of workforce data needed to support evidence-based policy. For example, in a 2014 report on "Graduate Medical Education that Meets the Nation's Health Needs," the IOM noted that the "United States has never established a data infrastructure to support an assessment of the health care workforce or the education system that produces it" (Institute of Medicine, 2014, p. 44).

Gaps in health workforce data at the state and national level are problematic in the context of rapid health system change as educators, employers, legislators, and funders struggle to evaluate the effect that new care delivery and payment models will have on the workforce. While some progress has been made in collecting national nursing data, more leadership, resources, and collaboration are needed to develop the robust, state-level data systems called for in the 2011 IOM report (Spetz, Cimiotti, & Brunell, 2016). Numerous stakeholders have called for state licensure boards to collect, at the time of initial licensure and renewal, a common set of data elements on the demographic, practice, and geographic characteristics of the nursing workforce (IOM, 2015; Nooney et al., 2010; Nooney, 2013). Such an approach would enable state-level data to be aggregated to the national level to create a much needed federal census of the nursing workforce.

A recent study by the Health Workforce Technical Assistance Center (HWTAC) found that health workforce data are collected in more than half of states (Armstrong, Forte, & Moore, 2015), but the high fixed costs of establishing a system may prevent some states from collecting data through the licensure renewal process (IOM, 2015; Spetz, Cimiotti, Brunell, 2016). Another HWTAC study noted that licensure boards may also have concerns about data ownership and confidentiality as well as questions about whether workforce data collection is part of their mandate to protect the public (Gaul, Moore, & Fraher, 2016). To address these challenges, nursing workforce stakeholders will need to demonstrate to licensure boards and policy makers how nursing data can be used to develop workforce policy that benefits patients and the health care system. The purpose of this article was to illustrate how nursing data have been used in North Carolina (NC) to inform discussions about access to care, evaluate progress on increasing the number of baccalaureate nurses, monitor how well the ethnic and racial diversity in the nursing workforce match the population, and investigate the educational and career trajectories of licensed practical nurses (LPNs) and registered nurses (RNs). The goal of this case study was to demonstrate the value of collecting, analyzing, and disseminating data that can be used to inform state nursing workforce policy discussions.

Methods

Data from this case study were drawn from the NC Health Professions Data System (HPDS), maintained by the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill. The HPDS is a long-standing and well-respected source of workforce data (Gresenz, Auerbach, & Duarte, 2013). Data are collected annually from initial licensure and renewal forms for 19 licensed health professions in NC, including nurses. The data include information about the demographic, education, practice, and geographic characteristics of RNs, LPNs, and nurse practitioners (NPs) licensed to practice in the state since 1979. Data on certified nurse midwives (CNMs) are available back to 1985. Every year, the HPDS publishes a Data Book detailing the number of LPNs, RNs, CNMs, NPs, physician assistants, physicians, dentists, pharmacists, chiropractors, occupational therapists, occupational therapy assistants, physical therapists, physical therapist assistants, dental hygienists, optometrists, podiatrists, psychologists, psychological associates, and respiratory therapists in active practice by county and statewide. A common set of data elements is collected across the health professions, and a full list of variables contained in the data system can be found in the appendices of the Data Book (Spero et al., 2014). Because licensure is required to practice in the state, the data provide a complete census of the workforce in NC as of October 31 of each year. The longitudinal nature of the files also allows researchers to concatenate records over time to analyze individual-level education trajectories, career patterns, and geographic moves.

Findings/Discussion

The primary focus of the HPDS is to monitor trends in the supply and distribution of health professionals in the state. However, special reports are often undertaken at the behest of key stakeholders including the legislature, the NC Area Health Education Centers program, educational programs, and health systems. This next section outlines how HPDS data have been used to "tell stories" that have informed nursing workforce policy in the state. The goal of these analyses has been to translate nursing workforce data into powerful visualizations—tables, charts, and maps—that provide an objective, evidence-based source of information that can be used by nursing stakeholders in policy discussions.

Educating Legislators

Requests to open new nursing programs, change scopes of practice, or allocate funds to new nursing

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