New York State Education Department

Midwife Survey

This questionnaire is a supplemental part of your registration application. Please complete and return it with the registration form and fee in the envelope provided. If you complete the survey online, you do not have to complete this form.

Your responses will be maintained in a strictly confidential manner by the Center for Health Workforce Studies (http://chws.albany.edu) at the School of Public Health, University at Albany, SUNY. The responses will be analyzed and presented only in aggregate form to document trends in the midwifery workforce in New York.

Item 2 asks for your NYS midwifery license number. This can be found on the enclosed registration application. Thank you for taking the time to complete this survey.

INSTRUCTIONS

- Make dark marks that completely fill the circle.
- Erase cleanly any marks you wish to change.
- Make no stray marks on this form.

CORRECT: ● INCORRECT: ✓ ✗

BASIC INFORMATION

1. DATE COMPLETING SURVEY

Month			Year
○ Jan	○ May	○ Sep	○ 2011
○ Feb	○ Jun	○ Oct	○ 2012
○ Mar	○ Jul	○ Nov	○ 2013
○ Apr	○ Aug	○ Dec	○ 2014

2. NYS Midwifery License No. (6 digit columns, 0–9)

3. NYS RN License No. (If Applicable) (6 digit columns, 0–9)

4. Year of Birth 1 9 _ _ (2 digit columns, 0–9)

5. Gender ○ Female ○ Male

18. WHICH BEST DESCRIBES YOUR PRINCIPAL AND, AS APPLICABLE, SECONDARY WORK SETTING(S). *(Mark only one in each column.)*

Principal	Secondary	
○	○	Health center, clinic, or hospital outpatient
○	○	Hospital emergency room/department
○	○	Hospital inpatient unit
○	○	Midwife-owned private practice
○	○	Physician practice
○	○	State/County public health department
○	○	Other *(specify)*: ____________________

19. IF YOU WORK IN A PHYSICIAN PRACTICE, WHAT BEST DESCRIBES THE SPECIALTY OF THAT PRACTICE? *(Mark one in each column if applicable.)*

Principal	Secondary	
○	○	Family Medicine
○	○	General Practice
○	○	Obstetrics and Gynecology
○	○	Perinatology
○	○	Other *(specify)*: ____________________

20. DO YOU ATTEND DELIVERIES?

○ Yes
○ No

If you answered no to question 20, skip to question 22.

21. IF YOU ATTEND DELIVERIES, WHAT PERCENT OF YOUR INTRAPARTUM CARE DO YOU PROVIDE IN:

	0%	1%-25%	26%-50%	51%-75%	76%-100%
Hospital labor & delivery rooms	○	○	○	○	○
Hospital birthing centers	○	○	○	○	○
Free-standing birthing centers	○	○	○	○	○
Homes	○	○	○	○	○

22. DOES YOUR PRINCIPAL PRACTICE SITE USE AN ELECTRONIC HEALTH RECORD (EHR)? An EHR is a computerized version of a patient's medical information.

○ Yes, all electronic
○ Yes, part paper, part electronic
○ No
○ Don't know

23A. DOES YOUR PRINCIPAL PRACTICE SITE USE A COMPUTERIZED SYSTEM ...

	Yes	No
for computerized provider order entry (CPOE)?	○	○
to generate/transmit prescriptions? (excluding fax)	○	○
to record patient demographics?	○	○
to record patient smoking status?	○	○
to maintain patient problem lists on current and active diagnoses?	○	○
for drug-drug and drug-allergy interaction checks?	○	○
to maintain active medication lists?	○	○
to maintain medication allergy lists?	○	○
to record and chart changes in patient vital signs?	○	○
for at least one clinical decision support rule?	○	○
to report clinical quality measures to CMS/state?	○	○
to provide patient with electronic copy of their health information?	○	○
to provide patient with a clinical summary for each office visit?	○	○

23B. DOES YOUR PRINCIPAL PRACTICE SITE ...

	Yes	No
have the capacity to exchange key clinical information?	○	○
send clinical information through a Regional Health Information Organization (RHIO)?	○	○
receive clinical information through a RHIO?	○	○
protect confidential electronic health information?	○	○

24. IN YOUR EXPERIENCE, WHICH OF THE FOLLOWING IS (ARE) THE MOST SUBSTANTIAL BARRIER(S) TO CURRENT MIDWIFERY PRACTICE? *(Mark all that apply.)*

○ High cost of liability insurance
○ Inability to obtain liability insurance
○ Inability to establish a relationship with physician/institution
○ Low insurance reimbursement for midwifery services
○ Inability to obtain hospital admitting privileges
○ Other *(specify)*: ______________________________
○ None

25. IN THE NEXT 12 MONTHS, DO YOU PLAN TO: *(Mark all that apply.)*

○ Retire from patient care?
○ Significantly reduce patient care hours?
○ Move to another location in NY and continue practicing?
○ Move to another state and continue practicing?
○ None of the above.

SERIAL

PROOF

6. RACE *(Mark all that apply.)*

- ◯ African American/Black
- ◯ American Indian /Alaska Native
- ◯ Asian/Pacific Islander
- ◯ White
- ◯ Other

7. ETHNICITY: ARE YOU HISPANIC/LATINO?

- ◯ Yes
- ◯ No

8. LANGUAGES IN WHICH YOU ARE FLUENT *(Mark all that apply.)*

- ◯ English
- ◯ Cantonese
- ◯ Italian
- ◯ Mandarin
- ◯ Russian
- ◯ Spanish
- ◯ Any African Language(s)
- ◯ Other European Language(s)
- ◯ Other Asian/Middle Eastern Language(s)
- ◯ Other *(specify)*: ______________________________

9. LOCATION OF EDUCATION

	Location of high school from which you graduated	Location of bachelor's program from which you graduated (if applicable)	Location of midwifery education program from which you graduated
New York	◯	◯	◯
Other state in the U.S.	◯	◯	◯
Outside the U.S.	◯	◯	◯

10. EDUCATION *(Mark one in each column, if applicable.)*

	Highest nursing degree (if applicable)	Highest non-nursing degree
Diploma/Associate	◯	◯
Bachelor's degree	◯	◯
Master's degree	◯	◯
Doctorate	◯	◯

11. MIDWIFERY EDUCATION *(Mark all that apply.)*

- ◯ Bachelor's degree
- ◯ Master's degree
- ◯ Doctorate
- ◯ Midwifery certificate

12. WHAT YEAR DID YOU GRADUATE FROM YOUR MIDWIFERY EDUCATION PROGRAM?

Yr. of Grad

	0	0	0
1		1	1
2		2	2
		3	3
		4	4
		5	5
		6	6
		7	7
		8	8
	9	9	9

13. FROM WHICH NATIONAL ORGANIZATION DO YOU HOLD A MIDWIFERY CERTIFICATON? *(Mark all that apply.)*

- ◯ American Midwifery Certification Board
- ◯ North American Registry of Midwives
- ◯ Other *(specify)*: ____________________

CURRENT WORK

14. FOR HOW MANY YEARS HAVE YOU WORKED IN POSITIONS AS A MIDWIFE?

If less than one year, indicate one year.

Yrs.

0	0
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9

15. CURRENT EMPLOYMENT STATUS. *(Mark all that apply.)*

- ◯ Working in at least one position that requires a midwife license
- ◯ Working in a position that only requires an RN license
- ◯ Working, but not as a midwife or RN
- ◯ Volunteering in a position requiring a midwife license
- ◯ Not currently working
- ◯ Retired

PROOF

16. FOR ALL MIDWIFERY POSITIONS HELD, INDICATE THE AVERAGE NUMBER OF HOURS SPENT PER WEEK ON EACH MAJOR ACTIVITY. *(Exclude overtime.)*

Hours/Week

	None	1-9	10-19	20-29	30-39	40-49	50+
Patient care	◯	◯	◯	◯	◯	◯	◯
Research	◯	◯	◯	◯	◯	◯	◯
Teaching	◯	◯	◯	◯	◯	◯	◯
Administration	◯	◯	◯	◯	◯	◯	◯
Other	◯	◯	◯	◯	◯	◯	◯

If you spend any of your work time providing patient care in midwifery, continue with the survey, otherwise STOP here and return the survey.

17. MIDWIFERY PATIENT CARE: PRACTICE LOCATIONS

Location of site(s) where you spend the most time providing patient care as a midwife. Print the address(es) of your practice location(s) including the zip code. Also, indicate the average number of patient care hours per week you spend at each practice location.

Principal Location

Number ________ Street ______________________________

City/Town ______________________________ State ________

Zip Code					Avg.Patient Care Hours Per Week	
0	0	0	0	0	0	0
1	1	1	1	1	1	1
2	2	2	2	2	2	2
3	3	3	3	3	3	3
4	4	4	4	4	4	4
5	5	5	5	5	5	5
6	6	6	6	6	6	6
7	7	7	7	7	7	7
8	8	8	8	8	8	8
9	9	9	9	9	9	9

Secondary Location

Number ________ Street ______________________________

City/Town ______________________________ State ________

Zip Code					Avg.Patient Care Hours Per Week	
0	0	0	0	0	0	0
1	1	1	1	1	1	1
2	2	2	2	2	2	2
3	3	3	3	3	3	3
4	4	4	4	4	4	4
5	5	5	5	5	5	5
6	6	6	6	6	6	6
7	7	7	7	7	7	7
8	8	8	8	8	8	8
9	9	9	9	9	9	9