

# Utah Medical Education Council

## Certified Registered Nurse Anesthetist Survey 2015

1. Are you currently certified as a CRNA?  Yes  No
2. Do you provide any health care services in Utah?  Yes  No  I live in Utah but don't provide services here
- a. If **NO**, please specify why you maintain a Utah license: \_\_\_\_\_
- b. If **NO**, on a scale of 1-5 (1 being the most influential and 5 being the least influential), please rank the individual factors that have influenced your choice to work outside of Utah:
- Family \_\_\_\_\_ Wage/Pay scale \_\_\_\_\_ Climate \_\_\_\_\_  
 Lifestyle \_\_\_\_\_ Work Environment \_\_\_\_\_ Other (specify) \_\_\_\_\_

**IF YOU DO NOT PROVIDE SERVICES OR LIVE IN UTAH, PLEASE STOP HERE AND RETURN THE SURVEY, THANK YOU**

3. Are you of Hispanic ethnicity?  Yes  No
4. What is your racial/ethnic background? (Please mark only one)
- American Indian/Alaska Native       African American       Asian  
 Native Hawaiian/Pacific Islander       White/Caucasian       Other (specify) \_\_\_\_\_
5. Please describe the area where you spent the majority of your upbringing (when you lived there):
- Rural       Suburban       Urban/Metropolitan Area      State: \_\_\_\_\_
6. What type of NURSING degree/credential qualified you for your first U.S. nursing license?
- Vocational/Practical Certificate       Associate Degree       Master's Degree  
 Diploma       Baccalaureate Degree       Doctorate Degree
7. How many years of experience as an RN did you have before STARTING a nurse anesthetist program? \_\_\_\_\_
8. Please provide the following information regarding the institution from which you received your nurse anesthetist education: College/ University: \_\_\_\_\_ State: \_\_\_\_\_ Year graduated: \_\_\_\_\_ Degree: \_\_\_\_\_
9. What is your highest level of education?
- Master's Degree-Nursing       Doctor of Nursing Practice (DNP)       Doctoral Degree-Nursing Other  
 Master's Degree-Non-Nursing       Doctoral Degree-Nursing (PhD)       Doctoral Degree- Non-Nursing
10. Please enter a code from the list of monetary ranges below indicating your **average annual gross compensation?** (Before taxes AND excluding benefits). Compensation: \_\_\_\_\_
11. Please enter a code from the list below indicating the amount of educational debt you **CURRENTLY** have from your training as an APRN, as well the **TOTAL** educational debt you had for your APRN training **at the time of your graduation.** (exclude any pre-APRN and non-education debt including relocation loans, cars and credit cards)  
 Current: \_\_\_\_\_ Total: \_\_\_\_\_

01= \$0.00	07= \$90,000-\$99,999	13= \$150,000- 159,999	19= \$210,000-\$219,999	25= \$270,000- 279,999
02= > \$0.00- \$49,999	08= \$100,000-\$109,999	14= \$160,000- 169,999	20= \$220,000-\$229,999	26= \$280,000- 289,999
03= \$50,000-\$59,999	09= \$110,000-\$119,999	15= \$170,000- 179,999	21= \$230,000-\$239,999	27= \$290,000- 299,999
04= \$60,000-\$69,999	10= \$120,000-\$129,999	16= \$180,000- 189,999	22= \$240,000-\$249,999	28= \$300,000 or more
05= \$70,000-\$79,999	11= \$130,000-\$139,999	17= \$190,000- 199,999	23= \$250,000-\$259,999	
06= \$80,000-\$89,999	12= \$140,000-\$149,999	18= \$200,000-\$209,999	24= \$260,000- 269,999	

**12. Please indicate the type(s) of position(s) you currently hold: (please mark all that apply)**

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Full Time CRNA                  | <input type="checkbox"/> Full Time Non- CRNA   | <input type="checkbox"/> Faculty- CRNA                         | <input type="checkbox"/> Single Employment Position    |
| <input type="checkbox"/> Part Time CRNA                  | <input type="checkbox"/> Part Time Non- CRNA   | <input type="checkbox"/> Retired                               | <input type="checkbox"/> Multiple Employment Positions |
| <input type="checkbox"/> Contractor- CRNA                | <input type="checkbox"/> Temp./ Per Diem- CRNA | <input type="checkbox"/> Volunteer as a CRNA                   | <input type="checkbox"/> Working as an RN              |
| <input type="checkbox"/> Unemployed-Seeking Work as CRNA |  | <input type="checkbox"/> Unemployed-Not Seeking Work as a CRNA |  |

- a. If you marked above that you are a contractor, on average, how many contracts do you provide services for per month? \_\_\_\_\_
- b. If you marked you were unemployed in the previous question, please indicate your reason for being unemployed (please mark all that apply):
- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Taking Care of Home          | <input type="checkbox"/> Taking Care of Family | <input type="checkbox"/> Disabled                         |
| <input type="checkbox"/> Inadequate Salary            | <input type="checkbox"/> Attending School      | <input type="checkbox"/> Difficulty Finding CRNA Position |
| <input type="checkbox"/> Other (please specify) _____ |  |   |

**13. Please indicate the Zip Code of your Primary & Secondary practice/contracting locations Also, Please estimate the total hours worked per week (not including on call) at each practice location.**

**Primary Practice** Zip: \_\_\_\_\_ Total hrs/wk: \_\_\_\_\_ **Secondary Practice** Zip: \_\_\_\_\_ Total hrs/wk: \_\_\_\_\_

**14. Please indicate the approximate number of hours you spend providing DIRECT PATIENT CARE each week, including charting, but excluding the hours spent providing patient care combined with teaching or training of other APRNs: (unless all of the hours you work each week are spent in direct patient care without any teaching or training of APRN students, this should be less than the number of total hours reported in the previous question). Primary Practice \_\_\_\_\_ hrs./wk Secondary Practice \_\_\_\_\_ hrs./wk**

**15. In an average week, how many patients do you provide services for? (please write N/A if option doesn't apply)**  
 Outpatients \_\_\_\_\_ Inpatients \_\_\_\_\_

**16. Please estimate the percentage (%) of patients you see from each of the following age groups (total of all practice locations) (The sum for each patient category (row) should equal 100%)**

Outpatients:	0-19 _____ %	20-64 _____ %	65-84 _____ %	85+ _____ %	Total (100%)
Inpatients:	0-19 _____ %	20-64 _____ %	65-84 _____ %	85+ _____ %	Total (100%)

**17. What percent of your patients at your primary/secondary practice/contracting location(s) (if applicable) have the following types of insurance coverage? (Estimates of all payers should equal 100% for each practice location. You may want to ask your billing office for assistance with these estimates):**

	<u>Primary</u>	<u>Secondary</u>		<u>Primary</u>	<u>Secondary</u>
Medicaid	_____ %	_____ %	Tri-Care (CHAMPUS)	_____ %	_____ %
Medicare	_____ %	_____ %	Workman's Comp	_____ %	_____ %
Private Insurance	_____ %	_____ %	Charity	_____ %	_____ %
Managed Care	_____ %	_____ %	Other	_____ %	_____ %
Self-Pay/ Uninsured	_____ %	_____ %	Total	(100%)	(100%)

**18. Please allocate the average hours per week you spend in the following non-patient care activities:**

- a. Teaching (didactic and/or classroom teaching without patient care) \_\_\_\_\_
- b. Research (academic, reports, applications, surveys, etc.) \_\_\_\_\_
- c. Admin/Management (planning, budgeting, etc. not in direct support of patient care) \_\_\_\_\_
- d. Consulting (Not directly related to pt. care) \_\_\_\_\_
- e. Policy/ Procedure Development \_\_\_\_\_
- f. Volunteer/ Charity Care \_\_\_\_\_
- g. Other: \_\_\_\_\_

**19. Do you precept/ mentor certified nurse anesthetist students?  Yes  No**

- a. If you answered Yes, How nurse anesthetist students have you precepted in the last five years? \_\_\_\_\_
- b. If you answered No, would you like to precept in the future?  Yes  No
- i. If No, please briefly explain why not? \_\_\_\_\_
- c. If you are not currently precepting, have you precepted in the last five years?  Yes  No

**20. In how many years do you plan to retire?**

- <1 yrs.    1-5 yrs.    6-10 yrs.    11-15 yrs.    16-20 yrs.    >20 yrs.

**21. Prior to retirement, do you plan to reduce the number of hours per week you practice?**    Yes    No

a. If Yes, please indicate: **How many years FROM NOW** you plan to reduce your hours: \_\_\_\_\_

**22. How many hours/week** you plan to work **AFTER THE REDUCTION**: \_\_\_\_\_

**23. Please enter codes from the list below for your Primary \_\_\_\_\_ and Secondary \_\_\_\_\_ practice setting:**

- |                                       |  |                                  |
|---------------------------------------|--|----------------------------------|
| 1 = Self-Employed/ Contractor (solo)  | 11 = Physician Multi- Specialty Group        | 21 = Hospice Care                |
| 2 = Group APRN Practice               | 12 = Non-hospital Based Outpatient Clinic    | 22 = Home Health Agency          |
| 3 = Hospital- Inpatient               | 13 = Non-hospital Based Urgent Care Facility | 23 = Nursing Home/ LTC facility  |
| 4 = Hospital- Outpatient              | 14 = Fed. Qualified Community Health Clinic  | 24 = Occupational Health         |
| 5 = Hospital- Emergency Department    | 15 = Certified Rural Health Clinic           | 25 = Student/ School Health      |
| 6 = Hospital- Ambulatory Care Center  | 16 = Free Standing Surgery Center            | 26 = Faculty (College or Univ.)  |
| 7 = Other unit of hospital            | 17 = Spa/ Aesthetic/ Weight Loss Clinic      | 27 = Insurance company           |
| 8 = Federal Hospital (VA)             | 18 = Gov't/ Planning Agency                  | 28 = Corrections facility        |
| 9 = Physician Practice Solo           | 19 = Birthing Center                         | 29 = Nonprofit/Donation Facility |
| 10 = Physician Single Specialty Group | 20 = Pharmaceutical Company                  | 30 = Other (specify) _____       |

**24. Have you voluntarily switched employers/practices within the past five years?**    Yes    No

a. If YES, please use the list of settings above to indicate the work setting you left and the work setting you moved to: Setting Code Left: \_\_\_\_\_ Setting Code Moved To: \_\_\_\_\_

b. If YES please check the reason(s) for this change of work setting

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Better Work/Education Fit | <input type="checkbox"/> Desire for Change       | <input type="checkbox"/> Higher Pay      | <input type="checkbox"/> More Challenging         |
| <input type="checkbox"/> Moved Residence           | <input type="checkbox"/> Personal/Family Reasons | <input type="checkbox"/> Preferred hours | <input type="checkbox"/> Professional Advancement |
| <input type="checkbox"/> Work Responsibilities     | <input type="checkbox"/> Other _____             |  |   |

**25. Which most accurately describes your primary practice setting?**

- Independent CRNA (you practice without anesthesiologist oversight)  
 Medically Supervised (anesthesiologist is available, but not necessarily in the same room)  
 Medically Directed (seven TEFRA conditions apply)

a. If you answered Medically Directed, what percent of the time are the seven conditions of TEFRA met when providing anesthesia for Medicare patients?

- Never    Rarely    Sometimes    Frequently    Almost Always    Always

**26. Do you anticipate CRNA expansion within your group within the next three years?**    Yes    No

**27. Do you practice in a team setting with anesthesiologists?**    Yes    No (if YES, please answer a. and b.)

- a. How many full-time anesthesiologists are in your group? \_\_\_\_\_  
b. Including yourself, how many full-time CRNAs are in your group? \_\_\_\_\_

**If you answered YES to question 27 above, please answer the questions on the back of this page about the team that you work with.**

28. **Would you say that the team works to establish shared goals that reflect patient and family priorities and can be clearly articulated, understood and supported by all team members?**  
 Strongly Disagree       Disagree       Neutral       Agree       Strongly Agree
29. **Would you say that there are clear expectations for each team member's functions, responsibilities and accountabilities, which often make it possible for the team to take advantage of division of labor, thereby accomplishing more than the sum of its parts?**  
 Strongly Disagree       Disagree       Neutral       Agree       Strongly Agree
30. **Would you say that team members earn each other's trust, creating strong norms of reciprocity and greater opportunities for shared achievement?**  
 Strongly Disagree       Disagree       Neutral       Agree       Strongly Agree
31. **Would you say that the team prioritizes and continuously refines its communication skills and has consistent channels for candid and complete communication, which are accessed and used by all team members across the setting?**  
 Strongly Disagree       Disagree       Neutral       Agree       Strongly Agree
32. **Would you say that the team agrees on and implements reliable and timely feedback on successes and failures in both the functioning of the team and achievement of the team's goals, and that these are used to track and improve performance immediately and over time?**  
 Strongly Disagree       Disagree       Neutral       Agree       Strongly Agree

**Thank you for your participation. Please return the survey in the enclosed envelope.**

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