

Advanced Practice Registered Nurse (APRN) Health Resource Survey 2012

PLEASE NOTE: The Kansas Health Care Workforce Partnership funded by the Health Research Services Administration (HRSA) and administered by the Kansas Department of Commerce in coordination with the Kansas Department of Health and Environment (KDHE) Bureau of Epidemiology and Public Health Informatics (BEPHI) and the Bureau of Community Health Systems (BCHS) is requesting information to help monitor health care practitioner supply, distribution and practice characteristics. **This information is needed for workforce planning and to assist in developing strategies for increasing the supply of primary health care providers.** Statistics derived from this information will be used in conjunction with a physician workforce assessment to apply for federal designations of Health Professional Shortage Areas and Medically Underserved Areas and public health reporting. The information you provide will not be disclosed except as provided by **KSA 65-6804**.

Your responses are very important! **PLEASE SIGN YOUR NAME, DATE AND RETURN THE SURVEY WHETHER COMPLETED OR NOT.** This is important in calculation of survey return rates.

Complete the questionnaire as accurately as possible using 2012 information effective at the time you complete the survey.

I. General

1. Please enter your Professional License Numbers(s) as assigned by the Kansas State Board of Nursing:

APRN Number _____ RN Number _____

2. Please list your first, middle initial and last name:

First _____ Middle Initial _____ Last Name _____

3. In which area do you practice as an APRN? (*check all that apply*)

- Nurse Anesthetist
- Nurse Practitioner
- Nurse Midwife
- Clinical Nurse Specialists

II. Demographic

4. Gender:

- Male
- Female

5. What is your ethnicity?

- Hispanic/Latino
- Non-Hispanic/Latino

6. What is your racial background?

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- Multi-Racial
- Other, please specify _____

7. Are you a permanent US resident or a US citizen? _____yes _____no

8. What language(s), **other than English**, do you speak fluently (*check all that apply*).

- English
- Spanish
- German
- Russian
- Arabic
- Tagalog
- Chinese
- Hindi
- Urdu
- Pilipino
- Vietnamese
- French
- American Sign Language
- Other, please specify _____

Should we make an assumption that they are fluent in English? Without these changes it seems the answer to 9 will always be yes.

9. Do you communicate with some of your patients using the language(s) checked above? __yes __no

10. Date of birth: Month _____ Day _____ Year _____

11. What is the estimated population of the city/town where you spent the majority of your upbringing?

- less than 2,500
- 2,500 - 9,999
- 10,000 - 14,999
- 15,000 - 19,999
- 20,000- 49,999
- 50,000 - 149,999
- >150,000

12. What is the estimated population of the city/town where you currently work?

- less than 2,500
- 2,500 - 9,999
- 10,000 - 14,999
- 15,000 - 19,999
- 20,000- 49,999
- 50,000 - 149,999
- >150,000

III. Education

13. Path to APRN Credentials: ***Please provide all applicable information in the column below***

Nursing Education Degrees	Year Degree Completed
Diploma in nursing	
Associate degree in nursing	
Baccalaureate degree in nursing	
Master's degree in nursing	
Doctor of Nursing Practice	
Nursing PhD	
Other doctoral degree	

14. The institution from which you received your Advanced Practice education:

Name of Institution _____ City _____ State _____ Country _____

15. If you were a part-time nursing student, please select the reason(s) you chose that option (select all that apply):

- Not applicable
- Needed to continue working full-time
- didn't want to attend full-time
- other, please specify: _____

16. How did you finance your Registered Nurse degree? (*check all that apply*)

- Worked (number of hours) _____
- Supported by family
- Received grants/scholarships
- Took out loans, Please list total loan debt incurred: _____
- Employer funded/support (_____ % or _____ years of **work commitment**)
- other please specify _____

17. How did you finance your **ADVANCED DEGREE**? (*check all that apply*)

- Worked (number of hours: _____)
- Supported by family
- Received grants/scholarships
- Took out loans, Please list total loan debt incurred: _____
- Employer funded/support (_____ % or _____ years of **work commitment**)
- other please specify _____

18. Did the need to pay off student debt...

- influence the job offer you accepted? ___yes ___no
- determine the type of specialty you became certified in? ___yes ___no

19. What is the name of the national certifying body from which you received your credentials (*check all that apply*)?

- American Academy of Nurse Practitioners (AANP)
- American Association of Nurse Anesthetists (AANA)
- American College of Nurse-Midwives (ACNM)
- American Nurse Credentialing Center (ANCC)
- National Certification Board of Pediatric Nurse Practitioners (NAPNAP)
- National Certification Corporation for the Obstetric, Gynecologist and Neonatal Nursing Specialists
- Other, please specify _____

20. Do you intend to pursue further nursing related education? ___yes ___no

21. If yes, which type: _____ PhD _____ Doctorate NP _____ Post-masters Certificate

IV. Employment

****THE TERM "**PRIMARY PRACTICE**" IN THE FOLLOWING SET OF QUESTIONS REFERS TO THE POSITION AT WHICH YOU WORK MOST HOURS DURING A TYPICAL WORK WEEK. THE TERM "**SECONDARY PRACTICE**" IS THE POSITION AT WHICH YOU WORK THE SECOND GREATEST NUMBER OF HOURS DURING A REGULAR WORK WEEK.****

22. In addition to your principal APRN position, are you employed in another position that required your registry as an APRN and/or your RN license? [MARK ONE BOX]

- Yes, I work in two or more APRN positions. [GO TO Q23]
- Yes, I work in one or more RN position(s) in addition to my APRN position. [GO TO Q23]
- No, I work in only one APRN position. [GO TO Q24]

23. **IF YES** to the last question, which of the following best describes the reason you are employed in more than one position? [MARK ONE BOX]

- To supplement the earnings from my principal APRN position.
- Wasn't offered fulltime work in my principal APRN position
- To gain experience in a different aspect of advanced practice nursing
- Enjoy working in various clinical settings
- Other (specify)

24. Which category most closely approximates your total gross income (before taxes) from all of your APRN positions combined? [MARK ONE BOX]

- \$40,000 or less
- \$40,001 to \$50,000
- \$50,001 to \$60,000
- \$60,001 to \$70,000
- \$70,001 to \$80,000
- \$80,001 to \$90,000
- \$90,001-\$100,000
- More than \$100,000
- Not Working as an APRN

PRACTICE LOCATION #1 (Primary Practice)

25. What is the address of your primary practice location?

- a. Organization/office name: _____
- b. Street address: _____
- c. Suite#/Box #/Mailstop/etc.: _____
- d. City: _____
- e. State (e.g. KS): _____
- f. County: _____
- g. Zip Code (5 digits): _____
- h. Phone Number: _____
- i. E-mail address: _____

26. Please estimate the average number of patients you see per day in your primary practice location.
_____ patients/day

27. In a typical week how many total hours of direct patient care do you provide in Kansas at your primary practice location? _____ hours/week

[Use a whole number or decimal rather than a range, i.e. 40 hours. Do not use <, >, or +). Direct patient care means medical service provided to an individual patient, including personal contact, telephone consultations, and related record keeping. It excludes time spent on call and in providing training, teaching or research.]

28. As of today, at your primary practice location, how many hours is it until the next available appointment time? _____

29. Please estimate the current payer mix in the clinical practice of your principal APRN position.

[PERCENT SHOULD ADD UP TO 100%]

_____ %	Private Insurance
_____ %	Medicare
_____ %	Medicaid
_____ %	CHP
_____ %	TriCare/CHAMPUS/VA
_____ %	Worker's Compensation
_____ %	Self-pay and sliding fee schedule
_____ %	Uncompensated care
_____ %	Other (specify) _____
100%	Total

30. What type of work setting is your primary practice location?

- Self-Employed, Solo Practice **Is this an option for KS APRNs?**
- Physician Partnership or Group Practice
- Community/General Hospital - Follow private inpatients; practice primarily ambulatory
- Hospital Based: Predominantly Inpatient Services, e.g. pathology, hospitalist
- Medical School/Teaching Hospital
- Residency or fellowship Participant
- Rural Health Clinic (federally certified)
- Federally Qualified Health Center
- Emergency Department (hospital)
- Emergency Medical Service/Transport
- Military, Federal or VA Hospital
- Locum Tenens (if more than 10 hours per week)
- Long-term nursing or other facility, home health care, assisted living, residential treatment
- Correctional Facility (jail, prison, detention - youth/adult)
- University/College Campus Health
- School System/School Clinic K-12
- Local or State Public Health/Governmental/Regulatory Agency
- HMO/Health Plan/Insurance Company
- Ambulatory Surgery Center
- Independent Laboratory
- Psychiatric Hospital (private)
- Radiology/Imaging Center
- Other Specialty Hospital
- Other Patient Care Employment
- Other Non-Patient Care Employment
- Other, please specify _____

31. Please indicate which category best describes your primary practice location using the selections listed below.

- | | |
|---------------------------|------------------------------|
| 1. Family | 5. Psychiatric/Mental Health |
| a. Diabetes Educator | a. Adult |
| 2. Adult/Gerontology | b. Child |
| a. Adult Medical-Surgical | c. Adult & Child |
| b. Cardiovascular | d. Community Health |
| c. Acute Care | 6. Gender-Specific |
| d. Diabetes Educator | a. Gynecology |
| e. Oncology | b. Obstetrics |
| 3. Neonatal | 7. Other |
| 4. Pediatric | a. Emergency |
| a. Community Health | b. Orthopedics |
| b. Acute Care | c. Rehabilitation |
| c. Diabetes Educator | d. Rheumatology |
| d. Oncology | |

32. Of the hours you spend in direct patient care at your primary practice location, please indicate what percentage of time you work in each of the main categories identified in Q31?

- | | |
|--------------------------------|-----------------------------------|
| 1. ___% Family | 5. ___% Psychiatric/Mental Health |
| a. ___% Diabetes Educator | a. ___% Adult |
| 2. ___% Adult/Gerontology | b. ___% Child |
| a. ___% Adult Medical-Surgical | c. ___% Adult & Child |
| b. ___% Cardiovascular | d. ___% Community Health |
| c. ___% Acute Care | 6. ___% Gender-Specific |
| d. ___% Diabetes Educator | a. ___% Gynecology |
| e. ___% Oncology | b. ___% Obstetrics |
| 3. ___% Neonatal | 7. ___% Other |
| 4. ___% Pediatric | a. ___% Emergency |
| a. ___% Community Health | b. ___% Orthopedics |
| b. ___% Acute Care | c. ___% Rehabilitation |
| c. ___% Diabetes Educator | d. ___% Rheumatology |
| d. ___% Oncology | Total 100% |

33. At your primary practice location, how often is a physician present on site to discuss patient problems as they occur?

- Never
- Seldom (25% or less of the time)
- Sometimes (26% - 50%)
- Usually (51% - 75%)
- Nearly always (76% - 100%)

34. How would you characterize your primary practice location?

- Independent Practice
- Group practice, no physician in the group
- Group practice, with physician(s) in the group
- Other

35. How satisfied are you with your APRN position at your primary practice location?

- Very Satisfied
- Somewhat Satisfied
- Neutral
- Somewhat Dissatisfied
- Very Dissatisfied

36. What are your plans for future employment as an APRN?

- Remain in current position
- Looking for new employment
- Plan to retire in the next year
- Other, please specify _____

#36 ... Add "in you primary practice location" at the end -OR- do not repeat ask Q36-38 in secondary practice location? (i.e., ask only once like Q39-41)

37. If you marked yes to *looking for new employment*, are you planning to leave your principal APRN position in the next 12 months? ___ Yes ___ No

38. **IF YES** to Q37, which of the following factors are influencing your decision to leave your principal APRN position? [MARK THE RELATIVE IMPORTANCE OF EACH FACTOR]

Very Important	Somewhat Important	Not Important	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Desire a primary care position that does not utilize my APRN training
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Desire non-clinical health-related position
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Want to pursue additional education
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Want to work in nursing education
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lack of respect for APRNs by physicians and employers
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Work is not professionally challenging
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Insufficient wages given the workload and responsibilities involved
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Family responsibilities interfere with my ability to continue working
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Health does not allow me to continue working as an APRN
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Plan to retire from the active workforce
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other specify _____

39. When are you eligible to retire?

- less than 1 year
- 1-5 years
- 6-10 years
- 11-15 years
- 16-20 years
- 21-30 years
- greater than 30 years

40. When do you plan to retire?

- less than 1 year
- 1-5 years
- 6-10 years
- 11-15 years
- 16-20 years
- 21-30 years
- greater than 30 years

41. Do you plan to reduce your hours prior to retiring? _____yes _____no

42. Do you have a second practice location?

- Yes (continue survey)
- No (skip to Q57)

PRACTICE LOCATION #2 (Secondary Practice)

43. What is the address of your secondary practice location?

- a. Organization/office name: _____
- b. Street address: _____
- c. Suite#/Box #/Mailstop/etc.: _____
- d. City: _____
- e. State (e.g. KS): _____
- f. County: _____
- g. Zip Code (5 digits): _____
- h. Phone Number: _____
- i. E-mail address: _____

44. Please estimate the average number of patients you see per day in your secondary practice location.

_____ patients/day

45. In a typical week how many total hours of direct patient care do you provide in Kansas at your secondary practice location? ___ hours/week
[Use a whole number or decimal rather than a range, i.e. 40 hours. Do not use <, >, or +). Direct patient care means medical service provided to an individual patient, including personal contact, telephone consultations, and related record keeping. It excludes time spent on call and in providing training, teaching or research.]

46. As of today, at your secondary practice location, how many hours is it until the next available appointment time? _____

47. Please estimate the current payer mix in the clinical practice of your secondary APRN position.

[PERCENT SHOULD ADD UP TO 100%]

_____ %	Private Insurance
_____ %	Medicare
_____ %	Medicaid
_____ %	CHP
_____ %	TriCare/CHAMPUS/VA
_____ %	Worker's Compensation
_____ %	Self-pay and sliding fee schedule
_____ %	Uncompensated care
_____ %	Other (specify) _____
100%	Total

48. What type of work setting is your secondary practice location?

- Self-Employed, Solo Practice
- Physician Partnership or Group Practice
- Community/General Hospital - Follow private inpatients; practice primarily ambulatory
- Hospital Based: Predominantly Inpatient Services, e.g. pathology, hospitalist
- Medical School/Teaching Hospital
- Residency or fellowship Participant
- Rural Health Clinic (federally certified)
- Federally Qualified Health Center
- Emergency Department (hospital)
- Emergency Medical Service/Transport
- Military, Federal or VA Hospital
- Locum Tenens (if more than 10 hours per week)
- Long-term nursing or other facility, home health care, assisted living, residential treatment
- Correctional Facility (jail, prison, detention - youth/adult)
- University/College Campus Health
- School System/School Clinic K-12
- Local or State Public Health/Governmental/Regulatory Agency
- HMO/Health Plan/Insurance Company
- Ambulatory Surgery Center
- Independent Laboratory
- Psychiatric Hospital (private)
- Radiology/Imaging Center
- Other Specialty Hospital
- Other Patient Care Employment
- Other Non-Patient Care Employment
- Other, please specify _____

49. Please indicate which category best describes your secondary practice location using the selections listed below.

- | | |
|---------------------------|------------------------------|
| 1. Family | 5. Psychiatric/Mental Health |
| a. Diabetes Educator | a. Adult |
| 2. Adult/Gerontology | b. Child |
| a. Adult Medical-Surgical | c. Adult & Child |
| b. Cardiovascular | d. Community Health |
| c. Acute Care | 6. Gender-Specific |
| d. Diabetes Educator | a. Gynecology |
| e. Oncology | b. Obstetrics |
| 3. Neonatal | 7. Other |
| 4. Pediatric | a. Emergency |
| a. Community Health | b. Orthopedics |
| b. Acute Care | c. Rehabilitation |
| c. Diabetes Educator | d. Rheumatology |
| d. Oncology | |

50. Of the hours you spend in direct patient care at your secondary practice location, please indicate what percentage of time you work in each of the main categories identified in Q49?

- | | |
|--------------------------------|-----------------------------------|
| 1. ___% Family | 5. ___% Psychiatric/Mental Health |
| a. ___% Diabetes Educator | a. ___% Adult |
| 2. ___% Adult/Gerontology | b. ___% Child |
| a. ___% Adult Medical-Surgical | c. ___% Adult & Child |
| b. ___% Cardiovascular | d. ___% Community Health |
| c. ___% Acute Care | 6. ___% Gender-Specific |
| d. ___% Diabetes Educator | a. ___% Gynecology |
| e. ___% Oncology | b. ___% Obstetrics |
| 3. ___% Neonatal | 7. ___% Other |
| 4. ___% Pediatric | a. ___% Emergency |
| a. ___% Community Health | b. ___% Orthopedics |
| b. ___% Acute Care | c. ___% Rehabilitation |
| c. ___% Diabetes Educator | d. ___% Rheumatology |
| d. ___% Oncology | |
- Total 100%**

51. At your secondary practice location, how often is a physician present on site to discuss patient problems as they occur?

- Never
- Seldom (25% or less of the time)
- Sometimes (26% - 50%)
- Usually (51% - 75%)
- Nearly always (76% - 100%)

52. How would you characterize your secondary practice location?

- Independent Practice
- Group practice, no physician in the group
- Group practice, with physician(s) in the group
- Other

53. How satisfied are you with your APRN position at your secondary practice location?

- Very Satisfied
- Somewhat Satisfied
- Neutral
- Somewhat Dissatisfied
- Very Dissatisfied

54. What are your plans for future employment as an APRN?

- Remain in current position
- Looking for new employment
- Plan to retire in the next year
- Other, please specify _____

See #36

55. If you marked yes to looking for new employment, are you planning to leave your secondary APRN position in the next 12 months? ___ Yes ___ No

56. IF YES to Q55, which of the following factors are influencing your decision to leave your secondary APRN position? [MARK THE RELATIVE IMPORTANCE OF EACH FACTOR]

Very Important	Somewhat Important	Not Important	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Desire a primary care position that does not utilize my APRN training
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Desire non-clinical health-related position
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Want to pursue additional education
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Want to work in nursing education
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lack of respect for APRNs by physicians and employers
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Work is not professionally challenging
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Insufficient wages given the workload and responsibilities involved
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Family responsibilities interfere with my ability to continue working
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Health does not allow me to continue working as an APRN
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Plan to retire from the active workforce
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other specify _____

V. Immunizations & Electronic Health Records

KDHE is very focused on preventive services and appreciates your active role in our mission to keep Kansans healthy. The next four questions address two specific topics associated with the provision of health care services. Please fill them out to the best of your ability.

57. Do you provide immunizations as part of your scope of practice in any of your office locations?
- a. No
 - b. Yes, for children only
 - c. Yes, for adults only
 - d. Yes, for both children and adults

The following questions pertain to your office's use of an Electronic Health Record (EHR) system. An EHR is different than a Practice Management System, in that it captures patient health information over time, generated by one or more encounters in any care delivery setting. Included in this information are patient demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data, and radiology reports. The EHR has the ability to generate a complete record of a clinical patient encounter - as well as supporting other care-related activities directly or indirectly via interface - including evidence-based decision support, quality management, and outcomes reporting.

For the following questions, consider your main practice office location (i.e., where you spend the most time delivering patient care):

58. Does your main office use an Electronic Health Record (EHR) system?
- a. Yes
 - b. No (You have completed the survey at this time)
59. Is your current EHR system certified by The Office of the National Coordinator for Health Information Technology at the U.S. Department of Health and Human Services?
- a. Yes
 - b. No
 - c. Unknown
60. Please list the vendor, product, and version number of your EHR system:
- a. Vendor: _____
 - b. Product: _____
 - c. Version number: _____

Please type name and date of completion below: **Electronic and name provided in Q2. Is this needed?**

Name

Date

THANK YOU FOR COMPLETING THIS SURVEY AND PROVIDING VALUABLE
HEALTH CARE WORKFORCE INFORMATION.