Department of Health & Human Services

Health Workforce Information Center (HWIC)

Utah Physician Assistant Survey

Proposed profession-specific survey tool for physician assistant (PA) license renewals

Utah Health Workforce Advisory Council

Adopted: December 4, 2023

Contents

Document background and overview

The Health Workforce Advisory Council (HWAC), with help from its Data Subcommittee and the Health Workforce Information Center (HWIC), developed the Utah Cross-Profession Minimum Data Set (UCPMDS). This list of survey questions is used to gather key information for health workforce planning throughout Utah**.** The UCPMDS was adapted from a Cross-Profession Minimum Data Set tool developed through a collaboration among seven national healthcare regulatory organizations. The UCPMDS was reviewed and approved by HWAC on March 15, 2023. The HWIC maintains and analyzes health workforce data and uses the UCPMDS as a foundational framework for collecting consistent, comparable information across time and health professions to support the HWAC in workforce monitoring and planning.

The UCPMDS serves as the foundational data system upon which this physician assistant health profession-specific tool was developed. For UCPMDS questions requiring profession-specific response options, the questions were customized to include response categories relevant to the physician assistant profession. These proposed response options were informed by historic workforce surveys conducted by the Utah Medical Education Council (UMEC) and developed and approved through voluntary committees of stakeholders with expertise in the respective professions.

PA minimum data set (MDS) survey questions

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. Middle Eastern or North African
   e. Native Hawaiian/Pacific Islander
   f. White
   g. 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. High school diploma or equivalency
   b. Some college but no degree
   c. Technical or vocational certificate
   d. Associate degree
   e. Bachelor's degree

f. Master's degree
g. Post-graduate training
h. Professional/doctorate degree
i. Postdoctoral training

Year completed qualifying education

5. What year did you complete the education program/degree that first qualified you for this PA license?
   [Single select] [Drop-down list ranging from 1925 - 2025]

Qualifying education state

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 the United States)

Qualifying education country

7. In which city & country did you complete the education program or degree that first qualified you for this license?

Highest level of education

8. Please indicate your highest level physician assistant degree
   [Single select]
   a. Bachelor degree
   b. Master degree
   c. Doctorate (PhD)
   d. Doctorate – Other
   e. Other

Highest level of physician assistant education year

9. What year did you complete your highest level of physician assistant education?
   [Single select] [Drop-down list ranging from 1925 - 2025]

Employment status

10. What is your employment status?
[Single select]
    a. Actively working in a position that requires a PA license.
    b. Actively working in a position in the field of medicine that does not require a PA license.
    c. Actively working in a position in a field other than medicine.
    d. Unemployed and seeking work that requires a PA license.
    e. Unemployed and not seeking work that requires a PA license.
    f. Volunteer work only.
    g. Retired.
    h. Other

Employment plans

11. What best describes your employment plans for the next 2 years?
[Single select]
    a. Continue as you are.
    b. Increase hours in a field related to this license.
    c. Decrease hours in a field related to this license.
    d. Seek employment in a field unrelated to this license.
    e. Retire
    f. Unknown.

Employment hour change

12. If you indicated you plan to increase 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. 1–4 hours per week
    b. 5–8 hours per week
    c. 9–12 hours per week
    d. 13–16 hours per week
    e. 17–20 hours per week
    f. 21–24 hours per week

g. 25–28 hours per week
h. 29–32 hours per week
i. 33–36 hours per week
j. 37-40 hours per week
k. 41 or more hours per week
l. Not applicable

13. If you indicated that you plan to 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. 1–4 hours per week
    b. 5–8 hours per week
    c. 9–12 hours per week
    d. 13–16 hours per week
    e. 17–20 hours per week
    f. 21–24 hours per week
    g. 25–28 hours per week
    h. 29–32 hours per week
    i. 33–36 hours per week
    j. 37-40 hours per week
    k. 41 or more hours per week
    l. Not applicable

Specialty

14. Which of the following best describes your primary specialty/field/area of practice, in which you spend most of your professional time?
    a. No Patient Care
    b. Addiction Medicine
    c. Allergy
    d. Anesthesiology
    e. Dermatology
    f. Diagnostic Radiology
    g. Emergency or Trauma Care
    h. Family Medicine

i. Genetics
j. Geriatrics
k. Hospice/Palliative care
l. Hospital Medicine
m. Internal Medicine
n. Interventional Cardiology
o. Interventional Radiology
p. Obstetrics or Gynecology
q. Occupational Medicine
r. Ophthalmology
s. Pain Management
t. Pathology
u. Pediatrics
v. Physical Medicine or Rehab
w. Primary Care
x. Psychiatry
y. Public Health
z. Pulmonary Disease/CCM
aa. Radiation Oncology
bb. Surgical
cc. Other
dd. No Specific Area

Surgical specialty

15. Please indicate your surgical subspecialty
    a. General
    b. Cardiovascular or Cardiothoracic
    c. Colon and Rectal
    d. Hand
    e. Neurological
    f. Oncology
    g. Orthopedics
    h. Otolaryngology
    i. Pediatric
    j. Plastic

k. Thoracic
l. Transplant
m. Trauma
n. Urology
o. Vascular
p. Bariatric
q. Other

Pediatrics subspecialty

16. Please indicate your pediatrics subspecialty
    a. General
    b. Adolescent Medicine
    c. Allergy
    d. Cardiology
    e. Critical Care
    f. Endocrinology
    g. Gastroenterology
    h. Hematology
    i. Infectious Disease
    j. Neonatal Perinatal
    k. Nephrology
    l. Neurology
    m. Pulmonology
    n. Rheumatology
    o. Oncology
    p. Emergency Medicine
    q. Other

Internal medicine subspecialty

17. Please indicate your internal medicine subspecialty
    a. General
    b. Cardiology
    c. Critical Care
    d. Endocrinology
    e. Gastroenterology

f. Hematology
g. Immunology
h. Infectious Disease
i. Nephrology
j. Neurology
k. Pulmonology
l. Rheumatology
m. Oncology
n. Other

Secondary specialty

18. Which of the following best describes your secondary specialty/field/area of practice
    a. No Patient Care
    b. Addiction Medicine
    c. Allergy
    d. Anesthesiology
    e. Dermatology
    f. Diagnostic Radiology
    g. Emergency Medicine
    h. Family Medicine
    i. Genetics
    j. Geriatrics
    k. Hospice and Palliative care
    l. Hospital Medicine
    m. Internal Medicine
    n. Interventional Cardiology
    o. Interventional Radiology
    p. Obstetrics or Gynecology
    q. Occupational Medicine
    r. Ophthalmology
    s. Pain Management
    t. Pathology
    u. Pediatrics
    v. Physical Medicine or Rehab
    w. Primary Care

x. Psychiatry
y. Public Health
z. Radiation Oncology
aa. Surgical
bb. Other
cc. No Specific Area

Secondary surgical subspecialty

19. Please indicate your surgical subspecialty
    a. General
    b. Cardiovascular or Cardiothoracic
    c. Colon and Rectal
    d. Hand
    e. Neurological
    f. Oncology
    g. Orthopedics
    h. Otolaryngology
    i. Pediatric
    j. Plastic
    k. Thoracic
    l. Transplant
    m. Trauma
    n. Urology
    o. Vascular
    p. Bariatric
    q. Other

Secondary pediatrics subspecialty

20. Please indicate your pediatrics subspecialty
    a. General
    b. Adolescent Medicine
    c. Allergy
    d. Cardiology
    e. Critical Care
    f. Endocrinology

g. Gastroenterology
h. Hematology
i. Infectious Disease
j. Neonatal Perinatal
k. Nephrology
l. Neurology
m. Pulmonology
n. Rheumatology
o. Oncology
p. Emergency Medicine
q. Other

Secondary internal medicine subspecialty

21. Please indicate your secondary internal medicine subspecialty
    a. General
    b. Cardiology
    c. Critical Care
    d. Endocrinology
    e. Gastroenterology
    f. Hematology
    g. Immunology
    h. Infectious Disease
    i. Nephrology
    j. Neurology
    k. Pulmonology
    l. Rheumatology
    m. Oncology
    n. Other

Telehealth

22. 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] [Drop-down list ranging from 0 hours per week or "Not applicable" -41+]

Patient characteristics

23. 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 and older)
    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

Primary practice location

24. What is your primary practice location? Leave blank if not applicable

    a. Address _____
    b. Address 2 _____
    c. City _____
    d. State _____
    e. Postal code _____
    f. Country/Region _____

Primary practice arrangement

25. 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

Primary practice position role or title

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

[Multi Select]

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

Primary practice setting type

27. 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
b. Ambulatory Surgical Center
c. Certified Rural Health Clinic
d. Corrections Facility
e. Faculty (College or University)
f. Federal Hospital (VA) and other military settings
g. Federally Qualified Health Center
h. Home Health Setting
i. Hospice Care
j. Hospital – Ambulatory Care Center
k. Hospital Emergency Department
l. Hospital Inpatient

m. Hospital Outpatient
n. Hospital Other
o. Industrial Facility or Work Site
p. Mobile Health Unit
q. Non-Hospital Based Urgent Care Facility
r. Nonprofit or Donation Facility
s. Non-clinical setting (e.g., business, insurance)
t. Nursing Home or Long Term Care Facility
u. Office or Clinic Multi Specialty Group
v. Office or Clinic Single Specialty Group
w. Office or Clinic Solo Practice
x. Psychiatric or Mental Health Facility
y. Research Laboratory
z. Retail Clinic or Convenient Care Clinic
aa. Spa or Aesthetic or Weight Loss Clinic
bb. State or Local Health Department
cc. Student or School Health
dd. Substance Abuse Facility
ee. Telehealth
ff. University or College Student Health Facility
gg. Volunteer in a Free Clinic or Other Volunteer Setting
hh. Other
ii. Not applicable

Primary practice hours

28. 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] [Drop-down list ranging from 0 hours per week or "Not applicable" – 41+]

Primary practice hours/week in direct patient care

29. 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] [Drop-down list ranging from 0 hours per week or "Not applicable" – 41+]

Secondary practice

30. In addition to your primary practice location, do you work at any other practice locations?
    a. Yes
    b. No
    c. Not applicable

Secondary practice location

31. What is your secondary practice location?

    a. Address _____
    b. Address 2 _____
    c. City _____
    d. State _____
    e. Postal code _____
    f. Country/Region _____

Secondary practice employment type

32. Which of the following best describes your current employment arrangement at your secondary practice location?

    [Multi Select]

    a. Self-employed/consultant
    b. Salaried
    c. Hourly
    d. Temporary employment/locum tenens
    e. Other
    f. Not applicable

Secondary practice role or title

33. Please identify the roles or titles that most closely correspond to your secondary employment/practice type.

    [Multi Select]

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

Secondary practice setting type

34. Which of the following best describes the practice setting at your secondary practice location? If this does not apply, please select "Not applicable."

    [Single select]

    a. Academic institution
    b. Ambulatory Surgical Center
    c. Certified Rural Health Clinic
    d. Corrections facility
    e. Faculty (College or University)
    f. Federal Hospital (VA) and other military settings
    g. Federally Qualified Health Center
    h. Home Health Setting
    i. Hospice Care
    j. Hospital – Ambulatory Care Center
    k. Hospital Emergency Department
    l. Hospital Inpatient
    m. Hospital Outpatient
    n. Hospital Other
    o. Industrial Facility or Work Site
    p. Mobile Health Unit
    q. Non-Hospital Based Urgent Care Facility
    r. Nonprofit or Donation Facility
    s. Non-clinical setting (e.g., business, insurance)
    t. Nursing Home or Long Term Care Facility
    u. Office or Clinic Multi Specialty Group
    v. Office or Clinic Single Specialty Group
    w. Office or Clinic Solo Practice
    x. Psychiatric or Mental Health Facility
    y. Research Laboratory
    z. Retail Clinic or Convenient Care Clinic
    aa. Spa or Aesthetic or Weight Loss Clinic
    bb. State or Local Health Department
    cc. Student or School Health
    dd. Substance Abuse Facility
    ee. Telehealth
    ff. University or College Student Health Facility

gg. Volunteer in a Free Clinic or Other Volunteer Setting

hh. Other

ii. Not applicable

Secondary practice hours

35. Estimate the average number of hours per week spent at your secondary practice location. If this does not apply, please select "Not applicable." Does not include time on call.

[Single select] [Drop-down list ranging from 0 hours per week or "Not applicable" – 41+]

Secondary practice hours in direct patient care

36. Estimate the average number of hours per week spent IN DIRECT PATIENT CARE at your secondary practice location. If this does not apply, please select "Not applicable."

[Single select] [Drop-down list ranging from 0 hours per week or "Not applicable" – 41+]

PA educational debt

37. Please indicate the total amount of educational debt you had at time of graduation from your PA program (exclude pre-physician assistant 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-$260,000
o. $260,001-$280,000
p. $280,001-$300,000
q. $300,001 or more

r. Prefer not to answer

Precepting

38. Have you mentored or precepted students within the last 2 years? [Single select]

    a. Yes
    b. No
    c. Prefer not to say
    d. Not applicable

Financing

39. How did you finance your physician assistant education? Please mark all that apply.

    a. Earnings from Healthcare Related Employment
    b. Earnings from Non-Healthcare Related Employment
    c. Earnings from Other Household Members
    d. Personal Household Savings
    e. Federal Traineeship, Scholarship, or Grant
    f. State or Local Government Scholarship or Grant
    g. Non-Government Scholarship or Grant
    h. Educational Institution Scholarship
    i. Employer Tuition Reimbursement Plan
    j. Federally Assisted Loan
    k. Private Loan (non-federal)
    l. Other Type of Loan
    m. Other Family Resources
    n. Other Resources

The End

Thank you for completing Utah's Health Workforce Advisory Council biennial survey. Your participation will help the Council fulfill its purpose of providing information and recommendations to assist in expanding and strengthening Utah's health professional workforce. When you click the arrow pointing right, you will be redirected to your license renewal page. From there, go to "Activity"and select "your started renewal form" and continue from there.