Testimony Presented by
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Pennsylvania Association of Nurse Anesthetists
before the
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The Pennsylvania Association of Nurse Anesthetists, which represents more than 4,000 certified registered nurse anesthetists (CRNAs) and student registered nurse anesthetists (SRNAs) across the Commonwealth, respectfully requests that you oppose HB 1956 which proposes to license anesthesiologist assistants (AAs) for the first time in Pennsylvania. Healthcare legislation should aim to improve patient care, enhance patient safety, increase medical access and control healthcare costs – licensing AAs is detrimental to these goals.

CRNAs and physician anesthesiologists have a long-proven history of providing safe anesthesia services to Pennsylvania residents. For the past two decades, the mortality rate attributed to anesthesia has precipitously fallen as a direct result of these already proven, highly trained, educated, and clinically experienced providers.

CRNAs are anesthesia experts independently licensed to practice in all 50 states and the District of Columbia. Because of our extensive education and training, CRNAs are permitted by the federal and state legislation and regulations to provide every type of anesthesia service to patients with or without physician anesthesiologists. As anesthesia experts, CRNAs practice as the hands-on providers in all anesthetizing locations including: hospitals, ambulatory surgical centers, and offices throughout the commonwealth.

The same cannot be said for AAs. In contrast to CRNAs, AAs are only permitted to practice in 14 states, plus the District of Columbia, and there are only 12 accredited programs. They are significantly limited by their training and licensure to provide only clinical support as an assistant to physician anesthesiologists. This point is directly made by the American Society of Anesthesiologists (ASA) in their position statement regarding AA practice: “Thus by history, tradition, philosophy of education and personal preference, the anesthesiologist assistant is trained to work within the ACT under the supervision of a physician anesthesiologist,” where ACT stands for “anesthesia care team.” AAs are not required to have any healthcare experience or education prior to anesthesiologist assistant school. As such, they are trained as dependent providers that are not licensed to make critical decisions regarding patient care, even when emergencies arise and seconds count.

Due to the direct supervision requirement for AAs, the AA/physician anesthesiologist model creates a provider redundancy that is one of the costliest anesthesia delivery models with no generalizable scientific evidence of patient safety. These increased healthcare costs will be absorbed by our facilities through increased anesthesia subsidies or by patients and Pennsylvania residents. At a time when our healthcare systems are straining to provide cost-efficient care to their communities, it is unwise to introduce an unproven and inflexible anesthesia provider to a system that is already struggling to contain costs.

It is also important to understand that AAs do not improve access to care because of their reliance on an anesthesiologist's supervision. CRNAs remain the primary and often solo provider of anesthesia care in rural America. Without CRNAs, many facilities would not be able to maintain obstetrical, surgical, pain management or trauma stabilization services for their communities. In fact, 72% of Pennsylvania counties are rural, making PA the third largest rural population in the United States. In most instances, CRNAs are already providing anesthesia services in those communities without any involvement of a physician anesthesiologist – making it impossible for AAs to alleviate any anesthesia provider deficiencies in those parts of our state which need it most. Due to the shortage of autonomous hands-on anesthesia providers across the country, requiring an anesthesiologist to closely supervise lesser-trained and inexperienced AAs, only adds more strain to our healthcare system.

Both CRNAs and physician anesthesiologists have a vast body of peer-reviewed evidence proving their quality and safety in providing anesthesia services. National studies have demonstrated time and again that the administration of anesthesia is equally safe when administered by a CRNA or an anesthesiologist. The National Practitioner Data Bank (NPDB) is a database that tracks actions taken regarding a health care practitioner as it pertains to medical malpractice and adverse action reports. Both CRNAs and physician anesthesiologists are clearly tracked through the NPDB. However, it is not clear how complaints against AAs are tracked because they work under the supervision and liability of anesthesiologists. According to the NPDB, AAs *may* appear in "other" categories in which multiple unclassified practitioners are lumped together. This exemplifies the challenges of tracking AA adverse events, negative patient outcomes, and malpractice payments.

The Centers for Medicare and Medicaid Services (CMS) also recognizes the difference in prior healthcare experience, education, and training between a CRNA and an AA. CMS recently clarified and confirmed their position that CRNAs may practice autonomously and independent of a physician anesthesiologist and bill directly for those services. AAs, however, must be medically directed by an anesthesiologist to bill Medicare. Over the past ten years in Pennsylvania, an analysis of CMS billing modifiers proves that anesthesia groups and facilities are moving away from the medical direction model for billing. This model requires that an AA be directed by an anesthesiologist, and it represents a regression to a system of increased cost and decreased flexibility in the delivery of anesthesia care in Pennsylvania. Instead, Pennsylvania anesthesia models are trending towards either a collaborative anesthesia model or a model that utilizes CRNAs practicing autonomously – neither meet the legal requirement for AAs.

AAs simply do not have a broad foundation to fall back on when patient conditions become critical. When life or death decisions are required, AAs rely on physician anesthesiologists to direct them, and in many instances, the anesthesiologist may not be immediately available. This cultivates algorithmic decision-making and will delay decisions on patient care and treatment when time is most critical. In fact, a 2012 study by Epstein published in *Anesthesiology* proved that there is an alarmingly high rate of lapse in anesthesiologist direction during critical portions of an anesthetic. The study showed that an anesthesiologist is available 65% of the time when they are medically directing up to two anesthesia providers and only 1% of the time when medically directing three providers. This means that if AAs are authorized to practice in PA, then we are setting our healthcare practitioners, our facilities and most importantly, our patients up for a system and model that has already been proven to fail.

If AAs want to practice in Pennsylvania, there is currently an approved bridge program to combine some of the hands-on knowledge gained in AA practice with the high standards currently in place for all CRNAs. For our Commonwealth to maintain the highest level of anesthesia care safety, this inclusive program provides AAs with the additional education and training necessary to bridge the gap in training between AAs and CRNAs. CRNAs adhere to an uncompromising standard of education, training, and experience to deliver the highest level of safe anesthesia care for Pennsylvanians. Even though AAs receive hands-on experience in assisting an anesthesiologist, this bridge program is necessary to close the knowledge and competency gaps from an assistant requiring continuous direction and supervision to a CRNA.

Our great state must support its existing, high quality nurse anesthesia programs and physician residencies. Pennsylvania already has over 5,500 proven anesthesia professionals – we need to focus on reducing unnecessary barriers to CRNA practice and optimizing the number of physician anesthesiologists that provide hands-on anesthesia care rather than regressing to a more expensive, unproven model for anesthesia deliver.

We request that you oppose HB 1956, and instead, PANA stands ready to work with all stakeholders to design policies which improve healthcare in Pennsylvania.