

Senate Public Health and Welfare Committee
Testimony Re: SB 223
Presented by Dr. Juan Quintana
March 18, 2019

Mr. Chairman and honorable members of the committee,

Re: Opponent of SB 223 licensure of AAs in Kansas.

The healthcare landscape in the United States is changing, and professionals whose services result in cost-effective, efficient, high-quality, safe outcomes will be needed more than ever. Today, a large segment of our population is moving into retirement. It is estimated that currently, Medicare enrollees approximate 42 million and that by 2030, they will increase to 80 million. These folks will need more care and more access to quality safe cost-effective services. Nurse Anesthetists and Anesthesiologists play a critical role in meeting that challenge by providing PROVEN safe, quality anesthesia care efficiently at a cost that ensures access to anesthesia for millions of Americans.

My name is Dr. Juan F. Quintana, DNP, MHS, CRNA, and I come before you today as a former President for the American Association of Nurse Anesthetists, speaking against the credentialing of AAs to practice in Kansas. I am humbled to appear before you to bring a national perspective and a little of our experience in Texas. I come to you with 21 years of practice as a CRNA, a veteran and a business owner. In Gallop polls, nursing has been voted the most honest and ethical healthcare profession 16 years running.

I'd like to start by framing this from an historical perspective on the education of anesthesia providers. CRNAs are first RNs with a bachelor's degree and an average 3 years of ICU experience BEFORE matriculating into a nurse anesthesia program which results in approximately 6 years of nursing experience, 3 years anesthesia specific. Anesthesiologists must have completed their 4 year MD degree BEFORE entering their residency programs which results in a 3-4 year anesthesia specific education. Prior to ever putting hands on a patient from an anesthesia perspective, both have years of hands on experience working with patients. AAs are not PAs. The education of AAs requires no prior hands on experience with patients. And yet, within 24 months, they can begin administering medications that make patients, including your parents and children, unconscious and stop your breathing. In fact, they can take their accreditation test after 18 months of education. (Exhibit 1)

Perhaps, I would feel better, if I had well-documented, reasonable peer reviewed evidence to support AA utilization, but I don't. Both CRNAs and Anesthesiologists have a peer reviewed body of evidence proving their quality and safety in the provision of anesthesia services. Studies by nationally respected researchers time and again have shown that the administration of anesthesia services is equally safe when administered by CRNAs or anesthesiologists (see references).

Kansas has personal experience in the safety of CRNAs - for the last 15 years, CRNAs have been the solo providers of anesthesia services in 65 counties with excellent results. In fact, data obtained from CMS regarding the billing of anesthesia services by CRNAs in Kansas indicates that approximately 53% of all anesthesia is done by CRNAs alone (QZ modifier), and another 17% is done with anesthesiologists (QK modifier), meaning at least 70% of all anesthesia in Kansas is done with CRNAs. This point is **critical** since it's clear that CRNAs provide quality, safety and access to services in a cost-effective manner that no other provider brings to the table and that interference with the ability of Kansas to obtain and maintain CRNA services can be critical, in fact **harmful to the public** in the ability to provide surgical services. This trend has been consistent for over a decade. (Exhibit s 2-3)

The military uses CRNAs in FST on the front lines of conflict, they use Anesthesiologists in field hospitals, but they don't use AAs. The ability of each anesthesia provider to administer quality, safe anesthesia without need of additional oversight expands access to anesthesia services.

Access to services **directly impacts** the Kansas citizens. Any reduction in available proven resources harms the public. AAs don't increase access to services due to their reliance on anesthesiologist's supervision. The education of AAs therefore reduces the valuable clinical educational slots needed to support the PROVEN providers of anesthesia services. A recent studyⁱ published in the September/October 2015 Nursing Economic\$ found that CRNAs are providing the majority of anesthesia care in U.S. counties with lower-income populations and populations that are more likely to be uninsured or unemployed. Access to services is imperative. Valuable, yet limited, Kansas resources should be optimized to achieve the goal of providing outstanding care from proven providers.

Speaking of resources, I have mentioned several times about the need for quality, safe, accessible, cost-effective anesthesia services. This brings me to another problem with utilization of AAs in the workplace. Anesthesiologists have indicated that AAs must work under direct medical direction. Medical direction is an anesthesia practice model term which means that one anesthesiologist works directly with 2-4 AAs.

Of course, given the educational history of AAs (Exhibit 1), their lack of experience prior to entering anesthesia programs, and the glaring lack of evidence to prove their quality and safety, one would hope anesthesiologists could guarantee us all that they would be immediately available to assist these folks as they move our parents and children into unconsciousness and stop their breathing during anesthesia, but they don't. Epstein and Dexter, two anesthesiologists, proved in a simple study that we can safely expect the anesthesiologist to be available to the AA, 65% of the time if they are 1:2 ratio and 1% of the time if they are 1:3 ratio. A 65 is a failing grade where I come from.

Hospitals are adversely affected by the use of AAs in the workplace through cost and potential fraud. The medical direction model of anesthesia services is one of the

costliest and by far the most inefficient (Exhibit 2). AAs are tied to having an anesthesiologist available and rightly so. However, this means each anesthetic has to be administered by two providers. This adds additional costs to the facility. Usually, CRNAs and Anesthesiologists administer anesthesia without need of two providers. Hospitals using medical direction practice model are trapped into spending millions of dollars to sustain this practice model. If a facility had, for example, 12 anesthetizing locations, the base staffing model 2 AAs /1 MDA would be 12 AAs and 6 MDAs. The base cost of using this model would be a minimum of \$4.52M and, given the fact that, according to Epstein, the medical direction model would fail 65% of the time, the exposure to fraudulent billing would be frightening (Exhibit 3). This flies in the face of the impact on healthcare costs: In addition, workforce studies have shown that academic facilities using medical direction models, on average, subsidized anesthesiologists over \$130,000 per anesthesiologist in order to sustain this model of practice. In other words, 10 anesthesiologists with AAs results in \$1.3M dollars coming out of the facilities pocket to support the anesthesia department. Instead of hospital wide efforts to improve quality and safety of patients, the money goes to the anesthesia department. Imagine, given this simple example, putting \$1.3M dollars **back** in the pockets of hospitals. All this at a time when revenue is declining, and the number of Medicare recipients is doubling in healthcare.

Relating to healthcare costs, I provide the following information. 3 Studies, 2 from the Lewin Group and one from the Research Triangle Institute, starting in 2010 and the last in 2016 found; A CRNA acting as the sole anesthesia provider is the most cost-effective model of anesthesia delivery (Lewin 2010), noted that there are no differences in patient outcomes when anesthesia services are provided by CRNAs, physician anesthesiologists, or CRNAs supervised by physicians (RTI 2010), and noted when CRNA practice to their full authority, there was no measurable impact on anesthesia-related complications (2016). The results show that CRNAs acting as the sole anesthesia provider cost 25 percent less. The results of the Lewin study are particularly compelling for people living in rural and other areas of the United States where anesthesiologists often choose not to practice for economic reasons. Kansas has had it right all along!

AAs cannot be flexible and meet the growing needs of the facility. Anesthesiologists do not meet the TEFRA rules required under Medicare rules to appropriately run Medical Direction models of practice, resulting in fraud. Today, anesthesia practice models are changing with an increased focus on quality, safety, inefficiency, access and cost-effectiveness. CRNAs and anesthesiologists working together can effectively bring all this and more to facilities (Exhibit 4). Perhaps if AAs could be used in a more flexible manner or brought a large measure of cost reduction to the system, we could work to mitigate their lack of education, lack of evidence of quality and safety and potential fraud, but they don't.

Finally, the AAs serves only to amplify the billing possibilities of anesthesiologists. The anesthesiologists can bill up to 200% of what they can bill if they personally performed the anesthesia.

In summation:

Perhaps, I would feel better if I had well documented reasonable peer reviewed evidence to support AA utilization, **but I don't.**

The military uses CRNAS in FST on the front lines of conflict, they use Anesthesiologists in field hospitals, **but they don't use AAs.**

Valuable, yet limited, Kansas resources should be optimized to achieve the goal of providing outstanding care from proven providers.

One would hope that anesthesiologists could guarantee to be immediately available in the operating arena when our parents and children are put into unconscious states **but they won't.**

Thank you,

Dr. Juan F. Quintana DNP, MHS, CRNA

Additional research sources:

A 2008 study titled, "Anesthesia Provider Model, Hospital Resources, and Maternal Outcomes." That study, led by Drs. Jack Needleman, PhD, MS and Ann Minnick, PhD, RN, FAAN, concluded that obstetrical anesthesia is equally safe in hospitals that use only CRNAs or a combination of CRNAs and anesthesiologists, compared with hospitals that use only anesthesiologists.

A 2007 study titled, "Anesthesia Staffing and Anesthetic Complications During Cesarean Delivery." That study, led by Daniel Simonson, CRNA, MHPA, concluded there is no difference in complication rates or mortality rates between hospitals that use only CRNAs compared with hospitals that use only anesthesiologists.

A 2003 study titled, "Surgical Mortality and Type of Anesthesia Provider." The study, led by Dr. Michael Pine, a board-certified cardiologist, concluded that patients are just as safe receiving their anesthesia care from CRNAs or anesthesiologists working individually as from CRNAs and anesthesiologists working together.

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Pine, M, Holt, KD, Lou, YB. "Surgical Mortality and Type of Anesthesia Provider." *AANA Journal.* 2003; 71:109-116.

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Medicare Part B Carrier Summary Data Files

<https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Part-B-Carrier-Summary-Data-File/Overview.html>
