Utah Medical Education Council
230 South 500 East, Suite 210
Salt Lake City, Utah 84102

«FULL_NAME»
«ADDR_LINE_1» «ADDR_LINE_2»
«CITY», «STATE», «ZIP»

Utah Medical Education Council
2015 Physician Workforce Survey

Dear «Prefix» «LAST_NAME»

The Utah Medical Education Council, in conjunction with the Utah Division of Occupational and Professional Licensing and the Utah Medical Association requests your continued support and partnership in updating the status of Utah's physician workforce by completing the attached survey. Your participation in previous surveys has generated critical data for physician workforce development and planning to meet the healthcare needs of Utah. For a free copy of the report, please visit our website www.utahmec.org.

We are committed to maintaining your privacy. Only de-identified, aggregate data will be published. For any further questions regarding this survey, please contact us at (801) 526-4550. Please return the completed survey in the envelope provided.

For any questions regarding this survey please contact the UMEC at 801-526-4564. **Please return the completed survey to the UMEC within 30 days** in the enclosed postage paid envelope.

Sincerely,

Richard Campbell
Executive Director
Utah Medical Education Council

Grant Cannon, M.D
Associate Chief of Staff
George E. Wahlen VAMC

B. Dee Allred, M.D.
President
Utah Medical Association

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Family Health and Preparedness Director,
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Michelle McOmber
Chief Executive Officer
Utah Medical Association

Utah's Physician Workforce Survey 2015

SECTION 1: GENERAL INFORMATION, BACKGROUND AND EDUCATION

1. **Are you practicing medicine in Utah?** □ Yes □ No
   a. ***If* NO**, *please specify* ***why you maintain a Utah license***.
   _____
   b. **If NO, 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)*_____

IF YOU DO NOT PRACTICE MEDICINE IN THE STATE OF UTAH, PLEASE STOP HERE AND RETURN THE SURVEY IN THE INCLUDED PRE-PAID ENVELOPE, THANK YOU FOR YOUR TIME.

2. **Are you of Hispanic ethnicity?** □ Yes □ No
3. **What is your race?** (*please mark only one*)
   □ American Indian/Alaska Native □ African American □ Asian
   □ Native Hawaiian/Pacific Islander □ White/Caucasian □ Other *(specify)*_____
4. **Please describe the area where you spent the majority of your upbringing** *(when you lived there):*
   □ Rural □ Suburban □Urban/Metropolitan Area State:_____
5. **The county, state and country where you attended high school:**
   County ***(if in Utah)***:_____ State: _____ Country: _____
6. **The institution from which you received your □ MD or □ DO degree** ***(please check the degree that applies)***:
   Institution: _____ Year: _____
   City: _____ State: _____ Country: _____
7. **Please check the program***(s)* **you have completed** *(or are currently in),* **list the specialties in which you have trained** *(or are training),* **name of the institution, state, and the year** *(or expected year)* **of completion**: *(please fill in details for all programs you have attended/are attending)*
   a. □ Internship □ Residency □ Fellowship **Specialty**:_____
   Institution: _____ State: ____ Year of Completion: _____
   b. □ Internship □ Residency □ Fellowship **Specialty**:_____
   Institution: _____ State: ____ Year of Completion: _____
   c. □ Internship □ Residency □ Fellowship **Specialty**:_____
   Institution: _____ State: ____ Year of Completion: _____
8. **Please enter a code from the list below indicating the amount of educational debt you CURRENTLY have from your medical training. Also, please enter a code indicating the TOTAL educational debt you had for your medical training at the time of your graduation from medical school.** *(exclude any premedical and non-education debt including residency relocation loans, cars and credit cards)* **Current:_____ Total:_____**

01= $0.00	04= $75,000 to $99,999	07= $150,000 to $174,999	10= $250,000 to $274,99
02= > $0.00 to $49,999	05= $100,000 to $124,999	08= $175,000 to $199,999	11= $275,000 to $299,999
03= $50,000 to $74,999	06= $125,000 to $149,999	09= $200,000 to $249,999	12= $300,000 or more

9. **Please enter a code indicating your average annual gross compensation? (before taxes AND excluding benefits)**
   Compensation: _____

01= $49,999 or less	04= $100,000 to $124,999	07= $175,000 to $199,999	10= $250,000 to $274,999
02= $50,000 to $74,999	05= $125,000 to $149,999	08= $200,000 to $224,999	11= $275,000 to $299,999
03= $75,000 to $99,999	06= $150,000 to $174,999	09= $225,000 to $249,999	12= $300,000 or more

SECTION 2: YOUR WORK SETTING/ SPECIALTY

10. What is your primary work status? (please check **ONE** of the following)

□ Actively working in a position that requires a medical license | □ Actively working in a field other than medicine | □ Not currently working | □ Retired

11. Please enter a code from the list below to describe your Primary _____ and Secondary _____ practice settings:

01= Office/Clinic- Solo Practice	08= Federal Hospital (VA)	15= Local Health Department
02= Office/Clinic- Single Specialty Group	09= Research Laboratory	16= Academic Faculty
03= Office/Clinic- Multi Specialty Group	10= Medical School	17= Volunteer in a Free Clinic
04= Hospital- Inpatient	11= Nursing Home/ Ext. Care Fac.	18= Correctional Facility
05= Hospital- Outpatient	12= Home Health Setting	19= University/College Student Health Fac.
06= Hospital- Emergency Department	13= Hospice Care	20= Other (specify):_____
07= Hospital- Ambulatory Care Center	14= Federally Qualified Community Health Center	

12. Excluding residency/ fellowship, 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 _____

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

Primary specialty: _____ Secondary specialty: _____

01= Allergy and Immunology	18= Internal Medicine (General)	35= Psychiatry
02= Anesthesiology (General)	19= Internal Medicine and Pediatrics	36= Psychiatry-Child and Adolescent
03= Anesth.-Pain Management	20= Other IM Subspecialties	37= Other Psychiatry Subspecialties
04= Other Anesth. Subspecialties	21= Nephrology	38= Pulmonary Disease/CCM
05= Cardio-Thoracic Surgery	22= Neurology	39= Radiology (Diagnostic)
06= Cardiology	23= Nuclear Medicine	40= Radiology (Therapeutic)
07= Critical Care Medicine	24= OB/GYN (General)	41= Rheumatology
08= Dermatology	25= OB/GYN Subspecialties	42= Sleep Medicine
09= Emergency Care	26= Ophthalmology	43= Sports Medicine
10= Endocrinology and Metabolism	27= Otolaryngology	44= Surgery (General)
11= Family Practice	28= Pathology (General)	45= Surgery-Cardio-Thoracic
12= Gastroenterology	29= Pathology Subspecialties	46= Surgery-Orthopedic
13= Geriatrics	30= Pediatrics (General)	47= Surgery-Plastic
14= Hematology/Oncology	31= Pediatrics Subspecialties	48= Other Surgical Subspecialties
15= Hospice and Palliative Medicine	32= Physical Med. and Rehab.	49= Urology
16= Hospitalist	33= Plastic Surgery	50= Other Specialty
17= Infectious Diseases	34= Prev. Med./Public or Occ. Health	

a. If you indicated a Subspecialty or Other above, please indicate the specific specialty._____

14. Are you currently board certified in the specialties you indicated in question 13:

a. Primary specialty □ **Yes** □ **No** **b.** Secondary specialty □ **Yes** □ **No**

15. At what age do you plan to retire? _____

16. Prior to retirement, do you plan to reduce the number of hours you practice per week? □ Yes □ No
If yes, please specify:
- **a.** How many years from now do you plan to reduce your hours? _____ Yrs
- **b.** How many hours per week will you practice after reducing your hours? _____ Hrs/Wk

SECTION 3: YOUR PRACTICE

17. Please indicate Zip Code, of your primary practice setting and secondary practice setting *(if applicable)* **Also, please estimate the total hours worked per week** *(not including on-call)* **at each practice location AND the number of hours you spend in DIRECT PATIENT CARE each week, including charting, but excluding the hours spent providing patient care combined with teaching or training of other medical professionals:** *(unless all of the hours you work each week are spent in direct patient care without any teaching or training of other medical professionals, the total hours worked should be less than the number of direct patient care hours reported.*)

Primary Practice Zip: _____ Total Hours/ wk: _____ Direct Patient Care Hours/ wk:_____
Secondary Practice Zip: _____ Total Hours/ wk: _____ Direct Patient Care Hours/ wk: _____

- **a. If you DO provide direct patient care, please indicate what PERCENT of the hours you spend with patients is dedicated to the following types of care:**

	Preventative Care	Acute Care	Chronic Care	Total
Primary Practice:	_____	_____	_____	(100%)
Secondary Practice:	_____	_____	_____	(100%)

- **a. If you DO NOT provide direct patient care, how many years has it been since you did? _____ years.**

18. Please indicate the average hours per week you spend in the following NON-PATIENT CARE activities:
(The total number of hours distributed between non-patient care activities should not exceed the number of hours left over after the hours reported being spent in direct patient care per week are subtracted from the total number of hours worked per week reported above).

NON-PATIENT ACTIVITY	Hrs./Wk. PRIMARY SITE	Hrs./Wk. SECONDARY SITE
a. Classroom Training of other Professionals (Clinical and/or classroom teaching of students without patient care)	_____	_____
b. Combined Patient Care with Teaching/Training other Physicians (Supervising/training of residents/ students while delivering patient care)	_____	_____
c. Administration/ Management (budgeting, personnel management, NOT in support of patient care)	_____	_____
d. Practice Management (budgeting, planning, activities to maintain operation of a practice)	_____	_____
e. Consulting/ Research (Reports, applications, surveys, etc., NOT in support of patient care)	_____	_____
f. **Other:** _____ (NOT in support of patient care)	_____	_____

19. In a typical day, how many Out-patients do you see per hour? Office:_____ Urgent Care: _____ ER: _____

20. In a typical day, how many In-patients do you see per hour? Hospital: _____ Extended Care Facilities: _____

21. Please estimate the <u>percentage (%)</u> of patients you see from each of the following age groups
(Total of all practice locations. Sum for each patient category should equal 100%)

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

22. What percentage of your patients are insured by: *(please make sure the percentages add up to a 100%)*

Medicaid _____ % Self-Pay/Uninsured _____ % Charity Care _____ %
Medicare _____ % Private Ins./Managed Care _____ % VA/Tri-Care (CHAMPUS) _____ %

23. Do you limit the number of new patients in the following categories: *(please check all that apply)*

☐ Medicaid ☐Medicare ☐ Self Pay/Uninsured ☐ Other New Insured ☐ Not Limiting

24. On average, how many days must patients wait for an appointment?

Primary Practice: New Patients: _____days Established Patients: _____days
Secondary Practice: New Patients: _____days Established Patients: _____days

25. Please indicate a code for the status of your primary_____ and secondary_____ practice location(s).

01= <u>Full</u> (cannot accept additional patients) 03= <u>Unfilled</u> (can accept many new patients, far from full)
02= <u>Nearly Full</u> (can accept a limited number of new patients) 04= <u>N/A</u> (practice site is VA, military, or corrections)

26. Please check the technology(s) that you currently use in your practice *(please check all that apply)*:

☐ Electronic (patient) Medical Record (EMR) system ☐ Electronic Patient Panel
☐ *e*-Prescribing system ☐ Health Information Exchange ☐ Telemedicine ☐ None of the above

SECTION 4: Healthcare Team Interaction

27. In providing direct patient care, what percent of your time is spent working in a team with each the following medical professionals?

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

28. 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

29. 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

30. 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

31. 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

32. 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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