Department of Health & Human Services

Health Workforce Information Center (HWIC)

Utah Pharmacist Survey

Proposed profession-specific survey tool for pharmacist license renewals

Utah Health Workforce Advisory Council

Adopted: December 18, 2024

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 pharmacy profession-specific tool was developed. For UCPMDS questions that required profession-specific response adjustments, customized options relevant to those in the pharmacy profession have been incorporated. 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.

Pharmacist 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. Bachelor of Science in Pharmacy (B.S. Pharm)
   b. Bachelor's degree – other
   c. Master's degree
   d. Doctor of Pharmacy (Pharm.D.)

e. Professional/doctorate degree – other
f. Postdoctoral training

Year completed qualifying education

5. What year did you complete the education program/degree that first qualified you for this license?
   [Single select] [Drop-down list ranging from 1925 - 2028]

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 your qualifying education program/degree?

   _____

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 position in the field of pharmacy that does not require this license
   c. Actively working in a position in a field other than pharmacy
   d. Unemployed and seeking work that requires this license
   e. Unemployed and NOT seeking work that requires this license
   f. Volunteer
   g. Retired
   h. Other

Residency or fellowship

9. Did you complete a residency or fellowship?
   [Single select]

a. Yes
b. No
c. Not applicable

10. If you have completed a residency, in which specialty was your residency program? Select not applicable if you did not complete a residency.
[Single select]

a. Not applicable/did not complete a residency
b. Ambulatory care
c. Cardiology
d. Community
e. Critical care
f. Drug information
g. Emergency medicine
h. Geriatric
i. Infectious diseases
j. Informatics
k. Internal medicine
l. Health-system pharmacy administration
m. Managed care pharmacy systems
n. Medication-use safety
o. Nuclear
p. Nutrition support
q. Oncology
r. Pediatric
s. Pharmacotherapy
t. Psychiatric
u. Solid organ transplant
v. Other

11. If you have completed a fellowship, in which specialty was your fellowship program? Select not applicable if you did not complete a fellowship.
[Single select]

a. Not applicable/did not complete a fellowship
b. Academia
c. Ambulatory care
d. Cardiology
e. Clinical pharmacogenomics
f. Clinical Pharmacology
g. Critical care pharmacy
h. Digital health and informatics
i. Drug development
j. Emergency medicine pharmacy
k. Geriatric pharmacy
l. Health policy and advocacy
m. HIV/AIDS
n. Infectious diseases pharmacy
o. Internal medicine
p. Investigational drugs and research
q. Medication use safety and policy
r. Neonatology pharmacy
s. Nephrology pharmacy
t. Neurology pharmacy
u. Oncology pharmacy
v. Outcomes research
w. Pain management and palliative care
x. Pharmaceutical industry
y. Pharmacy informatics
z. Pharmacy outcomes and healthcare analytics

aa. Population health management and data analysis

bb. Psychiatric pharmacy

cc. Regulatory affairs

dd. Solid organ transplant pharmacy

ee. Toxicology

ff. Translational research

gg. Other

Employment plans

12. 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
g. Other

Employment hour change

13. You indicated that 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

14. 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

15. Indicate any factors related to plans for field change or reduction in hours. Select all that apply.
[Multi select]
    a. To complete further training
    b. Family reasons/commitments
    c. Finances
    d. Physical demands
    e. Stress/burnout
    f. Other

Specialty

16. Indicate any additional specialty certification you have received. Select not applicable if this does not apply.
[Multi select]
    a. Not applicable
    b. Ambulatory care pharmacy (BCACP)

c. Cardiology pharmacy (BCCP)
d. Compounded sterile preparations pharmacy (BCSCP)
e. Critical care pharmacy (BCCC)
f. Emergency medicine pharmacy (BCEMP)
g. Geriatric pharmacy (BCGP)
h. Infectious diseases pharmacy (BCIDP)
i. Nuclear pharmacy (BCNP)
j. Oncology pharmacy (BCOP)
k. Pain management pharmacy (BCPMP)
l. Pediatric pharmacy (BCPPS)
m. Pharmacotherapy (BCPS)
n. Psychiatric pharmacy (BCPP)
o. Solid organ transplantation pharmacy (BCTXP)
p. Other

Telepharmacy and telehealth

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

17. 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

18. Please indicate the population groups to which you provide clinical services. Please check all that apply.

    [Multi select]

    a. Newborns (0-12 months)
    b. Children (ages 2-10)
    c. Adolescents (ages 11–19)
    d. Adults (ages 20-64)
    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. Privately insured individuals
    p. None of the above

Primary practice location

19. What is your primary practice location? If this does not apply, please enter "N/A".

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

Primary practice employment arrangement

20. Which of the following best describes your current employment arrangement at your principal practice location?

    [Single 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

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

[Single Select]

a. Administrator
b. Clinical practice
c. Consultant
d. Faculty/educator
e. Researcher
f. Sales/training/technical support
g. Other
h. Not applicable

Primary practice setting type

22. 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. Academic institution
c. Ambulatory care community pharmacy-based practice
d. Ambulatory care office-based practice/clinic-based pharmacy
e. Federal government hospital/health system-inpatient
f. Federal government hospital/health system-outpatient
g. Health center (FQHC/FQHC look-alike)
h. Home Health/infusion
i. Independent pharmacy (1 store)
j. Small chain pharmacy (2-10 stores)
k. Large chain pharmacy (11+ stores)
l. Mail service pharmacy
m. Mass merchandiser (big box store)

n. Non-government hospital/health system-inpatient
o. Non-government hospital/health system-outpatient
p. Non-government hospital/health system-other
q. Nursing home/long term care
r. Occupational health
s. Pharmacy benefit administration (PBM, managed care)
t. Regulatory practice
u. School-based health service
v. Supermarket pharmacy
w. Telepharmacy
x. Other

Primary practice hours

23. 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/Not applicable – 41+]

Primary practice hours/week in direct patient care

24. 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/Not applicable – 41+]

Secondary practice

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

Secondary practice location

26. What is your secondary practice location? If this does not apply, please enter "N/A".

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

Secondary practice employment arrangement

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

[Single Select]

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

Secondary practice role or title

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

[Multi Select]

a. Administrator
b. Clinical practice
c. Consultant
d. Faculty/educator
e. Researcher
f. Sales/training/technical support
g. Other
h. Not applicable

Secondary practice setting type

29. 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. Not applicable

b. Academic institution
c. Ambulatory care community pharmacy-based practice
d. Ambulatory care office-based practice/clinic-based pharmacy
e. Federal government hospital/health system-inpatient
f. Federal government hospital/health system-outpatient
g. Health center (FQHC/FQHC look-alike)
h. Home health/infusion
i. Independent pharmacy (1 store)
j. Small chain pharmacy (2-10 stores)
k. Large chain pharmacy (11+ stores)
l. Mail service pharmacy
m. Mass merchandiser (big box store)
n. Non-government hospital/health system-inpatient
o. Non-government hospital/health system-outpatient
p. Non-government hospital/health system-other
q. Nursing home/long term care
r. Occupational health
s. Pharmacy benefit administration (PBM, managed care)
t. Regulatory practice
u. School-based health service
v. Supermarket pharmacy
w. Telepharmacy
x. Other

Secondary practice hours

30. Estimate the average number of hours per week spent at your secondary practice location. Does not include time on call.
[Single select] [Drop-down list ranging from 0 hours per week/Not applicable – 41+]

Secondary practice hours in direct patient care

31. Estimate the average number of hours per week spent IN DIRECT PATIENT CARE at your secondary practice location. Does not include time on call. If this does not apply, please select “Not applicable.”
[Single select] [Drop-down list ranging from 0 hours per week/Not applicable – 41+]

Precepting

32. Have you mentored students within the last two years?

    [Single select]

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

33. If you indicated that you mentor/precept students. How many 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

34. If you have not mentored/precepted students within the last 2 years, what are your reasons for not choosing to do so?

    [Single select]

    a. Not applicable
    b. Do not meet the necessary requirements
    c. Insufficient time
    d. Lack of administrative support
    e. Not interested in providing supervision
    f. Do not feel confident in my ability to supervise
    g. Organization does not offer mentoring/precepting/supervising opportunities for students
    h. No financial incentives for supervision
    i. Do not know of any students or associate-level professionals in need of supervision

j. Other

35. Would you like to precept in the future?

[Single select]

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

Educational debt

36. Please indicate the amount of educational debt you had AT THE TIME OF GRADUATION (excluding any non-education 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 - $320,000
r. $320,001 - $340,000
s. $341,001 - $360,000
t. $360,001 - $380,000
u. $380,001 - $400,000
v. $400,001 - $420,000
w. $420,001 - $440,000

x. $440,001 - $460,000
y. $460,001 - $480,000
z. $480,001 - $500,000
aa. $500,001 or above
bb. Prefer not to answer

Multidisciplinary care team

37. Do you work in a multidisciplinary care team?
[Single select]
    a. Yes
    b. No

38. If yes, which healthcare professionals do you work with?
[Multi select]
    a. Certified nurse midwives (CNM)
    b. Certified registered nurse anesthetists (CRNA)
    c. Dentists
    d. Dieticians
    e. Health educators
    f. Nurses (LPN/RN)
    g. Physicians (MD/DO)
    h. Physician assistants (PA)
    i. Nurse practitioners (NP)
    j. Recreation therapist/physical therapist/occupational therapists
    k. Social workers or other behavioral health workers
    l. Other

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.