This Health Equity Essentials research brief outlines an innovative and efficient data collection method that will help Illinois to better:

1. Measure Health Profession Shortage Areas (HPSAs) (location, severity, and type)
2. Measure surpluses and shortages for all professions and specialties, beyond HPSA tracking, which is limited to primary care, psychiatry, and dentistry
3. Track the diversity of the workforce across all health professions
4. Engage in data-informed health workforce planning, development, and access improvements
5. Target and measure success of investments in health workforce diversity, expanding access to different professions and specialties, and across geographic areas and underserved populations
6. Reduce and move toward elimination of healthcare access inequities, a state and national priority

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Executive Summary

- **An efficient health workforce data collection and analysis system is needed for making progress** on Illinois’ health workforce needs and ensuring healthcare access.
- **Ensuring high-quality healthcare access requires having a diverse, highly-trained, culturally competent, or culturally humble, health workforce** across different provider categories and appropriately distributed geographically throughout the State.

**Problem:** Illinois has an outdated and inefficient approach to collecting data on the number of healthcare providers for the establishment and renewal of Health Professions Shortage Areas (HPSAs). The current method is completed via phone on a discontinuous, rather than systematic basis. Also, Illinois’ current license renewal data collection is inadequate for determining health professionals’ practice locations, amount of time in practice at each location, and the diversity of the health workforce.

Illinois has seen large gains in health insurance coverage and the diversity of its population; however, the State has significant shortages of different types of health professionals in many parts of the state, which can limit healthcare access. Illinois currently ranks 25th nationally in primary care percent of need met, with roughly 60% of its need met (for more, see the map on page 14). Illinois does not systematically track its health workforce diversity, but the Illinois Health Workforce Investment Board Healthcare Task Force recommended such data collection, which could measure success of investments in workforce diversity.

License renewal is an untapped opportunity for systematic collection of valuable data about Illinois’ health workforce. Some states collect a minimum data set for health professions, and Illinois’ lack of such data collection and analysis disadvantages health workforce planning and healthcare access.

**Policy Change Recommendation:** Illinois should collect and analyze detailed information during the license renewal process for all health professionals through a policy change made to each health profession’s practice act. Efficient data collection at the point of license renewal will: 1) minimize the administrative burden of data collection; 2) systematically and efficiently collect data on more factors than are currently collected; 3) help ensure data-informed, strategic health workforce investments.

**Policy Change Rationale:** Data collection and analysis based on a combination of the predefined HRSA Health Professions Minimum Data Set (MDS) and some questions from the HRSA Full Time Equivalents Survey will allow Illinois to better, consistently, and efficiently:

1. Measure HPSAs, including location, severity, and type
2. Measure surpluses and shortages for all professions and specialties, beyond HPSA tracking, which is limited to primary care, psychiatry, and dentistry
3. Track the diversity of the workforce across all health professions
4. Engage in data-informed health workforce planning, development, and access improvements
5. Target and measure success of investments in health workforce diversity, expanding access to different professions and specialties, and across geographic areas and underserved populations
6. Reduce and move toward elimination of healthcare access inequities, a state and national priority

**This policy change matters for health equity:** Achieving health equity and eliminating disparities—one of four overarching goals in Healthy People 2020, the national public health agenda—requires strategic efforts targeted at specific inequities. Collecting this data can help Illinois measure and reduce inequities in access to different types of health providers and use data-informed strategies to diversify the State’s health workforce.
Background

Title V of the Patient Protection and Affordable Care Act (ACA) seeks to improve access and delivery of health care services with a focus on low income, underserved, uninsured, minority, health disparity, and rural populations by:

1. Gathering and analyzing data to ensure the health care workforce can meet the needs of individuals, including research on the supply, demand, distribution, diversity, and skills of the current workforce;
2. Increasing the supply of quality health care professionals;
3. Enhancing education and training of the health care workforce; and
4. Providing any additional support to the existing health care professionals.

Because of the ACA, many more Illinois residents have insurance than before its passage, with 12,797,900, or 91% of all Illinois residents having some form of health insurance (employer, private, or public). Despite large gains in insurance coverage, Illinois still has significant shortages of various health professionals, limiting access to care statewide. Illinois needs a systematic method of gathering data regarding health professionals practicing in Illinois to better plan investments and track progress toward ensuring that the State is addressing the unmet and growing health care needs of residents. Data-informed health workforce investments are necessary for meeting the triple aim of “improving the individual experience of care; improving the health of populations; and reducing the per capita costs of care for populations” sought by both the ACA and Illinois health reforms.

Policy Challenge

Recognizing the challenges presented by the changing demographics and healthcare needs in Illinois, this brief represents research and policy recommendations to help the state:

1. Efficiently gather health workforce data,
2. Better understand the degree to which it has a diverse and well-distributed health workforce; and
3. Ensure more targeted and successful health workforce development investments.

Gathering and analyzing high-quality data on the health workforce would better align Illinois with the standards of Title V of the ACA, improve the efficiency of such data collection, and improve the targeting and return on Illinois’ investments in its health workforce. Policy changes that would modify Illinois’ license renewal procedures, conducted through Illinois Department of Financial and Professional Regulation’s (IDFPR) Division of Professional Regulation, is a “winnable battle” for Illinois. Because health professionals are required to renew their licenses on a regular basis, collecting data at that point in time is a cost-effective approach that other states have begun to implement. According to a report from the Federation of State Medical Boards, 68% of member boards include workforce questions in their license renewal process.
Current Process in Illinois

IDFPR’s role in data collection:
Currently, the license renewal process for health professionals in Illinois asks the professionals to certify that they have completed their required continuing education credits and that they are not delinquent on their child support or taxes. IDFPR carries out the law as written as it relates to the license renewal process of health professionals, with the collected data being directly relevant to the license renewal process. Generally, IDFPR does not collect more data than is required by statute to ensure that “licensure qualifications and standards for professional practice are properly evaluated, applied, and enforced.” (More information on the data being collected by IDFPR for physicians specifically, used as an example, can be found on page 6.) The license renewal process collects an address, but the collected information may reflect the home address of the licensee, or one of several practice locations. Both the number of hours that health professionals practice and the addresses of the different places where a health professional might work are not collected.

IDPH’s role in data collection:
The federal government established ten essential services to public health in an effort to describe the activities that all public health systems should engage in to support a healthy population. Two of those ten—“8. Assure competent public and personal health care workforce” and “9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services”—require the Illinois Department of Public Health (IDPH), to collect data on health professionals. Currently, this is done through requesting information from provider groups and clinics within HPSAs and reporting this information to HRSA. IDPH staff does this by calling individual clinics and asking for information and completion of a survey regarding providers. HRSA uses this information to determine funding levels for loan repayment programs that aim to increase provider capacity in underserved areas.

This current method presents a significant administrative burden because data collection is conducted via phone. Also, it is only gathered for a limited number of professions, including primary care physicians, advanced practices nurses, dentists, and psychiatrists. This process collects incomplete information on a smaller subset of professions than the State could collect if it utilized the HRSA MDS for each licensed health profession at the time of license renewal.

IDPH also manages the Health Care Worker Registry, which, according to the associated IDPH webpage:

“...lists individuals with a background check conducted pursuant to the Health Care Worker Background Check Act (225 ILCS 46). It shows training information for certified nursing assistants (CNA) and other health care workers. Additionally, it displays administrative findings of abuse, neglect or misappropriations of property.”

The Health Care Worker Background Check Act could provide another opportunity to gather useful demographics and practice location data for those health professions that are not covered by a specific practice act, including home health care aides, nurse aides, personal care assistants, private duty nurse aides, day training personnel, any other direct care provider, and community health workers. Communication with IDPH will be important to ensure that this data is collected in alignment with that of other health professions.
Policy Change Recommendation

Health & Medicine recommends that Illinois’ health professionals’ practice acts be amended to require that when health care practitioners renew their licenses, the IDFPR be required to collect more useful data based on a combination of the predefined HRSA Health Professions MDS and some questions from the HRSA Full Time Equivalents Survey. This will help the State to collect better data regarding the health workforce, including:

- Race and ethnicity
- Age and other demographic information
- Education
- Practice location(s)
- Number of patient care hours at each location
- Populations served

This policy change would require each of the included health professions to agree to incorporate this language into their individual practice acts. It would also require a nominal increase in re-licensure fees for included professions in order to cover the cost of processing the new data. The exact increase would be calculated based on the existing supply of health professionals in the State. Although there are various means to accomplish the goal of a robust database of the Illinois health care workforce, gathering and analyzing license renewal data based primarily on a predefined Minimum Data Set, with some additional questions from the Full Time Equivalents Survey, is the optimal route.

What are the HRSA Health Professions Minimum Data Sets?

The HRSA Health Professions Minimum Data Set was established by the National Center for Health Workforce Analysis to answer critical health workforce questions such as:

- How many practitioners does the state have within different provider groups?
- Where are they practicing?
- Who is providing patient care?
- What type of care are practitioners providing?

Coupling the MDS questions with some of the HRSA Full Time Equivalents Survey (discussed more on the next page) and analysis of the collected data, some additional questions will be able to be answered:

- Where are there shortages and surpluses within different categories of providers?
- Are these providers serving the state’s most vulnerable populations (including homeless, Medicaid recipients, migrant and seasonal farmworkers, Native Americans, non-English speakers, low-income residents and those receiving care on a sliding scale)?
- How diverse is our workforce (as it relates to age, gender, race/ethnicity, language, education, etc.)?

Because inconsistencies in the questions asked make comparison between states difficult, the MDS provides accurate, comparable, and consistent data spanning profession, location, and time. This data can be used in the policy development process on the state and Federal level. Table 1 below lists all health professions licensed through IDFPR with an established MDS questionnaire.
Table 1. Health Professions Licensed through IDFPR Alongside Number of Questions on Minimum Data Set Questionnaires

<table>
<thead>
<tr>
<th>Health Profession</th>
<th>Number of Questions on MDS questionnaire</th>
<th>Renewal Frequency</th>
<th>Renewal on Odd/Even Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Hygienist</td>
<td>25 questions</td>
<td>3 years</td>
<td>N/A</td>
</tr>
<tr>
<td>Licensed professional counselors</td>
<td>26 questions</td>
<td>2 years</td>
<td>Odd year</td>
</tr>
<tr>
<td>Nurses (including APNs)</td>
<td>29 questions</td>
<td>2 years</td>
<td>Even year</td>
</tr>
<tr>
<td>Occupational therapists</td>
<td>12 questions</td>
<td>2 years</td>
<td>Odd year</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>16 questions</td>
<td>2 years</td>
<td>Even year</td>
</tr>
<tr>
<td>Physical therapists</td>
<td>13 questions</td>
<td>2 years</td>
<td>Even year</td>
</tr>
<tr>
<td>Physician assistants</td>
<td>15 questions</td>
<td>2 years</td>
<td>Odd year</td>
</tr>
<tr>
<td>Physicians (including psychiatrists)</td>
<td>16 questions</td>
<td>3 years</td>
<td>N/A</td>
</tr>
<tr>
<td>Psychologists, clinical</td>
<td>28 questions</td>
<td>2 years</td>
<td>Even year</td>
</tr>
<tr>
<td>Social Workers</td>
<td>HRSA is working with partners to finalize MDS</td>
<td>2 years</td>
<td>Odd year</td>
</tr>
</tbody>
</table>

Appendix A includes a sample of minimum data set questions from HRSA specific to physicians. While some states have been able to systematically collect data on their dentists (California and Virginia, for example), there is currently no established HRSA MDS questionnaire for dentists.

Gathering Data on Patient Care Hours and Populations Served through FTE Surveys

In addition to the base-level questions asked on the MDS questionnaire, Illinois should consider adding questions from HRSA’s Full Time Equivalents, or FTEs, survey. (Appendix B contains the sample FTE survey questions currently asked by HRSA.) This data is required of states in order to regularly update the health professions shortage area (HPSA) designation process through HRSA.

A HPSA designation demonstrates a shortage of health professionals. As of 2014, Illinois had 227 Primary Care HPSAs (ranked 25 out of 50), falling just short of the national average of Percent of Need Met (Illinois has 60.37% of its primary care need met; the nation has 60.41%). The map in Appendix C shows the distribution of the state’s Primary Care HPSAs. The FTE survey also asks questions about patient populations served. Systematically collecting better data will allow Illinois to gain a more nuanced understanding of who is being served and who is being underserved in the state, with a specific focus on homeless, Medicaid recipients, migrant and seasonal farmworkers, Native Americans, non-English speaker, low-income residents and those receiving care on a sliding scale.

While both the MDS and FTE Surveys provide a strong basis for data collection on health professionals and the populations that they serve, both surveys can be modified to better fit the needs of Illinois prior to dissemination.

Increasing Collaboration and Efficiency of State Agencies to Collect and Analyze Health Workforce Data

According to a 2013 HRSA webinar, Health Workforce Webinar: Health Professions Minimum Data Set, state licensure boards are best able to support the collection of this health workforce data. Although IDFPR is directly responsible for the license renewal process of Illinois health professionals, IDPH, as the
state agency that oversees public health, works to assure a competent public and personal healthcare workforce, one of the ten essential public health services, which they fulfill in part by tracking and attempting to address HPSAs. If a change were to be made in Illinois regarding data collection during the health workforce license renewal process, IDFPR would be responsible for implementing the data collection change, but IDPH would likely be responsible for analyzing such data, providing HPSA information to HRSA, and providing actionable reports and recommendations for various health workforce stakeholders. As mentioned before, IDPH currently oversees both the data collection for HPSA designation and the administration of some State health workforce scholarship and loan repayment programs. A similar division of labor and responsibilities exists in other states as well, which indicates that a more streamlined process can be adapted.

Collecting better health workforce data at the time of re-licensure will make this data collection more efficient and systematic while provide useful data on a consistent basis and for all licensed health professionals in the State. It will also allow Illinois a more complete understanding of the capacity of its health workforce, the diversity of providers, and its distribution throughout the state. This data could provide opportunities for valuable insights to schools, health workforce pathway and trajectory programs, hospitals, and other private entities to better target their workforce investments and programming. The newly developed health workforce database will also be useful to inform current and future data collection efforts and reporting, making identification of HPSAs easier and potentially much less administratively burdensome. Additionally, data collection for HPSA designation focuses on primary care (family practice and internal medicine physicians, pediatricians, and OB/GYNs), mental health (psychiatrists), and dental health (dentists). By collecting information for all licensed providers—not only these three—Illinois will have a more complete picture of its capacity and needs, and may find ways to better inform its health workforce development and pipeline programs.

**Uses of Health Workforce Data: Diversity and Inclusion**

Measuring health workforce diversity is essential to measuring a crucial element of health reform. Evidence indicates that racial and ethnic similarities between physicians and patients lead to higher patient satisfaction. Current health workforce data collection in Illinois lacks systematically collected information about the race or ethnicity of all health professionals, despite the fact that various organizations in Illinois receive funding through HRSA to increase the diversity of its health workforce. In order to ensure access to culturally humble healthcare, Illinois (and the U.S. more broadly) invests significant efforts and funds into diversifying the health workforce through health workforce pathways and trajectories programs (i.e., “pipeline” programs). Providing this demographic information would be very valuable to Illinois’ pipeline programs and could allow them to better measure effectiveness and to make necessary adjustments to their programming. As Illinois residents become increasingly more diverse, data on the diversity of the workforce will become even more critical to targeting investments toward identifying inequities in access to high-quality, culturally competent/humble, and compassionate healthcare and making investments in a more diverse health workforce to help reduce and eliminate such inequities.

**Data Collection at Health Professional License Renewal: A Practical Examination**

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Pilot program implemented in Illinois: Gathering nurse workforce data

This process of collecting detailed workforce data has been piloted in Illinois by nurses through their Nursing Workforce Survey. The survey collected information about nurses’ demographics, employment settings, working conditions, salaries, satisfaction with career, retirement intention, barriers to continuing education, and interest in teaching. Another survey and report produced in 2014, used the HRSA MDS to gather similar information at the time of license renewal. Both of the surveys were completed on a voluntary basis, with a response rate ranging from 22-30%.

These reports shed light on the supply of nurses in the state and identified areas of focus for future health policy and planning efforts. They also helped with understanding the level and direction of diversity within workforce categories, education levels attained, and geographic distribution of nurses, among many other factors. These survey reports show that completion of such data collection can yield very useful information about health workforce categories that can inform health workforce planning and investments. Additional survey reports for the approximately 230,000 Illinois LPNs, RNs, and APNs can be found on the Illinois Center for Nursing website.

Program implemented in Wisconsin: Gathering physician data

Data collection during the license renewal process of health professionals has been effectively implemented in other states. In fact, Wisconsin is one of many states gathering HRSA’s MDS during license renewal.

Through a partnership with the University of Wisconsin School of Medicine and Public Health, the Wisconsin Health Workforce Data Collaborative, Wisconsin Council on Medical Education and Workforce, Wisconsin Medical Society, and the Wisconsin Department of Workforce Development, Wisconsin began collecting MDS information for the States’ physicians in 2011, which is helping to build robust body of data ever since.

Concurrently, the Illinois Department of Financial & Professional Regulation created a web-based physician profile, mandated by the Illinois Medical Practice Act in 2011. The law mandated that they include in public profiles:

- Legal name
- Description of disciplinary or legal action
- Education
- Years in practice and locations
- Faculty appointments (optional)
- Publications (optional)
- Professional or community service activities and awards (optional)
- Primary practice location (required)
- Identification of any available translating services
- Medicaid participation (optional)
- Age
- Gender
- Race/ethnicity
- Languages spoken
- Time designation
- County, City, Zip of primary place of practice
- Hours per week at each location (allows for 5 specific locations)
- City and zip of up to 5 practice locations
Next Steps for Data Collection in Illinois

Both IDFPR and IDPH face limitations based both upon their capacities as agencies and, specifically for workforce data collection and analysis, what the law requires and allows for collection.

Illinois is growing in both its population and the diversity of its residents. IDPH plays a key role in advancing the health of all Illinoisans and one of its duties is to help ensure that Illinois has the health workforce to meet the health needs of the population. IDFPR is responsible for the licensure process and can help with acquiring data that can help drive policy requiring that state agencies work together to gather and analyze robust data on each of the professions that make up the state’s health workforce to inform IDPH’s work.

Given this underutilized opportunity, Health & Medicine Policy Research Group recommends systematic and comprehensive data collection efforts at the time of license renewal for all Illinois health professionals licensed through IDFPR.

This is the initial brief that Health & Medicine has produced on this topic. We encourage feedback and are actively seeking additional information related to this recommendation.

Acknowledgements

We wish to acknowledge the guidance provided by representatives from various organizations throughout the development of this brief. First, we want to thank the many representatives from the Health Resources and Services Administration who provided valuable insight on the HPSA process and the Health Professions MDS. We would also like to express gratitude to staff from the Illinois Department of Public Health for allowing us a better understanding of the data collection process and needs in the State. Finally, we are grateful to the Illinois Department of Financial and Professional Regulation for their comments early on in project on their data collection processes for Illinois health professionals. This brief would not have been possible without the thoughtful input of each of these agencies.

Health & Medicine Policy Research Group

The Health & Medicine Mission is to promote social justice and challenge inequities in health and health care. We are an independent policy center that conducts research, educates and collaborates with other groups to advocate policies and impact health systems to improve the health status of all people.
References


12. Communications with IDFPR staff

13. IDFPR Webpage


15. IDPH Webpage http://dph.illinois.gov/topics-services/life-stages-populations/rural-underserved-populations/Shortage

16. Communications with IDPH Staff

17. Communications with HRSA Staff


37 L. Roberts (personal communication, October 19, 2016)
### Appendix A

Example HRSA Minimum Data Set: Physicians

**MDS: PHYSICIANS**

**Demographics**

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
</table>

1. Birth date

2. Sex: ○ Male ○ Female

3. Race (1 or more categories may be selected)—Recommended as Optional
   - ○ White
   - ○ Black or African American
   - ○ American Indian or Alaska Native
   - ○ Asian
   - ○ Native Hawaiian/Other Pacific Islander
   - ○ Other (specify) __________

The workgroup acknowledges that this is a condensed list and state boards may choose to use more detailed response sets (e.g., HHS Data Standards for Race and US Census Bureau Race Categories).

4. Ethnicity
   - Are you Hispanic, Latín, or of Spanish origin?
     - (1 or more categories may be selected)—Recommended as Optional
     - ○ No
     - ○ Yes, Mexican, Mexican American, Chicano/a
     - ○ Yes, Puerto Rican
     - ○ Yes, Cuban
     - ○ Yes, Another Hispanic, Latino/a, or of Spanish origin (specify) __________

5. Do you speak a language other than English at home? (optional)
   - ○ Yes
   - ○ No

6. What is this language? (If you answered Yes to #5)
   - ○ Spanish
   - ○ Other Language (identify) __________

**Education & Training**

7. Medical Education
   - A. What is your medical degree?
     - ○ M.D.
     - ○ D.O.
     - ○ M.D.D.S.
   
   - B. What year did you complete your medical degree?

8. Residency Training/Graduate Medical Education
   - A. First Specialty Training
     - ○ Location (State)
     - ○ Number of Years of Training
     - ○ Year Completed

**Practice Characteristics**

9. What is your employment status?
   - ○ Actively working in a position that requires a medical license
   - ○ Actively working in a field other than medicine
   - ○ Not currently working
   - ○ Retired

10. Are you currently providing direct clinical or patient care on a regular basis?
    - ○ Yes
    - ○ No

11. If no, how many years has it been since you provided clinical or patient care?
    - ○ Less than 2 years
    - ○ 2 to 5 years
    - ○ 5 to 10 years
    - ○ More than 10 years

12. Which of the following best describes the area(s) of practice in which you spend most of your professional time?

<table>
<thead>
<tr>
<th>Area of Practice</th>
<th>Principal</th>
<th>Secondary</th>
<th>Completed Accredited Residency Program or Fellowship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescent Medicine</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Family Medicine</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>General Practice</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Gynecology</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Nephrology</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

**September 1, 2013**

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Developed by: Health and Medicine Policy Research Group (September 2015)
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### 13. Which of the following categories best describes your primary and secondary practice or work setting(s) where you work the most hours each week?

<table>
<thead>
<tr>
<th>Practice Setting</th>
<th>Principal</th>
<th>Secondary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office/Clinic—Solo Practice</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Office/Clinic—Partnership</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Office/Clinic—Single Specialty Group</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Office/Clinic—Multi Specialty Group</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Hospital—Inpatient</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Hospital—Outpatient</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Hospital—Emergency Department</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

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### 14. How many weeks did you work in medical related positions in the past 12 months? __

### 15. For all medical related positions held in (insert state names), indicate the average number of hours per week spent on each major activity:

- Clinical or patient care: _____ hours/week
- Research: _____ hours/week
- Teaching/Education: _____ hours/week
- Administration: _____ hours/week
- Volunteering (medical related only): _____ hours/week
- Other (specify): _____ hours/week

Another approach to obtaining this information would be to ask licensees: (1) number of weeks worked in the past 12 months, (2) average number of hours worked per week, and (3) the percentage of time per week spent on each major activity (e.g., clinical or patient care, research etc.).

### 16. What is the location of the site(s) where you spend most of your time providing direct clinical or patient care? Please enter the complete address for up to three locations and your direct patient care hours per week at each site.

(The workgroup strongly recommends collecting full addresses if at all possible, but zip codes only would be acceptable for a minimal data set.)

**Principal Location Address**

- Number: __________
- Street: __________
- City/Town: __________
- State: __________
- Zip Code: __________
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Appendix B
Full Time Equivalency Survey

PRIMARY MEDICAL CARE PHYSICIAN FTE SURVEY

This survey may be used for both geographic and population group primary medical care HPSA requests. This information should be collected for each primary care physician at a practice location. All questions may not apply to a specific HPSA request.

Physician’s Name:
First Name:
Middle Name:
Last Name:
Suffix:
Provider Status:
Provider Address Status:
Physician’s License Number:
Is Physician an Intern? (Y/N):
Yes  No
Is Physician a J1 Visa Holder? (Y/N):
Yes  No
Is Physician a Federal Employee? (Y/N):
Yes  No
Is Physician a National Health Service Corp (NHSC) Employee? (Y/N):
Yes  No
Specialty (GP, FP, IM, PD, OBG):
Percent of Practice:
Subspecialty:
Percent of Practice:
Address Line 1:
Address Line 2:
City:
County:
State:
Zip Code:

Federal Information Processing Standard (FIPS) Code State:
FIPS County:
Census CT location code (six digits):
Census MCD location code (five digits):
Latitude (signed decimal degrees):
Longitude (signed decimal degrees):

Hours/Week in Patient Care Activities:
Annual Number of Medicaid Claims:
Does Physician have Hospital Privileges? (Y/N):
Yes  No
If Yes, Are Hospital Patient Care hours included in Practice Location hours? (Y/N):
Yes  No
If Physician works less than a total of 40 Hours/Week, provide a brief explanation (semiretired, teaching, etc):

Does Physician serve the following patients? Percentage of Patients seen in Practice:
Homeless(Y/N) | Yes | No | Percentage
---|---|---|---
Medicaid(Y/N) | Yes | No | Percentage
Migrant Farmworkers(Y/N) | Yes | No | Percentage
Seasonal Farmworkers(Y/N) | Yes | No | Percentage
Native Americans(Y/N) | Yes | No | Percentage
Other Patient Group (Percent of Practice)
Does Physician offer Sliding Fee Scale based on income or ability to pay?(Y/N): Yes | No
If Yes, what percent of patients are Sliding Fee Scale patients?
Does Physician's Practice offer language interpretation for patients?(Y/N): Yes | No
What language? Percentage of Patients:

Total
Does Physician accept new patients?(Y/N): Yes | No
When a patient calls the Physician's office to request an appointment, what is the usual wait time between the request and the appointment:
New Patients (Days):
Current Patients (Days):
When a patient has an appointment, what is the usual wait time between the appointment time and the actual time that the physician sees the patient?
New Patients (Hours):
Current Patients (Hours):
Other Data Printed from Database (For reference if the actual record is printed on this form):
Provider ID:
Provider Address Info ID:
## Appendix D

### Table 2. A Comparison of Data Collected During License Renewal for Illinois and Wisconsin Physicians

<table>
<thead>
<tr>
<th>Type of Information Asked</th>
<th>Illinois</th>
<th>Wisconsin</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DEMOGRAPHIC INFORMATION</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full legal name</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Hispanic origin</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Race/ethnicity</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Hometown (rural, suburb, city)</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Citizenship/visa status</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Home location (in state?)</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td><strong>LEGAL ACTIONS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Description of any felony criminal convictions, class A misdemeanors, discipline in Illinois and other states</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Description of any final disciplinary actions within last 5 years</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Description of revocation of hospital privileges</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Medical malpractice court judgements and settlements</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td><strong>EDUCATION AND LICENSURE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High school education</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Names of medical schools attended, dates of attendance</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Type of medical degree</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>In what state/country did you receive degree</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Graduate medical education</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Field of post-graduate training</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Planned practice location following post-graduate education (staying in the state?)</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>State of residency training</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Multiple residencies?</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Specialty board certification</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>License number</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>License information (original date license was issued, expiration date)</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>State of first licensure</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>State of concurrent licensure</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>License status</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td><strong>PRACTICE INFORMATION</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of years in practice</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Primary practice location</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Change of practice location in the past year?</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Where is time spent? (hospital, office, residential facility, teaching, research)</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Names of hospitals where the physician has privileges</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Appointments to medical school faculties</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Location of primary practice setting</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Identification of any available translating services at primary practice location</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Ability to communicate with patients in a language other than English (and which languages)</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Indication of participation in the Medicare/Medicaid program</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Principal and secondary specialties</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Residency/certification in principal and secondary specialties</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Percent of patient care time in principal and secondary specialties</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Urgent care physician</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Facility type</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>Facility capacity (accepting new patients)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Number of physicians at location</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Patient-centered medical home practice model?</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Any advanced practice providers (physician assistant, nurse practitioner, certified nurse midwife, certified registered nurse anesthetist, other advanced practice nurses)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Providing primary care or mental health services</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

**EMPLOYMENT STATUS**

| Active in medicine                  | X |
| Salaried?                            | X |
| If retired:                          | X |
|   - Retirement age                  |   |
|   - Still teaching?                 |   |
|   - Volunteering? How many hours per month? |   |
| If planning to return to medicine:  | X |
|   - When?                           |   |
|   - Returning to medicine in the state? |   |
| Military?                            | X |
| Telemedicine?                        | X |
| Retirement plans                     | X |
| Practice plans in the next 2 years  | X |

**PATIENT CARE PRACTICE CHARACTERISTICS**

| Weeks per year on patient care       | X |
| Hours per week on patient care       | X |
| Hours per month on call              | X |
| Professional activities              | X | X |
| Hours per week on professional activities | X |
| Volunteer services?                 | X |
| Hours per month on volunteer services | X |
| Primary patient source of payment (Medicare, Medicaid, self-pay, private insurance) | X |
| Patient’s level of difficulty in arranging referral appointments | X |

Sources: