

**SHEA INFECTION CONTROL/ HEALTHCARE EPIDEMIOLOGY RESOURCES AND  
COMPENSATION SURVEY**

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**Personal Demographics**

1. Please indicate your degrees (Check all that apply):

- <sup>1</sup> MD, DO or MBBS
- <sup>2</sup> MPH, Masters in Epidemiology and/or Biostatistics (e.g. - MS, MSc, MSCE)
- <sup>3</sup> PhD, field: \_\_\_\_\_
- <sup>4</sup> RN or BSN
- <sup>5</sup> MA, MSN or other Masters degree: \_\_\_\_\_
- <sup>6</sup> Other (Please specify): \_\_\_\_\_

2. Please select your board certification from the list below. Check all that apply.

- <sup>1</sup> Internal Medicine
- <sup>2</sup> Pediatrics
- <sup>3</sup> Infectious Disease
- <sup>4</sup> Other: \_\_\_\_\_

3. Do you have an academic position?

- <sup>1</sup> Yes
- <sup>2</sup> No

4. What is your age?

- <sup>1</sup> Less than 40 years
- <sup>2</sup> 40-49 years
- <sup>3</sup> 50-59 years
- <sup>4</sup> 60 or older

5. Sex:

- <sup>1</sup> Female
- <sup>2</sup> Male

6. Describe the location of your workplace:

- <sup>1</sup> Northeast US
- <sup>2</sup> Midatlantic US
- <sup>3</sup> Southeast US
- <sup>4</sup> Midwest US
- <sup>5</sup> Northwest US
- <sup>6</sup> Southwest US
- <sup>7</sup> West US
- <sup>8</sup> Other US (e.g.-HI, PR, Guam)
- <sup>9</sup> Canada
- <sup>10</sup> Outside U.S., U.S. Territories and Canada(Please specify): \_\_\_\_\_

7. Is your primary role based at a:

- <sup>1</sup> Hospital/ Medical center (including academic medical centers)
- <sup>2</sup> Healthcare network/ Health system
- <sup>3</sup> Longterm care facility/ Rehab center
- <sup>4</sup> Private practice
- <sup>5</sup> State/ Local government (DPH)
- <sup>6</sup> Federal government
- <sup>7</sup> University/ Medical school (non-clinical)
- <sup>8</sup> Pharmaceutical/ Biotechnical industry
- <sup>9</sup> Retired
- <sup>10</sup> Other (Please describe): \_\_\_\_\_

8. Have you received formal training in hospital epidemiology/ infection control? Check all that apply.

- <sup>1</sup> SHEA/CDC course or other similar 3-5 day formal training
- <sup>2</sup> APIC course
- <sup>3</sup> CIC certification
- <sup>4</sup> EIS training
- <sup>5</sup> ≥1 year of training in hospital epidemiology/ infection control (outside of routine ID fellowship)
- <sup>6</sup> Other (Please specify): \_\_\_\_\_

***If you are not affiliated with a hospital or medical center, GO TO QUESTION 13.***

**Hospital Demographics**

9. How would you describe the medical center at which you practice?

- <sup>1</sup>  Urban setting
- <sup>2</sup>  Suburban setting
- <sup>3</sup>  Rural setting

10. What is the classification of the **primary** hospital with which you are affiliated?

- <sup>1</sup>  University hospital
- <sup>2</sup>  Community teaching hospital
- <sup>3</sup>  Non-teaching hospital
- <sup>4</sup>  City/ county hospital
- <sup>5</sup>  Veterans hospital
- <sup>6</sup>  Longterm care facility/ Rehab center

11. During 2006, what was the average daily occupancy at the medical center at which you are **primarily affiliated**?

- <sup>1</sup>  Less than 200 beds
- <sup>2</sup>  200-399 beds
- <sup>3</sup>  400-600 beds
- <sup>4</sup>  More than 600 beds

12. At the medical center at which you are **primarily affiliated**, please indicate whether you have the following:

- <sup>1</sup>  Bone marrow transplant service
- <sup>2</sup>  Solid organ transplant service
- <sup>3</sup>  Neonatal ICU
- <sup>4</sup>  Other ICUs. Please specify total # ICU beds: \_\_\_\_\_

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**Professional Responsibilities and Compensation**

13. Please indicate approximately what **percentage of your total professional time** is devoted to the following activities. **Sum of all rows should total to 100%.**

	<b>% effort</b>
Clinical patient care, including consulting	
Healthcare epidemiology/ Infection Control	
Occupational/Employee Health	
Risk management/ Patient safety/ Healthcare Quality	
Research	
Administration	
Teaching	
Other (Please specify): _____	
<b>TOTAL:</b>	<b>100</b>

14. For each of the services listed below, please indicate:

- If you **provide that type of service**
- If you have a **written contract or position description** that specifies what services you provide
- If you are **specifically compensated** for providing that service

	Provide Service?		Specified in Written Agreement?		Specifically Compensated?	
	Yes	No	Yes	No or N/A	Yes	No or N/A
Hospital Epidemiology/ Infection Control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Employee/ Occupational Health Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patient Safety/ Healthcare Quality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antimicrobial management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bioterrorism/ Emergency preparedness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

15. Does this written agreement specify the amount of compensation derived from individual infection control activities?

- 1  Yes  
 2  No  
 3  N/A

16. Did you negotiate this compensation or other aspects of the position **before** beginning the position?

- 1  Yes  
 2  No  
 3  N/A

17. Please indicate approximately what percentage of your professional **income or compensation** derives from the following **sources**? *Sum of all rows should total to 100%.*

	% effort
Private/Group (clinical) medical practice	
Hospital/Medical Center	
Health care network/Health system	
University (excluding research grants)	
Research grants	
Government (Local, State/Province, Federal)	
Corporate (e.g. pharmaceutical company)	
Other (please describe): _____	
<b>TOTAL:</b>	100

***If you do not work in the US, please GO TO QUESTION 22.***

18 What is the range of your **current professional earnings**?

- 1  ≤ \$50,000  
 2  \$51,000 – 100,000  
 3  \$101,000 – 125,000  
 4  \$126,000 – 150,000  
 5  \$151,000 – 200,000  
 6  \$201,000 – 250,000  
 7  > \$250,000

19. Approximately what **proportion** of your **professional income or compensation** derives from the categories below? (*Percentages do not need to total 100%*).

	None	<25%	26-50%	51-75%	>75%	Unable to calculate
Clinical work (patient care)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Healthcare epidemiology/ Infection Control activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

20. Please indicate the approximate amount of your healthcare epidemiology/ infection control compensation per year:

- <sup>1</sup> <\$10,000
- <sup>2</sup> \$10,000-19,999
- <sup>3</sup> \$20,000-29,999
- <sup>4</sup> \$30,000-49,999
- <sup>5</sup> \$50,000-100,000
- <sup>6</sup> ≥\$100,000
- <sup>7</sup> N/A

21. If you are paid by the hour for healthcare epidemiology/ infection control services, please specify the hourly rate:

- |   |   |
|---|---|
| <input type="checkbox"/> <sup>1</sup> ≤\$100    | <input type="checkbox"/> <sup>5</sup> \$251-300 |
| <input type="checkbox"/> <sup>2</sup> \$101-150 | <input type="checkbox"/> <sup>6</sup> > \$300   |
| <input type="checkbox"/> <sup>3</sup> \$151-200 | <input type="checkbox"/> <sup>7</sup> N/A       |
| <input type="checkbox"/> <sup>4</sup> \$200-250 |   |

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**Infection Control Program: Resources & Infrastructure**  
**General:**

***If you do not perform infection control activities at your institution, GO TO END.***

22. Please indicate your role at your institution. Check all that apply:

- <sup>1</sup> Hospital epidemiologist
- <sup>2</sup> Associate hospital epidemiologist
- <sup>3</sup> Infection control practitioner (ICP)
- <sup>4</sup> Infection control manager (Lead ICP)
- <sup>5</sup> Director of Antimicrobial Management
- <sup>6</sup> Pharmacist
- <sup>7</sup> Microbiologist
- <sup>8</sup> Other (Please specify): \_\_\_\_\_

23. How many years experience have you been involved in the field of hospital epidemiology (post-fellowship for MDs)? \_\_\_\_\_

**Hospital Epidemiologist resources/ Infection Control Practitioner Responsibilities and Resources:**

***If you are not the hospital epidemiologist or lead ICP at your institution, GO TO END.***

24. How many physician FTEs are there in hospital epidemiology/ infection control at your institution?

\_\_\_\_\_

25. Please specify the time allotment and experience for each ICP at your institution:

	Time allotment (FTE)	Years experience		
		<5	5-9	≥10
ICP #1		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ICP #2		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ICP #3		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ICP #4		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ICP #5		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ICP #6		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ICP #7		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

26. Is call coverage provided 24 hrs/day, 7 days/week for hospital epidemiology?

- <sup>1</sup>  Yes  
<sup>2</sup>  No

27. Do you have an administrative assistant dedicated to infection control?

- <sup>1</sup>  Yes  
<sup>2</sup>  No

28. How many FTEs of administrative support do you have in your department? \_\_\_\_\_

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**You have now completed the SHEA Infection Control/ Healthcare Epidemiology Resources and Compensation survey.**

**Thank you for your time and participation.**

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**In order to avoid sending you reminders to complete this survey, please complete the information below. This section will be removed in the SHEA office before being passed on to the survey task force for analysis.**

**Email address:** \_\_\_\_\_

**OR**

**SHEA membership number:** \_\_\_\_\_

**Please fax to SHEA office at 703-684-1009 or mail to:  
The Society for Healthcare Epidemiology of America  
66 Canal Center Plaza, Suite 600  
Alexandria, VA 22314**