

Utah Medical Education Council

Nurse Practitioner/ Certified Nurse Midwife/ Clinical Nurse Specialist Survey 2015

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

Nurse Practitioner (NP)	Certified Nurse Midwife	Clinical Nurse Specialist (CNS)
<input type="checkbox"/> Adult/ Gero Acute Care NP	<input type="checkbox"/> Family NP	<input type="checkbox"/> Acute Care CNS
<input type="checkbox"/> Adult/ Gero Primary Care NP	<input type="checkbox"/> Neonatal NP	<input type="checkbox"/> Geriatric CNS
<input type="checkbox"/> Pediatric Acute Care NP	<input type="checkbox"/> Psych/Mental Health NP	<input type="checkbox"/> Adult Health CNS
<input type="checkbox"/> Pediatric Primary Care NP	<input type="checkbox"/> Women's Health NP	<input type="checkbox"/> Pediatric CNS
<input type="checkbox"/> Other NP (specify) _____		<input type="checkbox"/> Adult/Gero CNS
		<input type="checkbox"/> Psych/ Mental Health CNS
		<input type="checkbox"/> Other CNS (specify) _____

2. Please indicate whether you are you currently practicing as a Nurse Practitioner, a Certified Nurse Midwife or a Clinical Nurse Specialist?

- Nurse Practitioner Nurse Midwife 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 **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 PROVIDE SERVICES OR LIVE IN UTAH, PLEASE STOP HERE AND RETURN THE SURVEY, THANK YOU

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)

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Full Time APRN | <input type="checkbox"/> Full Time Non- Nursing | <input type="checkbox"/> Faculty- APRN | <input type="checkbox"/> Single Employment Position |
| <input type="checkbox"/> Part Time APRN | <input type="checkbox"/> Part Time Non- Nursing | <input type="checkbox"/> Retired | <input type="checkbox"/> Multiple Employment Positions |
| <input type="checkbox"/> Contractor- APRN | <input type="checkbox"/> Temp./ Per Diem- APRN | <input type="checkbox"/> Volunteer as an APRN | <input type="checkbox"/> Working as an RN |
| <input type="checkbox"/> Unemployed-Seeking Work as an APRN | | <input type="checkbox"/> 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):

- | | | |
|---|--|---|
| <input type="checkbox"/> Taking Care of Home | <input type="checkbox"/> Taking Care of Family | <input type="checkbox"/> Disabled |
| <input type="checkbox"/> Inadequate Salary | <input type="checkbox"/> Attending School | <input type="checkbox"/> Difficulty Finding APRN Position |
| <input type="checkbox"/> Other (please specify) _____ | | |

13. Please enter a code from the list of monetary ranges below indicating your **average annual gross compensation?** (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 **at the time of your graduation.** (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.

Primary Practice Zip: _____ Total hrs/wk: _____ **Secondary Practice** Zip: _____ Total hrs/wk: _____

16. Please indicate the approximate number of hours you spend providing **DIRECT PATIENT CARE** 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 **percentage (%)** 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):

	<u>Primary</u>	<u>Secondary</u>		<u>Primary</u>	<u>Secondary</u>
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</u>	<u>Appt. for Est. Patient</u>	<u>Average Office Wait Time</u>
	(Days)	(Days)	(minutes)
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:

	<u>Medicaid</u>	<u>Medicare</u>	<u>Self-Pay/Uninsured</u>	<u>Other Insured Patients</u>
Primary Practice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Secondary Practice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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?

	<u>Free Services</u>	<u>Sliding Scale</u>	<u>Fixed Lower Fee</u>	<u>Not Offered</u>
Primary Practice:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Secondary Practice:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

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

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

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

26. 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 _____

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. If you are practicing as a CNM, on average, how many babies do you deliver in a year? _____

29. Do you precept/ mentor Advanced Practice (NP, NM, NA, NS) students? Yes No
- a. If 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

30. 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.

31. 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**: _____

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

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

33. 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

34. 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

35. 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

36. 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

37. 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.