2024 Utah physical therapy survey

Proposed profession-specific survey tool for physical therapist, physical therapist assistant, temporary physical therapist, and temporary physical therapist 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 physical 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 physical therapy professions.

Physical 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—PT
c. Bachelor's degree—other
d. Master's degree—MPT
e. Master's degree—other
f. Post-graduate training
g. Professional/doctorate degree—DPT
h. Professional/doctorate degree—other
i. 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 qualifying 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. What is your highest level of education?
[Single select]
   a. Associate degree
   b. Bachelor's degree–PT
   c. Bachelor's degree–other
   d. Master's degree–MPT
   e. Master's degree–other

f. Post-graduate training
g. Professional/doctorate degree–DPT
h. Professional/doctorate degree–other
i. Postdoctoral training

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.)

Certifications/credentials

10. Please indicate any board certifications for physical therapy that you currently hold:
[Multi-select]
   a. Cardiovascular and pulmonary
   b. Certified hand therapist
   c. Neurology
   d. Sports
   e. Clinical electrophysiology
   f. Orthopedics
   g. Pelvic health
   h. Geriatrics
   i. Pediatrics
   j. Wound management

k. Other

11. Do you hold credentials (license, certification, degree) in any of the following: [Single select]
    a. Athletic training
    b. Massage therapy
    c. Orthotics
    d. Art/dance therapy
    e. Nursing
    f. Prosthetics
    g. Chiropractic
    h. Occupational therapy
    i. Other

Employment status

12. 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 physical therapy that does not require this license
    c. Actively working in a position in a field other than physical 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

13. What best describes your employment plans for the next 2 years?

[Single select]

a. Increase hours in the field of physical therapy
b. Decrease hours in the field of physical therapy
c. Seek employment in a field unrelated to this license
d. Retire
e. Continue as you are
f. Unknown

14. 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

15. 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 patient care
b. No specific area

c. Academia
d. Cardiovascular or pulmonary
e. Chronic infectious and metabolic disorders (AIDs, diabetes, etc.)
f. Electrophysiologic
g. Geriatrics
h. Hospice and palliative care
i. Industrial or workplace related
j. Integumentary or wound care
k. Neurologic
l. Oncology
m. Orthopedic
n. Pediatric
o. Research
p. Sports
q. Wellness, prevention, or health
r. Pelvic health
s. Other

Telehealth

16. 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

17. 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. Pro bono/no charge
    u. Working poor/unemployed
    v. 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.

18. 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]

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

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

21. 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

22. 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

23. 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

24. 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. Academic institution (post-secondary)
    b. Certified rural health clinic
    c. Correctional facility
    d. Federally qualified health center
    e. Federal hospital (VA) and other military settings
    f. Health and wellness facility
    g. Home health setting
    h. Acute care hospital
    i. General hospital—inpatient
    j. Outpatient clinic affiliated with a hospital or health system
    k. Outpatient clinic not affiliated with a hospital or health system (private practice)
    l. Inpatient rehab facility (IRF)
    m. Non-patient care or non-clinical environment related to physical therapy
    n. Nursing home/long-term care/skilled nursing facility
    o. Pediatric clinic (non-school based)
    p. Research center/lab

q. Student/school health (preschool, K-12)
r. Telehealth
s. Other
t. Not applicable

Hours/week—primary practice

25. Estimate the average number of hours per week spent 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

Hours/week in direct patient care—primary practice

26. 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]
    m. 0 hours per week/not applicable
    n. 1–4 hours per week
    o. 5–8 hours per week
    p. 9–12 hours per week
    q. 13–16 hours per week
    r. 17–20 hours per week

s. 21–24 hours per week
t. 25–28 hours per week
u. 29–32 hours per week
v. 33–36 hours per week
w. 37–40 hours per week
x. 41 or more hours per week

***Note: Questions 18-26 will need to be repeated for 2 practice locations, primary practice, and secondary practice (questions 27-35).**

Education financing

36. Please mark the amount of educational debt you had AT TIME OF GRADUATION from your PT program (exclude non-physical therapy 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

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

38. 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

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

40. If you indicated that you mentor/precept students, how many physical 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

41. 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

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

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