Utah Medical Education Council
Nurse Practitioner/ Clinical Nurse Specialist Survey 2015

1. **Please indicate the advanced practice certification*(s)* you currently hold:** *(mark all that apply)*

Nurse Practitioner (NP)		**Clinical Nurse Specialist (CNS)**	
☐ Adult/ Gero Acute Care NP	☐ Family NP	☐ Acute Care CNS	☐ Geriatric CNS
☐ Adult/ Gero Primary Care NP	☐ Neonatal NP	☐ Adult Health CNS	☐ Pediatric CNS
☐ Pediatric Acute Care NP	☐ Psych/Mental Health NP	☐ Adult/Gero CNS	
☐ Pediatric Primary Care NP	☐ Women's Health NP	☐ Psych/ Mental Health CNS	
☐ Other NP (specify) _____		☐ Other CNS (specify) _____	

2. **Please indicate whether you are you currently practicing as a Nurse Practitioner or a Clinical Nurse Specialist?**
   ☐ Nurse Practitioner ☐ Clinical Nurse Specialist

3. **If you indicated being certified as a CNS in question 1 but you are not practicing as a CNS please indicate the primary reason why you are not practicing as a CNS.** _____

4. **Do you provide any health care services in Utah? ☐ Yes ☐ No ☐ I live in Utah but don't provide services here**
   a. **If <u>NO</u>, please specify why you maintain a Utah license:** _____
   b. **If <u>NO</u>, on a scale of 1-5 (1 being the most influential and 5 being the least influential), please rank the individual factors that have influenced your choice to work outside of Utah:**

Family	_____	Wage/Pay scale	_____	Climate	_____
Lifestyle	_____	Work Environment	_____	Other (specify)	_____

<u>IF YOU DO NOT PROVIDE SERVICES OR LIVE IN UTAH, PLEASE STOP HERE AND RETURN THE SURVEY, THANK YOU</u>

5. **Are you of Hispanic ethnicity? ☐ Yes ☐ No**
6. **What is your racial background?** *(Please mark only one)*

   ☐ American Indian/Alaska Native ☐ African American ☐ Asian
   ☐ Native Hawaiian/Pacific Islander ☐ White/Caucasian ☐ Other **(**specify**)** _____

7. **Please describe the area where you spent the majority of your upbringing** *(when you lived there):*
   ☐ Rural ☐ Suburban ☐ Urban/Metropolitan Area State:_____

8. **What type of NURSING degree/credential qualified you for your first U.S. nursing license?**
   ☐ Vocational/Practical Certificate ☐ Associate Degree ☐ Master's Degree
   ☐ Diploma ☐ Baccalaureate Degree ☐ Doctorate Degree

9. **How many years of experience as an RN did you have before STARTING an APRN program degree?** _____

10. **Please provide the following information regarding the institution from which you received your advanced practice education:** College/ University: _____State:_____ Year graduated: _____ Degree: _____

11. **What is your highest level of education?**
    ☐ Master's Degree-Nursing ☐ Doctor of Nursing Practice (DNP) ☐ Doctoral Degree-Nursing Other
    ☐ Master's Degree-Non-Nursing ☐ Doctoral Degree-Nursing (PhD) ☐ Doctoral Degree- Non-Nursing

12. **Please indicate the type(s) of position(s) you currently hold:** *(please mark all that apply)*
    ☐ Full Time APRN ☐ Full Time Non- Nursing ☐ Faculty- APRN ☐ Single Employment Position
    ☐ Part Time APRN ☐ Part Time Non- Nursing ☐ Retired ☐ Multiple Employment Positions
    ☐ Contractor- APRN ☐ Temp./ Per Diem- APRN ☐ Volunteer as an APRN ☐ Working as an RN
    ☐ Unemployed-Seeking Work as an APRN ☐ Unemployed-Not Seeking Work as an APRN

    a. **If you marked above that you are a contractor, how many contracts do you provide services for per month?** _____

    b. **If you marked you were unemployed above, please indicate your reason for being so.** *(mark all that apply)**:***
    ☐ Taking Care of Home ☐ Taking Care of Family ☐ Disabled
    ☐ Inadequate Salary ☐ Attending School ☐ Difficulty Finding APRN Position
    ☐ Other *(please specify)* _____

13. **Please enter a code from the list of monetary ranges below indicating your <u>average annual gross compensation</u>? (Before taxes AND excluding benefits). Compensation: _____**

14. **Please enter a code from the list below indicating the amount of educational debt you CURRENTLY have from your training as an APRN, as well the TOTAL educational debt you had for your APRN training <u>at the time of your graduation</u>.** *(exclude any pre-APRN and non-education debt including relocation loans, cars and credit cards)*
Current Debt :_____ Total Debt :_____

01= $0.00	04= $60,000-$69,999	07= $90,000-$99,999	10= $120,000-$129,999
02= > $0.00- $49,999	05= $70,000-$79,999	08= $100,000-$109,999	11= $130,000-$139,999
03= $50,000-$59,999	06= $80,000-$89,999	09= $110,000-$119,999	12= $140,000 or more

15. **Please indicate the Zip Code of your Primary & Secondary practice/contracting locations Also, Please estimate the total hours worked per week** *(not including on call)* **at each practice location.**
<u>Primary Practice</u> Zip:_____ Total hrs/wk:_____ **<u>Secondary Practice</u>** Zip:_____ Total hrs/wk:_____

16. **Please indicate the approximate number of hours you spend providing <u>DIRECT PATIENT CARE</u> each week, including charting, but excluding the hours spent providing patient care combined with teaching or training of other APRNs*: (****unless all of the hours you work each week are spent in direct patient care without any teaching or training of APRN students, this should be less than the number of total hours reported in the previous question).*
Primary Practice_____ hrs./wk Secondary Practice_____ hrs./wk

17. **In an average week, how many patients do you provide services for?** *(please write N/A if option doesn't apply)*
Outpatients _____ Inpatients _____

18. **Please estimate the <u>percentage (%)</u> of patients you see from each of the following age groups** *(total of all practice locations) (The sum for each patient category (row) should equal 100%)*

Outpatients:	0-19_____%	20-64_____%	65-84_____%	85+_____%	Total **(100%)**
Inpatients:	0-19_____%	20-64_____%	65-84_____%	85+_____%	Total **(100%)**

19. **What percent of your patients at your primary/secondary practice/contracting location(s)** (if applicable) **have the following types of insurance coverage?** *(Estimates of all payers should equal 100% for each practice location. You may want to ask your billing office for assistance with these estimates)*:

	Primary	Secondary		Primary	Secondary
Medicaid	_____%	_____%	Tri-Care (CHAMPUS)	_____%	_____%
Medicare	_____%	_____%	Workman's Comp	_____%	_____%
Private Insurance	_____%	_____%	Charity	_____%	_____%
Managed Care	_____%	_____%	Other	_____%	_____%
Self-Pay/ Uninsured	_____%	_____%	Total	**(100%)**	**(100%)**

20. **Please indicate the average wait time for an appointment in your practice location(s):**

	<u>Appt. for New Patient (Days)</u>	<u>Appt. for Est. Patient (Days)</u>	<u>Average Office Wait Time *(minutes)*</u>
Primary Practice	_____	_____	_____
Secondary Practice	_____	_____	_____

21. **Please allocate the average hours per week you spend in the following non-patient care activities:**
a. Teaching (*didactic and/or classroom teaching without patient care)* _____
b. Research *(academic, reports, applications, surveys, etc.)* _____
c. Admin/Management *(planning, budgeting, etc. not in direct support of patient care)* _____
d. Consulting *(Not directly related to pt. care)* _____
e. Policy/ Procedure Development _____
f. Volunteer/ Charity Care _____
g. Other: _____ _____

22. Please indicate if your *(if applicable)* practice/ contract location(s) currently ACCEPT new patients from the following payer types:

	Medicaid	Medicare	Self-Pay/Uninsured	Other **Insured** Patients
Primary Practice	☐	☐	☐	☐
Secondary Practice	☐	☐	☐	☐

23. Please indicate if your practice/contract location(s) offer services to uninsured patients for Free, a Fixed Lower Fee, or on a Sliding-Fee scale based on income or family size?

	Free Services	Sliding Scale	Fixed Lower Fee	Not Offered
Primary Practice:	☐	☐	☐	☐
Secondary Practice:	☐	☐	☐	☐

24. Please enter codes from the list below for your Primary _____ and Secondary _____ practice setting:

1 = Self-Employed/ Contractor (solo)
2 = Group APRN Practice
3 = Hospital- Inpatient
4 = Hospital- Outpatient
5 = Hospital- Emergency Department
6 = Hospital- Ambulatory Care Center
7 = Other unit of hospital
8 = Federal Hospital (VA)
9 = Physician Practice Solo
10 = Physician Single Specialty Group
11 = Physician Multi- Specialty Group
12 = Non-hospital Based Outpatient Clinic
13 = Non-hospital Based Urgent Care Facility
14 = Fed. Qualified Community Health Clinic
15 = Certified Rural Health Clinic
16 = Free Standing Surgery Center
17 = Spa/ Aesthetic/ Weight Loss Clinic
18 = Gov't/ Planning Agency
19 = Birthing Center
20 = Pharmaceutical Company
21 = Hospice Care
22 = Home Health Agency
23 = Nursing Home/ LTC facility
24 = Occupational Health
25 = Student/ School Health
26 = Faculty (College or Univ.)
27 = Insurance company
28 = Corrections facility
29 = Nonprofit/Donation Facility
30 = Other (specify)_____

25. Have you voluntarily switched employers/practices within the past five years? ☐ Yes ☐ No

a. If YES, please use the list of settings above to indicate the work setting you left and the work setting you moved to: Setting Code Left: _____ Setting Code Moved To: _____

b. If YES please check the reason(s) for this change of work setting

☐ Better Work/Education Fit ☐ Desire for Change ☐ Higher Pay ☐ More Challenging
☐ Moved Residence ☐ Personal/Family Reasons ☐ Preferred hours ☐ Professional Advancement
☐ Work Responsibilities ☐ Other _____

26. Please enter the code from the list below which most closely resembles your:

Primary specialty: _____ **Secondary specialty:** _____

1 = No Patient Care
2 = Acute Care
3 = Aesthetics/ Medical Spa
4 = Allergy & Immunology
5 = Ambulatory Care
6 = Anesthesiology/General
7 = Behavioral/ Mental Health
8 = Cardiac Care
9 = Case Management
10 = Clinical Research
11 = Community/ Public Health
12 = Critical Care/ ICU
13 = Dermatology
14 = Developmental Disability
15 = Domestic Violence
16 = Emergency or Trauma Care
17 = Endocrinology & Metabolism
18 = Environmental Health
19 = Family Practice
20 = Family Planning
21 = Forensics
22 = Genetics
23 = Gastroenterology
24 = Geriatrics
25 = Obstetrics/ Gynecology
26 = HIV/AIDS
27 = Home Health
28 = Hospice / Palliative care
29 = Hospitalist
30 = Infectious Diseases
31 = Informatics
32 = Internal Medicine
33 = Legal Nursing
34 = Medical/Surgical
35 = Nephrology
36 = Neonatal
37 = Occupational Health
38 = Hematology/ Oncology
39 = Medical/Oncology
40 = Radiation Oncology
41 = Ophthalmology
42 = Ostomy/ Wound Care
43 = Pain Management
44 = Pathology
45 = Pediatrics
46 = Preventive/ Occupational Medicine
47 = Psychiatric/ Mental Health
48 = Pulmonary Disease/CCM
49 = Radiology
50 = Rehabilitation
51 = Renal/ Dialysis
52 = Rheumatology
53 = Risk Management
54 = School Health
55 = Sports Medicine
56 = Surgery/General
57 = Cardio-Thoracic Surgery
58 = Neurological Surgery
59 = Orthopedic Surgery
60 = Otolaryngology
61 = Plastic Surgery
62 = Other Surgical subspecialty (Specify):_____
63 = Urology
64 = Other Specialty (Specify):_____

27. **Tell us about your Consultation and Referral Plan** *(this is a DOPL required agreement with a physician in order to prescribe schedule II-III controlled substances)* check all that apply:
    - **a.** ☐ I do not prescribe schedule II-III controlled substances, so I do not have a plan in place – ***(****If so, please provide the One MAIN reason you do not prescribe these substances)* _____
    - **b.** ☐ Patients being prescribed schedule II-III controlled substances are regularly discussed with a collaborating physician (e.g., through routine monitoring of a percentage of medical records on a regular basis).
    - **c.** ☐ A fee must be paid to the collaborating physician.
    - **d.** ☐ The collaborating physician works in the same office/location that I practice.
    - **e.** ☐ I have had difficulty finding a collaborating physician to sign my Consultation and Referral Plan
    - **f.** ☐ Other features (please specify) _____

28. **Do you precept/ mentor Advanced Practice (NP, NM, NA, NS) students? ☐ Yes ☐ No**
    - **a. If you answered Yes, How many advanced practice students have you precepted in the last five years?** _____
    - **b. If you answered No, would you like to precept in the future? ☐ Yes ☐ No**
        - **i. If No, please briefly explain why not?** _____
    - **c. If you are not currently precepting, have you precepted in the last five years? ☐ Yes ☐ No**

29. **In how many years do you plan to retire?**

☐ <1 yrs. ☐ 1-5 yrs. ☐ 6-10 yrs. ☐ 11-15 yrs. ☐ 16-20 yrs. ☐ >20 yrs.

30. **Prior to retirement, do you plan to reduce the number of hours per week you practice?** ☐ Yes ☐ No
    - **a.** If **Yes**, please indicate: **How many years FROM NOW** you plan to reduce your hours: _____

      How many hours/week you plan to work **AFTER THE REDUCTION**: _____

31. **In providing direct patient care, what percent of your time is spent working in a team** (collaborating or consulting with other professionals in an interprofesional context) **with each of the following health professionals?**

Other APRN	Care Coordinator	Mental Health Professional	PA	Pharmacist	Primary Care Physician	Sub-Specialist Physician	RN
_____%	_____%	_____%	_____%	_____%	_____%	_____%	_____%

32. **Would you say that the team works to establish shared goals that reflect patient and family priorities and can be clearly articulated, understood and supported by all team members?**

☐ Strongly Disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly Agree

33. **Would you say that there are clear expectations for each team member's functions, responsibilities and accountabilities, which often make it possible for the team to take advantage of division of labor, thereby accomplishing more than the sum of its parts?**

☐ Strongly Disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly Agree

34. **Would you say that team members earn each other's trust, creating strong norms of reciprocity and greater opportunities for shared achievement?**

☐ Strongly Disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly Agree

35. **Would you say that the team prioritizes and continuously refines its communication skills and has consistent channels for candid and complete communication, which are accessed and used by all team members across the setting?**

☐ Strongly Disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly Agree

36. **Would you say that the team agrees on and implements reliable and timely feedback on successes and failures in both the functioning of the team and achievement of the team's goals, and that these are used to track and improve performance immediately and over time?**

☐ Strongly Disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly Agree

Thank you for your participation. Please return the survey in the enclosed envelope.

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