

# Virginia Geriatric Training and Education (GTE) Demographic Evaluation

## Virginia Center on Aging (VCoA)

### Virginia Commonwealth University

Instructions: In order to evaluate this project for the General Assembly of Virginia we ask that this questionnaire be completed by everyone who participates in the GTE initiative. Your answers are extremely valuable. This and any other forms you complete related to this project are strictly confidential. Your responses will not be linked with your name in any data base. The data will be used only for the purposes of evaluation and all results will be grouped, so that no single person or organization may be distinguished. Your participation is voluntary. You have the right to withdraw at any time or refuse to answer any questions.

#### 1. **Your Education** (Circle the highest degree you hold)

High School     Associate's     Bachelor's     Master's/Other Advanced Professional Degree     Doctorate

Are you a student?                     Yes     No

What degree(s) do you hold? \_\_\_\_\_ Discipline? \_\_\_\_\_

What license(s) and certificate(s) do you hold? \_\_\_\_\_

Current Job Title (if any): \_\_\_\_\_

#### 2. **What is your background & training?**

Your Discipline (Please check **ONE** single response)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Allopathic Medicine (MD)        | <input type="checkbox"/> Chiropractic                                | <input type="checkbox"/> Dentistry                      |
| <input type="checkbox"/> Osteopathic Medicine (DO)       | <input type="checkbox"/> Nurse Practitioner                          | <input type="checkbox"/> Advance Practice Nurse (MSN)   |
| <input type="checkbox"/> Undergraduate Nurse (RN, BSN)   | <input type="checkbox"/> Other Nursing _____ (Specify)               |   |
| <input type="checkbox"/> Clinical Laboratory Sciences    | <input type="checkbox"/> Other Technician (EEG, EKG, EMT)            |   |
| <input type="checkbox"/> Dental Hygiene/Dental Assistant | <input type="checkbox"/> Other Health Assistant                      |   |
| <input type="checkbox"/> Health Information              | <input type="checkbox"/> Nutrition                                   |   |
| <input type="checkbox"/> Rehabilitation Therapies        | <input type="checkbox"/> Other Allied Health _____ (Specify)         |   |
| <input type="checkbox"/> Health Administration           | <input type="checkbox"/> Public Health                               | <input type="checkbox"/> Clinical/Counseling Psychology |
| <input type="checkbox"/> Social Work                     | <input type="checkbox"/> Other Counseling                            | <input type="checkbox"/> Social/Behavioral Sciences     |
| <input type="checkbox"/> Law (Attorney, Paralegal)       | <input type="checkbox"/> Law Enforcement/Protective Service/Security |   |
| <input type="checkbox"/> Other Field: _____              | <input type="checkbox"/> (Specify)                                   |   |

What is your area of specialization? \_\_\_\_\_

#### 3. **What is your work setting?**

Do you work in any of the following places? (Check **ALL** that apply)

- |   |  |
|---|--|
| <input type="checkbox"/> Community Health Center  | <input type="checkbox"/> Health Care for Homeless Center                         |
| <input type="checkbox"/> Rural Health Clinic  | <input type="checkbox"/> National Health Service Corps Site                      |
| <input type="checkbox"/> Federally-Qualified Health Center                              | <input type="checkbox"/> Ambulatory Practice Sites Designated by State Governors |
| <input type="checkbox"/> HPSA (Federally Designated Health Professionals Shortage Area) |  |
| <input type="checkbox"/> Migrant Health Center  | <input type="checkbox"/> Public Housing Primary Care Center                      |
| <input type="checkbox"/> Community Mental Health Center                                 | <input type="checkbox"/> Indian Health Service                                   |
| <input type="checkbox"/> State or Local Health Department                               | <input type="checkbox"/> Public Health Hospital                                  |

**4. Does your place of work emphasize service to any of the following groups?**

(Check ALL that apply)

- Older adults
- Geographically isolated people
- Economically disadvantaged groups
- Minority populations, Specify: \_\_\_\_\_

**5. What activities do you perform in your work? (Check ALL that apply)**

- |   |  |
|---|--|
| <input type="checkbox"/> Direct Care/Practitioner         | <input type="checkbox"/> Technical Duties              |
| <input type="checkbox"/> Counseling                       | <input type="checkbox"/> Administration                |
| <input type="checkbox"/> Academic Teaching                | <input type="checkbox"/> Curriculum Development        |
| <input type="checkbox"/> Clinical Teaching                | <input type="checkbox"/> In-Service Training           |
| <input type="checkbox"/> Research                         | <input type="checkbox"/> Continuing Education          |
| <input type="checkbox"/> Publications                     | <input type="checkbox"/> Community Work                |
| <input type="checkbox"/> Research Grant-writing           | <input type="checkbox"/> Other: _____                  |
| <input type="checkbox"/> Training/Education Grant-writing | <input type="checkbox"/> Board or Committee Membership |

**6. Please specify one of the following as your primary work role: (Please check ONE single response)**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Practitioner     | <input type="checkbox"/> Academic Faculty                 | <input type="checkbox"/> Clinical Faculty |
| <input type="checkbox"/> Administrator    | <input type="checkbox"/> Continuing / In-service Educator | <input type="checkbox"/> Community Work   |
| <input type="checkbox"/> Technical Duties | <input type="checkbox"/> Other: (specify) _____           |   |

**7. Your demographic information:**

The following information is used only to encourage funding support for underserved communities.

Gender     Male     Female

Age \_\_\_\_\_

**Race/Ethnicity (Please check ONE single response)**

- |   |   |
|---|---|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Asian, Specify: _____                  |
| <input type="checkbox"/> African American or Black        | <input type="checkbox"/> Native Hawaiian/Other Pacific Islander |
| <input type="checkbox"/> Caucasian or White               | <input type="checkbox"/> Hispanic/Latino                        |
| <input type="checkbox"/> Other, Specify: _____            |   |

Do you consider yourself ever to have been from:

- 1) an economically disadvantaged background?     Yes     No
- 2) an educationally disadvantaged background?     Yes     No

**8. Please tell us about your geriatric education needs by rating the importance of specific medical health issues and topics in aging to the work that you do. Please use this rating scale to respond: (1=not important, 2=somewhat important, 3=very important)**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Healthy Aging        | <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Pain Management         |
| <input type="checkbox"/> Geriatric Assessment | <input type="checkbox"/> Mental Health and Aging  | <input type="checkbox"/> Falls Prevention        |
| <input type="checkbox"/> Elder-caregiving     | <input type="checkbox"/> Arthritis                | <input type="checkbox"/> Cultural Sensitivity    |
| <input type="checkbox"/> Physiology of Aging  | <input type="checkbox"/> Medications/Polypharmacy | <input type="checkbox"/> Physical Rehabilitation |
| <input type="checkbox"/> Substance Abuse      | <input type="checkbox"/> Ethics                   | <input type="checkbox"/> Health Care Literacy    |
| <input type="checkbox"/> Community-based care | <input type="checkbox"/> Nutrition and Diet       | <input type="checkbox"/> Medicare/Medicaid       |
| <input type="checkbox"/> Osteoporosis         | <input type="checkbox"/> Palliative Care          | <input type="checkbox"/> Depression              |
| <input type="checkbox"/> Dementia             | <input type="checkbox"/> Elder Abuse              | <input type="checkbox"/> Other, Specify: _____   |