2024 Utah occupational therapy workforce survey

Proposed profession-specific survey tool for occupational therapist and occupational therapy assistant license renewals

Utah Health Workforce Advisory Council

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Utah Department of
Health & Human
Services

Contents

Document background and overview

The Utah Cross-Profession Minimum Data Set (UCPMDS) is a set of core questions which cover the highest-priority data elements that are considered the minimum necessary for the Utah Health Workforce Advisory Council (HWAC) health workforce planning. The UCPMDS was adapted from a cross-profession minimum data set tool developed as a collaboration between 7 national healthcare regulatory organizations. The UCPMDS was reviewed and approved by the Utah Health Workforce Advisory Council on March 15, 2023.

The UCPMDS serves as a foundational data system upon which this occupational therapy profession-specific tool is being developed. For UCPMDS questions that required profession-specific response adjustments, we customized and incorporated options relevant to those in occupational therapy professions.

Occupational therapist minimum data set (MDS) survey recommendations

UCPMDS questions with profession-specific response customizations

Sex

1. What is your sex?
   [Single select]
   a. Male
   b. Female
   c. Prefer not to say

Race/ethnicity

2. What is your race? Mark one or more boxes.
   [Multi-select]
   a. American Indian or Alaska Native
   b. Asian
   c. Black or African American
   d. Native Hawaiian/Pacific Islander
   e. White
   f. Other race

3. Are you of Hispanic, Latina/o, or Spanish origin?
   [Single select]
   a. No
   b. Yes

Qualifying education

4. What type of degree/credential first qualified you for this license?
   [Single select]

a. Associate degree
b. Bachelor's degree
c. Master's degree
d. Post-graduate training
e. Professional/doctorate degree
f. Postdoctoral training

Year completed qualifying education

5. What year did you complete the education program/degree that first qualified you for this license?
[Drop-down list]

Where completed education

6. Where did you complete the education program/degree that first qualified you for this license? (Note: for online programs, please select the location where this program was housed.)
[Single select]
   a. [LIST OF U.S. STATES and territories]
   b. Another country (not U.S.)

Highest level of education

7. Please indicate what degree was conferred with your highest-level occupational therapy degree:
[Single select]
   a. Associate degree
   b. Bachelor's degree
   c. Master's degree
   d. Post-graduate training
   e. Doctorate degree–OTD
   f. Professional/doctorate degree–other

g. Postdoctoral training
h. Other

Year completed highest education

8. What year did you complete the highest education program/degree for this license?
[Drop-down List]

Where completed highest education

9. Where did you complete your highest education program/degree for this license? (Note: for online programs, please select the location where this program was housed.)
[Single select]
   a. [LIST OF U.S. STATES and territories]
   b. Another country (not U.S.)

10. Please indicate any additional specialty certifications you have received from the American Occupational Therapy Association (AOTA):
[Multi-select]
   a. Not applicable
   b. Driving and community mobility (SCDCM or SCDCM-A)
   c. Environmental modification (SCEM or SCEM-A)
   d. Feeding, eating, and swallowing (SCFES or SCFES-A)
   e. Gerontology (BCG)
   f. Low vision (SCLV or SCLV-A)
   g. Mental health (BCMH)
   h. Pediatrics (BCP)
   i. Physical rehabilitation (BCPR)
   j. School systems (SCSS or SCSS-A)

Employment status

11. What is your employment status?
[Single select]
    a. Actively working in a position that requires this license
    b. Actively working in a position in the field of occupational therapy that does not require this license
    c. Actively working in a position in a field other than occupational therapy
    d. Unemployed and seeking work that requires this license
    e. Unemployed and not seeking work that requires this license
    f. Not currently working, disabled
    g. Volunteer work only
    h. Student
    i. Leave of absence or sabbatical
    j. Retired
    k. Other

Future employment plans

12. What best describes your employment plans for the next 2 years?
[Single select]
    a. Increase hours in a field related to this license
    b. Decrease hours in a field related to this license
    c. Keep my hours the same, but increase the number of facilities where I provide services
    d. Keep my hours the same, but decrease the number of facilities where I provide services
    e. Seek employment in a field unrelated to this license
    f. Leave my current job to complete further education/training in the occupational therapy field
    g. Leave my current job to complete further education/training in a field other than occupational therapy
    h. Leave my current job for family reasons/commitments
    i. Leave my current job due to physical demands
    j. Leave my current job due to stress/burnout
    k. Retire

l. Continue as you are
m. Unknown
n. Other

13. If you indicated you plan to **increase** or **decrease** hours in a field related to this license, please estimate the change in the total number of hours per week you expect compared to your current hours per week. If this does not apply, please select not applicable.
[Single select]
a. 0 hours per week
b. 1–4 hours per week
c. 5–8 hours per week
d. 9–12 hours per week
e. 13–16 hours per week
f. 17–20 hours per week
g. 21–24 hours per week
h. 25–28 hours per week
i. 29–32 hours per week
j. 33–36 hours per week
k. 37–40 hours per week
l. 41 or more hours per week
m. Not applicable

Specialty

14. Which of the following best describes the specialty/field/area of practice in which you spend most of your professional time?
[Single select]
a. No specific area/not applicable
b. Acute care
c. Administration and/or management
d. Developmental disability
e. Early intervention/NICU
f. Emerging practice setting

g. Geriatrics
h. Hand and upper extremity
i. Health and wellness
j. Home health
k. Hospice or palliative care
l. Mental health
m. Neurological
n. Orthopedics
o. OT professional education and/or research
p. Pediatrics
q. Physical rehabilitation
r. School systems
s. Work and industry
t. Other

Telehealth

15. Telehealth may be defined as the use of electronic information and telecommunications technologies to extend care to patients, and may include videoconferencing, audio only, stored-forward imaging, streaming media, and terrestrial and wireless communications.

Of the hours per week spent **in direct patient care**, estimate the average number of hours per week delivering patient care **via telehealth**.
[Single select]

a. 0 hours per week/not applicable
b. 1–4 hours per week
c. 5–8 hours per week
d. 9–12 hours per week
e. 13–16 hours per week
f. 17–20 hours per week
g. 21–24 hours per week
h. 25–28 hours per week
i. 29–32 hours per week

j. 33–36 hours per week
k. 37–40 hours per week
l. 41 or more hours per week

Patient characteristics

16. Please indicate the population groups to which you provide clinical services. Please check all that apply.
[Multi-select]
    a. Newborns
    b. Children (ages 2–10)
    c. Adolescents (ages 11–19)
    d. Adults
    e. Geriatrics (ages 65+)
    f. Pregnant women
    g. Veterans
    h. Incarcerated individuals
    i. Individuals with disabilities
    j. Individuals experiencing homelessness
    k. Individuals who speak a language other than English
    l. Medicaid beneficiaries
    m. Medicare beneficiaries
    n. Full self-pay individuals
    o. Sliding fee scale
    p. Uninsured individuals
    q. Privately insured individuals
    r. TriCare beneficiaries
    s. Workers Compensation
    t. Working poor/unemployed
    u. None of the above

Practice location—primary practice

Note: When the survey is distributed using survey software and not MyLicense, practice location will be asked as a single question, "What is your primary practice location? If this does not apply, please select N/A," Question will

include fields for street address, city, state, postal code, and country/region.

17. In what state is your primary practice location? If this does not apply, please select "N/A".
    [LIST OF U.S. STATES AND TERRITORIES AND OPTION FOR N/A]

18. In what city is your primary practice location? If this does not apply, please indicate N/A.
    [Open text field]

19. What is the street address of your primary practice location? If this does not apply, please indicate N/A.
    [Open text field]

20. What is the 5-digit ZIP code of your primary practice location? If this does not apply, please indicate N/A.
    [Open text field]

Employment type/arrangement—primary practice

21. Which of the following best describes your current employment arrangement at your principal practice location?
    [Multi-select]
    a. Self-employed/consultant
    b. Salaried
    c. Hourly
    d. Temporary employment/locum tenens
    e. Other
    f. Not applicable

Position type/role—primary practice

22. Please identify the role/title(s) that most closely corresponds to your primary employment/practice type.

[Multi-select]

a. Administrator
b. Clinical practice
c. Faculty/educator
d. Researcher
e. Other
f. Not applicable

Setting type—primary practice

23. Which of the following best describes the practice setting at your primary practice location? If this does not apply, please select not applicable.
[Single select]

a. Not applicable
b. Academia
c. Community
d. Early intervention
e. Outpatient clinic affiliated with a hospital or health system
f. Outpatient clinic not affiliated with a hospital or health system (private practice)
g. Home health setting
h. Hospital (non-mental health)
i. Mental health hospital or treatment center
j. Nursing home/long-term care/skilled nursing facility
k. Schools
l. Telehealth
m. Other

Hours/week—primary practice

24. Estimate the average number of hours per week spent at your primary practice location. If this does not apply, please select not applicable. Does not include time on call.
[Single select]

a. 0 hours per week/not applicable
b. 1–4 hours per week
c. 5–8 hours per week
d. 9–12 hours per week
e. 13–16 hours per week
f. 17–20 hours per week
g. 21–24 hours per week
h. 25–28 hours per week
i. 29–32 hours per week
j. 33–36 hours per week
k. 37–40 hours per week
l. 41 or more hours per week

Hours/week in direct patient care—primary practice

25. Estimate the average number of hours per week spent IN DIRECT PATIENT CARE at your primary practice location. If this does not apply, please select not applicable. [Single select]
    a. 0 hours per week/not applicable
    b. 1–4 hours per week
    c. 5–8 hours per week
    d. 9–12 hours per week
    e. 13–16 hours per week
    f. 17–20 hours per week
    g. 21–24 hours per week
    h. 25–28 hours per week
    i. 29–32 hours per week
    j. 33–36 hours per week
    k. 37–40 hours per week
    l. 41 or more hours per week

Facilities

26. In how many physical locations/addresses do you provide occupational care

services?
[Single select]

a. 0
b. 1
c. 2
d. 3
e. 4
f. 5
g. 6 or more

Educational debt

27. Please mark the amount of educational debt you had AT THE TIME OF GRADUATION from your occupational therapy program (exclude non-occupational therapy education and non-educational debt).
[Single select]

a. No debt
b. $1−$20,000
c. $20,001−$40,000
d. $40,001−$60,000
e. $60,001−$80,000
f. $80,001−$100,000
g. $100,001−$120,000
h. $120,001−$140,000
i. $140,001−$160,000
j. $160,001−$180,000
k. $180,001−$200,000
l. $200,001−$220,000
m. $220,001−$240,000
n. $240,001−$280,000
o. $280,000 or above
p. Prefer not to answer

Loan repayment programs

28. Did/do you participate in a loan forgiveness/repayment program (LRP)?
[Single select]
    a. Yes
    b. No
    c. Not applicable

29. If yes, which loan forgiveness/repayment programs did you participate in?
[Single select]
    a. Not applicable
    b. Public service loan repayment program (PLSF)
    c. Employer-based loan repayment program
    d. Indian Health Service loan repayment program
    e. AmeriCorps
    f. Volunteers in Service to America (VISTA)
    g. Military loan repayment program
    h. Other

Precepting

30. Have you mentored/precepted students within the last 2 years?
[Single select]
    a. Yes
    b. No
    c. Prefer not to say
    d. Not applicable

31. If you indicated that you mentor/precept students, how many occupational therapy students have you precepted in the last 2 years?
[Single select]
    a. 0/not applicable
    b. 1−2
    c. 3−4

d. 5–6
e. 7–8
f. 9–10
g. 11–12
h. 13–14
i. 15–16
j. 17–18
k. 19–20
l. More than 20

32. Would you like to precept in the future?
[Single select]
a. Yes
b. No
c. Prefer not to say
d. Not applicable

Licensure outside of Utah

33. Are you currently licensed as an occupational therapist in any state(s) OUTSIDE of Utah?
[Single select]
a. Yes
b. No

34. If so, what state(s)?
[Multi-select]
a. [LIST OF U.S. STATES and territories]
b. Another country (not U.S.)