Testimony in Opposition to HB 4108

Before the House Committee on Health Care

February 5, 2016
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Oregon Association of Nurse Anesthetists

Chair Greenlick and Members of the House Health Care Committee:

My name is Michael Wray, and I am Certified Registered Nurse Anesthetist (CRNA) and the small business owner of Praestantia Associates, LLC, which hires both physician anesthesiologists and CRNAs to work in hospitals, ambulatory surgery centers, and physician offices. I am also on the Board of Directors for Oregon Association of Nurse Anesthetists (ORANA), the professional organization for CRNAs residing or practicing in Oregon. Thank you for the opportunity to appear before the committee and speak in opposition to House Bill (HB) 4108. If approved, this bill would recognize a new type of anesthesia provider called an anesthesiologist assistant, or AA. For over 100 years, CRNAs have been safely providing anesthesia care in Oregon, and I can assure you that there is no workforce need for AAs in Oregon. ORANA asks for your opposition to HB 4108.

CRNAs are far better qualified to provide quality anesthesia services than AAs. By way of background, becoming a CRNA requires licensure as a Registered Nurse, at least one year of acute care experience as a Registered Nurse, for example in an intensive care unit, followed by the completion of an accredited Master level nurse anesthesia education degree program and successfully pass a national certification examination. CRNAs are trained and educated to deliver anesthesia care regardless of anesthesiologist involvement and have been proven to be safe and cost-effective anesthesia providers.

There are currently no workforce issues for anesthesia-related services in Oregon. There are over 650 licensed CRNAs, 350 of which are practicing primarily in Oregon. In fact, 40% of CRNAs who have graduated from OHSU's Nurse Anesthesia Program in the past 3 years have left Oregon to find employment elsewhere. As a business owner, I typically have 10 to 20 applicants for every open position and have the luxury of choosing the most qualified and experienced CRNA from a large pool of applicants. Based on my personal experience, there is clearly no shortage of providers.

In previous legislative sessions, this committee has seen two similar AA bills: HB 2295 in the 2015, and SB 630 in the 2013. I have taken the opportunity to compile letters from the following constituents who have previously opposed the licensure of AAs: Mary Karlet, the Program Director for the OHSU Nurse Anesthesia Program; several physicians including anesthesiologists and gastroenterologists; the Oregon Board of Nursing; Oregon Nurses Association; ORANA; and several individual CRNAs. Because HB 4108 is very similar to the previous proposed AA bills, the reasons to oppose the licensure of AAs have remained virtually unchanged.

As explained in more detail below, there are three reasons why ORANA is opposed to the AA bill: 1) AAs do not increase access to care in Oregon, 2) AAs create a negative economic impact, and 3) AAs have limited education scope and practice.

ACCESS TO CARE IN OREGON

CRNAs provide anesthesia care anywhere it is needed in both rural and urban settings. CRNAs practice in every setting, including hospital surgical suites and obstetrical delivery rooms, critical access hospitals, ambulatory surgical centers; the offices of dentists, podiatrists, ophthalmologists, plastic surgeons and other medical professionals, and U.S. Military and Veterans Administration healthcare facilities.

- **AA's LIMITED UTILIZATION:** Because AAs cannot practice without anesthesiologist supervision, AAs do not practice in rural areas where CRNAs working without anesthesiologist involvement are the primary providers of anesthesia care. The AA model's focus, i.e. on only practicing where anesthesiologists practice, greatly limits their utilization. Thus, AAs cannot help solve problems of inadequate access to anesthesia care in rural and underserved communities.
- **FAILURE TO MEET DEMAND:** If for any reason an AA's supervising anesthesiologist is not available, the AA may not provide anesthesia care. The inflexible AA/anesthesiologist-driven mode of practice thus fails to adequately meet the needs of patients and healthcare providers.
- **NO PROVEN OUTCOME DATA:** There are no peer-reviewed studies published in scientific journals regarding the quality of care of AA practice or AA anesthesia outcomes. AAs are explicitly recognized in state laws or regulations in only 13 states and the District of Columbia. Louisiana actually passed legislation that has the effect of prohibiting AA practice, declaring that "CRNAs receive a much higher level of education and training than do AAs.

ECONOMIC IMPACT:

Independent studies have shown that CRNAs acting as the sole anesthesia provider is the most cost-effective model for anesthesia delivery. This model is used in many of our hospitals in rural communities and in our top rated critical access hospitals in Oregon. The second-most cost effective model is the CRNA/anesthesiology care team model, which is similar to the well-established models used at Kaiser, OHSU and Legacy Good Samaritan Medical Center.

- **COSTLY MODEL OF CARE:** With an AA model, two healthcare providers (a supervising anesthesiologist and an AA) must be utilized to provide anesthesia care to one patient
- **DIFFICULTY WITH ANESTHESIOLOGIST SUPERVISON:** AAs must be supervised by anesthesiologists. The Society of Anesthesiology reports that even with an appropriate ratio of anesthesiologists to providers, lapses of supervision during critical portions of anesthetic cases would occur. In a review of one year of data from a tertiary hospital, supervision lapses occurred commonly during first-case starts even with a 1:2 supervision ratio.

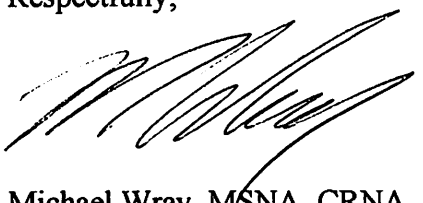
EDUCATION / SCOPE OF PRACTICE:

CRNAs are trained and educated to deliver anesthesia care regardless of anesthesiologist involvement. CRNAs are qualified to make independent judgments regarding all aspects of anesthesia care, based on their education, licensure, and certification. CRNAs have experience as critical care nurses and can assess and treat a broad range of health problems before even beginning anesthesia training.

- **AA's HAVE LIMITED SCOPE OF PRACTICE:** AAs administer anesthesia solely under the medical direction of anesthesiologists. AAs thus have a much more limited scope of practice than CRNAs. AAs are NOT physician assistants (PAs).
- **AA's ARE NOT A FULL SERVICE ANESTHESIA PROVIDER:** The AA program curriculum trains AAs only to assist anesthesiologists in technical functions. One of the largest AA programs (at Emory University) does not even provide clinical instruction in the administration of nerve blocks and spinal/epidural anesthesia.
- **AA's LACK HEALTH CARE EXPERIENCE:** AAs are not required to have any prior healthcare education or experience (e.g., nursing, medical, anesthesia or healthcare education, licensure, or certification) before they begin their AA educational programs.

The healthcare landscape in the United States is changing, and professionals whose services result in cost-effective, high quality, safe outcomes will be needed more than ever. CRNAs play a critical role in meeting that challenge by providing safe and high quality anesthesia care in a cost-effective manner. I strongly urge you to oppose HB 4108 as it will have a negative impact on the cost, access and quality of healthcare to Oregonians.

Respectfully,



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