Rural Assessment Results

Overview

All students in the Missouri State University School of Anesthesia will complete a clinical rotation in a rural site prior to graduation. These sites may be located in Missouri, Arkansas, Kansas, Oklahoma, Indiana or Idaho. Not only do these sites represent various populations, but the scope of practice for CRNAs will vary due to state variations in licensing and reimbursement. This assessment was designed to capture the variations in student experience.

Variations in types of facility accreditation will impact a CRNA practice. The Critical Access Hospital (CAH) designation was established in 1997 by the Centers for Medicare and Medicaid to improve rural healthcare access. The program was designed to provide necessary services to a community and in many cases a CRNA is the only professional who is licensed to provide anesthesia in a rural CAH. If a CRNA is practicing in such a facility, they will not only have to provide anesthesia for a population, they will often also be managing the department along with implementing quality assurance activities.

Other unique features of CRNA practice that will vary according the state practice laws include no supervision requirement in the advance practice nursing laws. These are commonly known as "opt-out" states referring to the letter that the state's governor has written to Centers for Medicare and Medicaid (CMS). In opt-out states, CRNAs may practice as independent practitioner and with fewer restrictions on their scopes of practice.

Response rate

17 out of a possible 22 Nurse Anesthesia senior students responded to the Qualtrics survey for a 77% response rate. An incentive gift for responding was the student's choice of a $10 gift card to either Starbucks or Andy's custard.

Types of facilities and services

The locations of the clinical sites are plotted on the Map of Clinical Rotation sites included in the Appendix. The majority (59%) of the population of the towns were noted to be in the 2500-5,000 range with only 12% reported to be in a town with a population of >10,000,

The majority of facilities were reported as community or neighborhood hospital, (58%) followed by public hospital (26%), ambulatory surgery center (10.5%) and for-profit hospital (5%). The majority of the facilities were noted as rural Critical Access hospitals (46%).

Populations served

The students reported diversity in the populations that were served at their facility. Hispanic populations were noted to be the most frequent (39%) followed by African-American (33%). Other racial minorities that were served included American Indian (18%), Asian, Pacific Islander and Alaskan natives all reported at 3%.

Service lines supported

The types of surgical services supported by anesthesia included most standard services. General surgery and GI (endoscopy) services were provided at 77% and 72% of the clinical sites. Other service lines included (in decreasing frequency) orthopedics, obstetrics, ophthalmology, podiatry, oral surgery, and plastics.

Services provided in this rotation included being on call for 24 hour shifts by 59% of the students. The majority of the students taking call were for the operating room (47%), only 1 student took OB-only call. 23% reported taking no call. When taking call 64% reported a response time requirement of less than 30 minutes. Only 1 student reported taking in-hospital call, the remainder took call from outside of the facility.

CRNA practice

There was a lack of knowledge of some unique practice and reimbursement aspects of the rural facilities. When asked if the facility was located in an "opt-out" state 2 of the 17 did not know. When asked if the facility was located in a CAH, 29% did not know.

The main types of employment arrangements of the CRNA mentors included independent contractor (47%) and CRNA-only group (29%). Other arrangements included Anesthesia Care Team (18%) and hospital employee (5%).

CRNA services

Types of anesthesia provided included all types of standard anesthetics. Regional anesthesia techniques included interscalene block, spinal, IV regional, epidural, and supraclavicular blocks. No ankle or axillary blocks were reported.

100% of the students reported caring for patients classified as American Society of Anesthesiologists (ASA) physical status 3. 17% reported providing anesthesia for patients who were classified as emergent.

Outside of the operating room services that were provided by the students included peripheral IV starts (76%), intubations and airway management (53%), providing sedation for diagnostic/therapeutic services (47%), central line placement (29%) and lumbar puncture (18%).

3 students reported various experiences in invasive pain management that included intrathecal opioids, epidural steroids, and facet blocks. Postoperative pain management experience included epidural administration of opioids and local anesthetics and patient-controlled-analgesia management.

Management services that the students participated included procurement of supplies (41%), providing orientation/education to staff (41%), schedule development (29%), attending hospital or department meeting (29%) and conducting anesthesia quality improvement activities (18%).

Rural practice desirability

When asked if after the rural anesthesia rotation, they felt that they would be better prepared to practice in a rural setting than if they had not completed the rotation; 82% said "yes" while 18% said "maybe".

When asked to rank various factors that would be most attractive in a future practice, pay, autonomy, and organizational policies were highest. The least attractive features of a future rural practice were task requirements/call hours (56% rated this as #1), organizational policies and interaction with hospital community.

Recommendations

To provide the students with a framework of the variations in CRNA practice.I would like to propose that students receive a written overview of the unique aspects of rural practice prior to beginning this rotation. This document would be prepared by myself and would cover the following areas:

Type of facility: CAH, rural, urban, VA, Indian Health service, ASC, community hospital

Are new service lines being added at the facility? Have service lines been discontinued?

Type of practice: independent contractor, locum tenems, hospital employee, group employee.

Type of Nurse Practice Act: is supervision required in the state? Is this an "opt-out" state? Are the CRNAs Licensed Independent Practitioners?

How is billing and reimbursement handled?

Is Prescriptive authority required for the facility? Are DEA numbers required?

What is the CRNA scope of practice for the state? Are there restrictions at the facility?

Rural Anesthesia Rotation Site

Facility locations

- St Maries ID
- orofino ID
- Hayti
- Neosho
- Grove OK
- MO
- Sullivan IN
- Iola KS
- Hermann MO
- Pryor OK
- Aurora MO

Untitled layer

Locations reported by students