Testimony Re: HB 2295
House Health and Human Services Committee
Presented by Jeff Glasgow
February 18, 2019

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Chairperson Landwher and honorable members of House Health and Human Services Committee,

My name is Jeffery W. Glasgow CRNA MSN, I am providing written testimony on behalf of the Kansas Association of Nurse Anesthetists. I was the 62nd elected president of our association that was founded on October 16, 1940 which is a subcomponent society of the American Association of Nurse Anesthetists (AANA). Nurse anesthetists have been practicing in the United States for over 150 years.
I am a Topeka native in which I completed my bachelors of Registered Nursing (RN) training in the Spring of 1995 from Baker University and after four years of nursing experience specifically in an intensive care unit (ICU) at the formally St. Francis Hospital, I started my CRNA training at Kansas University Medical Center (KUMC) and completed in the Fall of 2001. I bring this to your attention because this is the similar career path that all CRNA's follow to become board certified in nurse anesthesia.

Kansas allows CRNA's to practice independently without physician supervision or anesthesiologist supervision and bill Medicare and subsidiaries of Medicaid independently. Today there are 16 states of New Hampshire, Kentucky, Iowa, Wisconsin, North Dakota, South Dakota, Minnesota, Nebraska, Montana, Idaho, New Mexico, Washington, California, Oregon and Alaska that practice independently. Currently in Kansas, **66** counties are "CRNA-Only" in which the CRNA is providing anesthesia and chronic pain management interventions without supervision of an anesthesiologist, surgeon or family practitioner. CRNAs are providing "Access to Care" opportunities to underserved populations in Kansas (Exhibit KANSAS ANESTHESIA PROVIDERS). There are **18** counties that utilize the anesthesiologist and

CRNA team approach. Most of the "CRNA only" counties are rural and the anesthesiologist/CRNA relationship is mostly urban. There are **zero** counties that are "Anesthesiologist-only" in Kansas. Kansas receives quality anesthesia care because just as an anesthesiologist's training involves medical school and residency, the CRNA had patient care experience prior to receiving CRNA training

I have had the opportunity to truly research, examine and "take myself out of the equation" or remove my bias opinion of CRNA vs AA because, I am a business owner. I employ over 13 full-time employees and work to continue growing our practice. My unbiased opinion is that I cannot support credentialing of AAs in Kansas for multiple reasons. The simplest reason is that it does not support economic growth of hospitals and it exposes increased liability and "risk exposure" to not only the surgeon but the hospitals as well. In times of disappearing reimbursement for services using an AA that is 100% dependent on an anesthesiologist in a supervisory role, who is also not providing direct patient care will put an economical strain on the hospital. When a guarantee of anesthesia services (salaries) are established between the hospital and the anesthesia group it is difficult for the hospital to pay for a third provider 100% reliant upon a supervising anesthesiologist. This impact is seen when the hospital wants to expand four (4) rooms, hiring four (4) CRNAs accomplishes the hospital's goal. Utilizing the AA model, the hospital would have to hire four (4) AAs and one (1) anesthesiologist.

Secondly, when we think "anesthesia" most people assimilate in their mind, the" What If something happens during surgery?" "What If," something were to happen during surgery with an AA and the supervising anesthesiologist was not able to make direct contact with the anesthesiologist or even another anesthesiologist was not able to make direct contact with the AA in a timely manner? The "What If" responsibility is shifted to the surgeon who presumes "Captain of the Ship" and the liability

and “risk exposure” is shifted not only to the surgeon but the hospital as well. Most importantly, what is the harm to the patient that could have been prevented?

One, the AA is are not recognized by the United States Military Medical Team. The AA has had 50 years to prove themselves as an anesthesia provider to service our active / retired members of families including children and the supporting nation’s citizens we occupy. If the AA cannot be an effective anesthesia provider to our military, they are not a proven provider to Kansans

Two, AA’s have been prohibited in the state of Louisiana. Louisiana declared, “CRNAs receive a much higher level of education and training than do AAs” Louisiana R.S. 37-930 (G) (1) (I). This statute states that “No health care provider or other person, other than a certified nurse anesthetist, physician, dentist, perfusionist, or other explicitly authorized provider, shall elect or administer any form of anesthetic to any person either directly or by delegation unless explicitly authorized by this title.”

Three, since 1995 there has been multiple failures of the AA bill in other states. States of Tennessee, Maryland, New Jersey, Utah, Nevada, New York, Oregon, California, Arkansas, Mississippi, and Montana have had failed AA legislation attempts. The state of New Mexico restricts the AA to practice in university hospital settings and attempts to remove the restriction has failed. There has not been any successful AA legislation in the United States since 2012.

Four, Kentucky requires that if an AA is to practice in the state, the AA must have dual certifications of both AA and Physician Assistant (PA). This demonstrates a similar track as the CRNA and MDA training with prior patient experience before starting an anesthesia career. Again, AA training does not require previous nursing or medical related board certifications prior to admission into an AA program. Both

nurses and physicians in anesthesia training programs have mastered the simple concepts of taking a blood pressure, interpreting an electrocardiogram, have Advanced Cardiac Life Support certifications (ACLS) and experience in in complex health conditions and medications associated to sustain life. The AA student can simply have a college degree without patient experience for admission into an AA program.

Five, the AA was established in the 1960's, but today in over 50 years there are an approximate 2,000 AA's that practice in only 14 states including the District of Columbia and Guam. There is currently 12 education programs for AA's in comparison to 120 CRNA programs that has yielded a workforce of over 50,000 CRNAs practicing in all 50 states. The ratio of CRNAs to AAs is a 25:1 ratio.

Six, in 50 years there has been no true, peer-reviewed studies in the scientific journals that have been published regarding the quality of care of AA or AA anesthesia outcomes until most recently. In contrast, the excellent safe anesthesia care that CRNAs provided and associated anesthesia outcomes have been repeatedly demonstrated in peer-reviewed studies published in prominent journals in the past 150 years.

Seven, AAs must be 100% supervised by an anesthesiologist only. The AA cannot be directed or guided by the surgeon. AAs are trained to be the assistant to the anesthesiologist only. The CRNA is trained to be an independent provider and functions as the independent provider in 65 counties in Kansas. In a real-time scenario, in which the anesthesiologist has 4 AAs they are 100% supervising, then the real-time supervising anesthesiologist attention is 25% per AA. The time of decision to contact the anesthesiologist to the time actual intervention can be delayed due to other anesthesiologist's responsibilities of not only the other AAs of supervision but also real-time situations inside and outside

the operating room environment. The true component or situation when life or death decisions are required, the operating room surgeon will be forced to step in until the anesthesiologist becomes available. This situation very likely cause harm to the patient.

Eight, Kansas has over 800,000 Medicare and Medicaid recipients by report of the Henry J. Kaiser Family Foundation. In May 2013, the Center for Medicare Services (CMS) clarified and confirmed that AAs are prohibited from billing Medicare for non-medically directed services. CRNAs are authorized to bill Medicare for non-medically directed services. CMS recognizes that the CRNA and AA educational preparation and services are not the same.

Nine, the anesthesiologist/AA scenario is the most expensive anesthesia healthcare delivery model to any hospital. An anesthesiologist does not have to supervise the Kansas CRNA. In fact, four CRNAs can be performing anesthesia in separate rooms while an anesthesiologist performs anesthesia services independently in another operating room. If there are limited anesthesiologists unavailable, emergency cases are placed in time sensitive jeopardy until an anesthesiologist is available.

Ten, AAs are not the answer to fabricated anesthesia provider shortage in the state of Kansas or in the nation. CRNAs and AAs are not interchangeable. There is no statistical data that supports an "Anesthesia Shortage." Using a national job posting such as GasWork.com for anesthesia providers does not give an accurate picture of a "shortage." The applicants cannot provide statistical research data to support the "shortage." AAs cannot work in rural Kansas without an anesthesiologist. Telemedicine of Kansas has ruled out that both surgeons and anesthesia providers are excluded as providers in the components of telemedicine. Likewise, the AA does not provide the answer to Kansas's "Access to Care." AAs have a small potential of servicing the 18 counties with an anesthesiologist. Primarily,

when the duty of providing "Call Coverage" would exclude the AA, because the anesthesiologist would have to be "On-call" as well. Small hospitals cannot afford both an anesthesiologist and an AA.

On October 18t, 2017 the Commonwealth of Virginia, Board of Health Professions went through a credentialing process similar to what you are doing today. Their findings of why credentialing was not approved were noted as the following (Exhibit COMMONWEALTH OF VIRGINA).

- There is a lack of proof that there is a statewide shortage of anesthesia providers.
- AA students would increase competition for already training sites and slots needed by Virginia's Anesthesiologist and Nurse Anesthetists students.
- Certified Anesthesiologist Assistants (CAA) cannot practice independently but with only direct, on-site, supervision that is restricted to Anesthesiologist and no other physician or anesthesia care providers.
- CAA practice was thought to be unlikely to locate in underserved or rural areas.
- The Board of Medicine workloads would increase to accommodate in establishing an entirely new set of regulations and administration of the licensure program.

The Commonwealth of Virginia simply stated there was not a shortage in Virginia or in the nation. There is not an anesthesia shortage in Kansas.

The state of Kansas should not be responsible for staffing issues in localized urban regions of Kansas. It is the anesthesia group's responsibility to provide anesthesia coverage to their hospitals or facilities. Many reasons why both anesthesiologists and CRNAs leave a hospital or group cannot be controlled. Initializing an AA will not provide a solution, it will become another problem that in a "Millennial" generation does not discriminate by region, education but quality of life. Just because an AA would be

hired to a region that prominently struggles for anesthesia coverage does not mean the AA permanent solution.

Eleven, keeping the state of Kansas free from AA credentialing or legislation provides a more optimistic outlook towards recruitment of future CRNAs and anesthesiologists to Kansas. The Kansas Healthcare Stabilization Fund supplements malpractice coverage, making premiums low. Unfortunately, the AA is not perceived well by many CRNAs and some anesthesiologists. It cannot be assumed that CRNA will leave their urban community because of the AA and relocate to a rural community.

Twelve, as a committee you are evaluating criteria. As stated previously, other technical committees and legislative committees of the United States Military and other states have declined the utilization of the AA. Potential harm to patients has been discussed in regards to education requirements prior to anesthesia training. Both anesthesiologist and CRNA programs require extensive previous medical/nursing education, training and experience in complicated health conditions to be accepted into an anesthesia program. The AA training does not require these components prior to acceptance. Standardized testing or acceptance examinations does not provide patient experience.

Thirteen, the cost of the AA in Kansas will impact not only the state of Kansas in regards to expanding the Kansas Board of Healing Arts (BOHA) but to Kansas hospitals as well. Even with membership renewal costs for budgeted BOHA, a new provider will increase staff for investigation, discipline and administrative components on an unproven anesthesia provider that has not been successfully adopted in all 50 states. Most Kansas hospitals provide a security of financial guarantee to maintain anesthesia groups. Meaning, if a group of surgeons or specialists unexpectedly leave the hospital and there are less operating room cases to be performed, the anesthesia group would typically suffer financially during the

recruitment process of future surgeons or specialists. The anesthesiologist/AA concept, will cost the hospital twice the amount of basic anesthesia coverage. The anesthesiologist/CRNA would be able to maintain anesthesia coverage in the event an MDA leaves the hospital.

In the year 2000, Hutchinson, Kansas had a similar situation with their hospital. A terminal relationship occurred in which the anesthesiologists were removed from the hospital. The CRNAs of the anesthesia group were retained and the hospital was able to maintain the operating room production. In this same scenario, if it was an anesthesiologist/AA scenario, the hospital would have not been able to maintain their operating room to their Hutchinson community.

Fourteen, harm to our education centers in Kansas has directly described by the Commonwealth of Virginia. Missouri utilizes the AA for the anesthesia care team. This issue NOW impacts the KUMC NAD in regards to educating future CRNAs in Kansas. The SRNA cannot be trained by an AA (non-interchangeable), only a CRNA or anesthesiologist. SRNAs are limited on the amount what once was flourished pediatric opportunities to minimal exposure to complex pediatric cases. The KUMC NAD now looks beyond the boundaries of Kansas City to remote locations of Oklahoma, Nebraska, rural Kansas and Missouri for basic pediatric cases. If the AA was allowed to work in Kansas, a large anesthesia group would utilize the AA and the SRNA would again be limited to patient exposure in the Greater Kansas City area since the large group provides anesthesia coverage in all Greater Kansas City Area excluding Shawnee Mission Health Center. The current expectancy of the KUMC NAD SRNA is to travel over 7 months outside of KUMC for basic training. Currently, KUMC NAD has 18 locations outside of KUMC for adequate training experiences. Utilizing the AA would cause an increase the locations for the KUMC NAD. This is an increased cost and administration to the KUMC NAD and to the student as well.

Further harm to our education centers will be shown to the future training and retention of the SRNA. Currently both Newman University School of Nurse Anesthesia (NUSNA) and KUMC NAD has shown in the past 5 years a successful program of recruiting SRNAs from Kansas and non-residents of Kansas. All programs have also shown the retention of the SRNA/CRNA to stay in Kansas. When nurse anesthesia departments have to look outside Kansas for educational opportunities, Kansas takes on the risk of losing the CRNA to another state.

Fifteen, there exists potential total monopolization of anesthesia in Greater Kansas City. Currently a group known as Anesthesia Associates of Kansas City (AAKC) has taken over most Greater Kansas City hospitals excluding Shawnee Mission Health Center (SMHC) and KUMC. The long-term potential is utilizing the AA is to urban areas while excluding the CRNA to only the rural populations. We simply cannot assume that AA will provide "Access to Care" to our rural populations by pushing the CRNA out. Thriving healthcare community requires an abundant resource of nursing workforce. Rural populations have been affected when nursing workforce declines. "Millennial" generations choose the region of their choice that is not forced. By "pushing" the urban CRNA out of Kansas City, Topeka, Wichita, and Salina will not secure the "Access to Care" guarantee to our rural communities, it will push the urban CRNA to another state that does not have the AA in those urban state populations.

Sincerely,

Jeffery W. Glasgow CRNA MSN

KANA President 2018