House Professional Licensure Committee Hearing
H.B 1956 Certified Anesthesiologist Assistants (CAA)
April 25th, 2022
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My name is Christopher Heiss and I'm a Certified Registered Nurse Anesthetist (CRNA) representing the Pennsylvania Association of Nurse Anesthetists (PANA) and 4,000 CRNAs across the Commonwealth. I am here today to give testimony on our opposition of H.B 1956 and the introduction of Certified Anesthesiologist Assistants (CAAs) into Pennsylvania law. As a practicing anesthesia provider, I hope that I can paint a real-world illustration to justify my concern for this Bill and the restrictions on access to care and financial burden it poses for our patients and hospitals across rural Pennsylvania.

Introduction:

I'm a CRNA practicing in multiple locations and hospitals throughout Pennsylvania. These range from large tertiary care facilities to rural critical access hospitals. Additionally, I serve as one of two Pennsylvania CRNAs appointed to the National Disaster Medical System (NDMS) Trauma Critical Care Team, an international field surgery team under the U.S Department of Health & Human Services. We are deployed to render lifesaving care during disasters and terrorist attacks involving U.S citizens and diplomats. We are subjected to austere environments, collapsed hospital infrastructures, and little to no resources within the first 72 hours of a catastrophic event. We can be hundreds, if not thousands, of miles away from advanced tertiary settings, and thus, must function independent of an anesthesiologist and with a full scope of practice necessary to complete our mission. This format mimics the U.S military forward surgical teams, utilized heavily in Operations Iraqi and Enduring Freedom, where a CRNA is independent of anesthesiologist while providing life sustaining care to wounded patients on the frontlines. Because of the independent nature of these roles, CAAs are not, nor have ever been, recognized by a U.S Health & Human Services disaster team or branch of the U.S military.

Practice Models:

In each of my roles, depending on the setting, I work with or without an anesthesiologist. For instance, in a large tertiary care facility, I collaborate with an anesthesiologist as a team during open heart surgery, major trauma, and other complex procedures. Conversely, in rural communities and critical access hospitals, I provide highly autonomous anesthesia care in cooperation with a surgeon or proceduralist – without an anesthesiologist. This affords the CRNA the ability to practice dynamically in virtually any setting and at a moment's notice, while providing the hospital a choice in how they wish to implement anesthesia services. A CAA cannot practice under this model. Employing both an anesthesiologist and CAA in rural critical access hospitals would be far too costly to continue surgical or procedural services in geographically isolated regions of Pennsylvania.

Scope of Practice:

A CRNA can practice in conjunction with a surgeon or proceduralist, and it is done so by many critical access, ambulatory surgery centers, and rural hospitals throughout Pennsylvania.

It's important to highlight my scope of practice as a highly autonomous CRNA without an in-house anesthesiologist. This includes the placement and management of epidural catheters for labor pain relief in obstetric patients; providing immediate anesthesia care during the critical beginning phase of an emergency caesarean section (c-section); and performing resuscitation to newborns in distress. I respond to in-house emergencies, including patients suffering from cardiopulmonary arrest, wherein it is my responsibility to place an endotracheal (breathing) tube, manage their breathing/ventilation, and administration of lifesaving medications. I am also consulted for obtaining intravenous access on patients where advanced measures are required. I perform all of this without an anesthesiologist present. A CAA does not possess this ability, as an anesthesiologist would need to be in-house 24/7. For a rural facility, cost would exceed the benefit and pose a threat to patient access to care when operations become too costly for the health system.

Closing:

I have the privilege of observing an impeccable working relationship between CRNAs and anesthesiologists. Amidst the COVID-19 pandemic and surging healthcare costs, focus must be placed on an unimpeded scope of practice of existing healthcare providers to ensure patient access to care, all while placing safety at the forefront. It must be called into question the addition of a third anesthesia provider, which offers little to no expansion of access to care, healthcare cost savings, or proven safety metrics. As I've highlighted, there are opportunities for CRNAs and anesthesiologists to collaborate and ensure quality, affordable care to Pennsylvanians. I hope that my testimony and opposition will attest our commitment to work together for a common solution by maximizing the relationship between CRNAs and anesthesiologists alike, and without the addition of CAAs. This would certainly bring unnecessary division during a critical point in our healthcare delivery system.

Thank you.

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