2024 Utah medication aide survey

Proposed profession-specific survey tool for medication aide 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 medication aide profession-specific tool is being developed. For UCPMDS questions that required profession-specific response adjustments, we customized and incorporated options relevant to those in medication aide professions.

Medication aide 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

Highest level of education

4. What is your highest level of education?
   [Single select]
   a. High school diploma (or equivalency)

b. Some college, no degree
c. Technical/vocational certificate
d. Associate degree
e. Bachelor's degree
f. Other

Education

5. What education or training are you currently pursuing?
[Multi-select]
   a. Not applicable—I am not enrolled in any school/training
   b. Licensed practical nurse program
   c. Associate-level RN program
   d. Bachelor-level RN program
   e. Another education/training/certification program in healthcare
   f. Another education/training/certification program not in healthcare

6. If you are not currently pursuing education or training but interested in doing so, what program are you interested in?
[Single select]
   a. I am not interested in further school/training.
   b. Licensed practical nurse program
   c. Associate-level RN program
   d. Bachelor-level RN program
   e. Another education/training/certification program in healthcare
   f. Another education/training/certification program not in healthcare

7. If you indicated interest in a training program but are unable to enroll, please provide the potential barriers you may have faced. If you have not experienced any barriers or are not interested in training, please type "N/A".
[Open text field]

Employment status

8. What is your employment status?
   [Single select]
   a. Actively working in a position that requires this license
   b. Actively working in a medical/healthcare position that does not require this license
   c. Actively working in a position in a non-healthcare field
   d. Unemployed and seeking work that requires this license
   e. Unemployed and not seeking work that requires this license
   f. Volunteer as a medication aide
   g. Retired
   h. Other

Future employment plans

9. What best describes your employment plans for the next 2 years?
   [Single select]
   a. Increase hours as a medication aide
   b. Decrease hours as a medication aide
   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. Find a different type of job
   f. Leave my current job to complete further training
   g. Leave my current job for family reasons/commitments
   h. Leave my current job due to physical demands
   i. Leave my current job due to stress/burnout
   j. Retire
   k. Continue as you are
   l. Unknown
   m. Other

10. 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

Telehealth

11. 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

12. Please indicate the population groups to whom 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. Sliding fee scale
    o. Uninsured individuals
    p. Privately insured individuals
    q. 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". The question will include fields for street address, city, state, postal code, and country/region.

13. 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]

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

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

16. 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

17. 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

18. Please identify the role/title(s) that most closely corresponds to your primary employment/practice type.
[Multi-select]
    a. Medication aide

b. Medication assistant
c. Medication technician
d. Administrator
e. Clinical practice
f. Faculty/educator
g. Researcher
h. Other
i. Not applicable

Setting type—primary practice

19. 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. Assisted living
    c. Adult day center
    d. Continuing care retirement community (CCRC)
    e. Correctional facilities
    f. Federally-qualified health center
    g. Group home
    h. Intermediate care facility for individuals with intellectual disabilities (ICF/IID)
    i. Home health
    j. Hospice
    k. Hospital: community
    l. Hospital: federal
    m. Hospital: long-term
    n. Hospital: psychiatric/mental health facility
    o. Hospital: specialty
    p. Nursing home/long term care/skilled nursing facility
    q. Outpatient clinic affiliated with a hospital or health system
    r. Outpatient clinic not affiliated with a hospital or health system (private practice)
    s. Physical rehabilitation facilities

t. Public/community health
u. School health service
v. Telehealth
w. Other

Hours/week—primary practice

20. 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

21. 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

22. In how many physical locations/addresses do you provide medication aide services? [Single select]
    a. 0
    b. 1
    c. 2
    d. 3
    e. 4
    f. 5
    g. 6 or more

23. Which of the following have you received training or in-service hours for: [Multi-select]
    a. Resident rights
    b. Infection control
    c. Fire prevention/emergency
    d. Safety and accident prevention
    e. Needs of a specialized population
    f. Care of the cognitively impaired
    g. Dementia specific training
    h. Changes in condition/environment
    i. Communication
    j. Nutrition and fluid intake
    k. Activities of daily living (ADLs)
    l. Documentation

m. Other

Training

24. Did the medication aide training/education you received adequately prepare you for your job as a medication aide?
[Single select]
    a. No
    b. Yes

Experience

25. How many years have you worked as a medication aide?
[Drop down list]
    a. Prefer not to say
    b. Less than 1 year
    c. [Drop down list of numbers]