



**Department of Health
& Human Services**

Health Workforce
Information Center (HWIC)

Utah Physical Therapy Survey



Proposed profession-specific survey tool for physical therapy license
renewals

Utah Health Workforce Advisory Council

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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 physical therapy 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 physical therapy 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.

Physical therapy 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. 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 PA 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 the education program or degree that first qualified you for this license?

Highest level of education

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

Highest level of physical therapy education year

9. What year did you complete your highest education program/degree for this license?
[Single select] [Drop-down list ranging from 1925 - 2028]

Highest education program/degree state

10. 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 the United States)

Qualifying education country of highest education program/degree

11. In which city & country did you complete the education program/degree?
-

Certifications

12. Please indicate any board certifications for physical therapy that you currently hold:
- 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
13. Do you hold credentials (license, certification, degree) in any of the following?
- 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

14. 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

Employment plans

15. 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

Employment hour change

16. 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
17. 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

18. Which of the following best describes the specialty/field/area of practice in which you spend most of your professional time?
- a. No Patient Care
 - b. No specific care

- c. Academia
- d. Cardiovascular or pulmonary
- e. Chronic infectious and metabolic disorders (AID's, 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

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.

19. 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/ "Not applicable" -41+]

Patient characteristics

20. 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 (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. Uninsured individuals
- p. Privately insured individuals
- q. None of the above

Primary practice location

21. 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

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

Primary practice position role or title

23. 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/educator
- d. Researcher
- e. Other
- f. Not applicable

Primary practice setting type

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
- b. Certified rural health clinic
- c. Corrections facility
- d. Federally qualified health center
- e. Federal hospital (VA) and other military settings
- f. Health and wellness facility
- g. Acute care hospital
- h. General hospital-inpatient
- i. Outpatient clinic affiliated with a hospital or health system
- j. Outpatient clinic not affiliated with a hospital or health system
- k. Inpatient rehab facility (IRF)
- l. Non-patient care or non-clinical environment related to physical therapy
- m. Nursing home/long-term care/skilled nursing facility
- n. Pediatric clinic (non-school based)
- o. Research center/lab
- p. Student/school health (preschool, K-12)
- q. Telehealth
- r. Other
- s. Not applicable

Primary practice hours

25. 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

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] [Drop-down list ranging from 0 hours per week or “Not applicable” – 41+]

Secondary practice

27. 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

28. 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

29. 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

30. 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/educator
- d. Researcher
- e. Other
- f. Not applicable

Secondary practice setting type

31. 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. Certified rural health clinic
- c. Corrections facility
- d. Federally qualified health center
- e. Federal hospital (VA) and other military settings
- f. Health and wellness facility
- g. Acute care hospital
- h. General hospital-inpatient
- i. Outpatient clinic affiliated with a hospital or health system
- j. Outpatient clinic not affiliated with a hospital or health system
- k. Inpatient rehab facility (IRF)
- l. Non-patient care or non-clinical environment related to physical therapy
- m. Nursing home/long-term care/skilled nursing facility
- n. Pediatric clinic (non-school based)
- o. Research center/lab
- p. Student/school health (preschool, K-12)
- q. Telehealth
- r. Other
- s. Not applicable

Secondary practice hours

32. 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

33. 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+]

Educational debt

34. Please indicate the total amount of educational debt you had at time of graduation from your PT program (exclude non-physical 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–\$260,000
- o. \$260,001–\$280,000
- p. \$280,001–\$300,000
- q. Prefer not to answer

35. Did/do you participate in a loan forgiveness/repayment program (LRP)?

[Single Select]

- a. Yes
- b. No
- c. Not applicable

36. 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

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

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

38. 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

39. If you indicated that you mentor/precept students, how many physical therapy students have you precepted in the last 2 years?
[Single select]

- a. Yes

- b. No
- c. Prefer not to say
- d. Not applicable

Licensure outside of Utah

40. Are you currently licensed as a physical therapist in any other state(s) OUTSIDE of Utah?

- a. Yes
- b. No

41. If so, what state (s)?

[Single Select]

- a. [LIST OF U.S. STATES and territories]
- b. Another country (not the United States)

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.