Approved: 2-22-95
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Chair Sandy Praeger at 10:00 a.m. on February 14, 1995 in Room 526-S of the Capitol.

All members were present except:

Committee staff present: Emalene Correll, Legislative Research Department
Bill Wolff, Legislative Research Department
Norman Furse, Revisor of Statutes
Jo Ann Bunten, Committee Secretary

Conferees appearing before the committee:

Patsy L. Johnson, Executive Administrator, Kansas State Board of Nursing
Joseph P. Conroy, Certified Registered Nurse Anesthetist, Emporia
Chip Wheelen, Director of Public Affairs, Kansas Medical Society
Gregory K. Unruh, M.D., President, Kansas Society of Anesthesiologists
Larry Buening, Executive Director, Kansas Board of Healing Arts
Steve Clifton, President, Kansas Association of Nurse Anesthetists
Terri Roberts, Executive Director, Kansas State Nurses Association

Others attending: See attached list

The Chair announced that the minutes of February 7, 8 and 9, 1995 were distributed to the Committee for review.

Hearing on SB 152 - Registered nurse anesthetists licensure

Patsy Johnson, KSBN, addressed the Committee in support of **SB 152** and noted that most of the changes in the RNA statutes are merely an update, and that the most significant change was to add a decision to the RNA's scope of practice regarding what medications to utilize during surgical procedures. (Attachment 1)

During Committee discussion a member questioned if all HMO contracts require an anesthesiologist to be in attendance during surgery. Ms. Johnson commented that in some instances there are no anesthesiologists present, and the credentials of the individuals are their main concern. Staff questioned how the education requirements that would mandate a masters degree effect an individual from out-of-state who is not graduated from an accredited school, and it was noted by Ms. Johnson that the American Association of Nurse Anesthetists standards meet Kansas requirements. All of the graduates who come from other states that want to be certified by AANA have to come out of an accredited program. Staff called attention to a need for language change regarding persons engaged in administration of general or regional anesthesia without being authorized by the board to practice as a registered nurse anesthetist being guilty of a class A misdemeanor.

Joseph Conroy, Kansas Association of Nurse Anesthetists, addressed the Committee and outlined his support for changes in **SB 152** that would include a definition of active practice, a refresher course requirement if inactive for more than five years, and modifications in the authorization language. (Attachment 2)

Chip Wheelen, KMS, appeared in opposition to Sec. 5 of **SB 152** that would authorize CRNAs to practice anesthesia independent of any physician involvement. A balloon of the bill was submitted showing deletion of that section. (Attachment 3)

Gregory K. Unruh, M.D., testified in opposition to changes in **SB 152** which would remove the requirement that each registered nurse anesthetist be authorized to develop an anesthesia care plan with the physician or dentist which includes procedures for administration of medications and anesthetic agents, as well as objection to the removal of language in Sec. 9 (b) that states, "A registered nurse anesthetist shall perform duties and functions in an interdependent role as a member of a physician or dentist directed health care team." He noted that such action of removing the statutory requirement for interdependency would not improve the

quality of care for patients undergoing an anesthetic. Other concerns were addressed as noted in his written testimony. (Attachment 4)

Larry Buening, KBHA, noted that the State Board of Healing Arts met on February 11, and at that time reviewed the provisions of **SB 152** and expressed concern with Section 5 of the bill which would enable nurse anesthetists to develop their own anesthesia plan without physician or dentist involvement. (Attachment 5)

Steve Clifton, KANA, appeared in support of **SB 152** and noted that as a Certified Registered Nurse Anesthetist at Stormont Vail Regional Medical Center and Topeka Single Day Surgery, he conducts pre- and post-anesthesia visits and assessments, develops an anesthesia plan, then induces and maintains the anesthetic intra-operatively and post-operatively. (Attachment 6)

Terri Roberts, KSNA, supports the changes embodied in **SB 152** especially cleaning up the statute by removing dated language that applies to the initial implementation of the statute as noted in her written testimony. (Attachment 7)

The meeting was adjourned at 11:00 a.m.

The next meeting is scheduled for February 15, 1995.

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
GUEST LIST

DATE: 2-14-95

NAME	REPRESENTING
Tom Bruno	Allen & Assoc.
Rick Guthrie	Health Midwest
Joe Turgeon	KCA
Dale R Allen	GC on A.
Jim Hall	University of Kansas
Cheri Shelton	SRS
Chip Wheelen	KS Medical Soc.
Stacey Simpson	Hein, Ebert & Weir
John Peterson	KS Governmental Consulting
Harold Riehm	KAOM
Larry Buening	Bd of Healing Arts
Patty Johnson	" " "
Steve Claffa	President Kansas Assoc of Nurse Anesthetists
Joseph P. Conroy	2414 Apple Emporium KANA
Tami Roberts	KSNA

Kansas State Board of Nursing

Landon State Office Building
900 S.W. Jackson, Rm. 551
Topeka, Kansas 66612-1230
913-296-4929
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Patsy L. Johnson, R.N., M.N.
Executive Administrator
913-296-5752

To: The Honorable Senator Sandy Praeger, Chairperson
and Members of the Public Health & Welfare Committee

From: Patsy L. Johnson, M.N., R.N., A.R.N.P.
Executive Administrator
Kansas State Board of Nursing

Date: February 14, 1995

Re: SB 152

Thank you for allowing me to testify on SB 152 for the Board of Nursing. The changes in this bill address issues for the registered nurse anesthetist (RNA).

In Section 2, (page 1, lines 28-29) a new definition of active practice has been added. This definition is referenced in the refresher course requirement. The requirement for a refresher course if out of active anesthesia practice for more than five years has been moved from the temporary permit language in Section 2, (page 1, line 43 and page 2, line1-2). The Board believes that a refresher course is essential for the RNA who has not been in practice. The requirements for the refresher course will be put in rule and regulation following the guidelines from the American Association of Nurse Anesthetists (AANA).

In Section 2 (c), (page 2, lines 6-8), the Board would like a change so that any school of nurse anesthesia in Kansas will offer a masters degree. There is only one school in Kansas accredited by the Board and it is already at the masters level. Nurse anesthesia applicants without a masters degree, but graduates from approved schools outside of the state, will still be authorized for anesthesia practice in Kansas.

Section 2 (d), (lines 13-23) has been revoked. The Board of Nursing is not using a questionnaire to review schools of nurse anesthesia elsewhere in the United States. All candidates for authorization in

Janette Pucci, R.N., M.S.N.
Education Specialist
296-3782

Patricia McKillip, R.N., Ph.D.
Education Specialist
296-3782

Diane Glynn
Practice S
296-

Kansas must have passed the national standardized examination administered by the AANA. Both the exam and schools of nurse anesthesia accredited by AANA meet Kansas standards.

In Section 3, (page 2, lines 28-43 and page 3, line 1) the provision for temporary permits include one for the new graduate, the completion of a refresher course, and a period for completing requirements for reinstatement or verification of licensure. Revision of this section standardizes the permits with other licensees.

K.S.A. 65-1158 lists the duties for the RNA, Section 5 (page 3). A revision of (a) (2), (lines 23-27) addresses development of an anesthesia plan including the medications and anesthetics to be given pre-operative, intra-operative, and post-operative. The change in this section places the responsibility of selection of anesthetic agents for the total course of the operative procedure on the RNA. RNA's are educationally prepared as graduates of an intense two year program. To be certified by AANA, the RNA must attend 40 hours of continuing education in anesthesia every two years. In reality, the physician performing the surgical procedure does not order the medications, the dosages, and times to be given. The physician is present for most of the anesthetic procedure so there is communication as to the patient's status. Where there is an anesthesiologist, there is oversight of the anesthesia being given, but there is still probably not direct orders for the medications used.

The Board does not believe there will be much change in RNA practice if this revision occurs. There has been a minimal number of problems with RNA practice. Of 14 cases of substandard care that have been reported to the Board in five years, there have been two actions taken with four pending. In another case which is still pending, it is believed the RNA was practicing beyond the scope of the nurse anesthetist when he ordered an antibiotic to be given pre-operatively. Ordering an antibiotic would not be appropriate if the allegation is proven true. The Board does require verification of liability insurance with payment into the health care stabilization fund upon initial application and renewal. In most facilities there is a requirement for anesthesia review as part of maintaining quality of care.

Other changes in Section 5 include the RNA inducing and maintaining anesthesia or analgesia, (page 3, line 28). More RNA's are involved with placement of epidural spinal catheters for the purpose of pain control. This procedure may be used for post-operative pain or long term control of chronic

pain. Physicians prescribe the pain control medication to be used. New (b), (line 35), has been revised to read that the RNA **may** participate in periodic and joint evaluation of services. Some facilities have a committee which performs this procedure. Although there will usually be a RNA participating on the committee, not all RNA's will be directly involved. The activity is changed from a **shall** to a **may** by deleting (a) (9), (lines 39-40). The last change is deleting (b) which refers to the interdependent role with a physician. The RNA always performs in a collaborative role with the surgeon in meeting the goal of a safe operative procedure. The language in (b) is not needed.

In Section 6, the stem **shall** was moved to the (a) statement, (page 4, line 3) and then removed from the lines as needed. The one change in Section 7 was to broaden the category from only nurses to all persons who might try to practice nurse anesthesia without authorization, (page 4, lines 19-20). In Section 8, the stem **nothing in this act shall** was moved to the beginning, (page 5, line 4). New section (f) was added to allow a RNA who is employed by the United States government to practice in Kansas without being authorized (page 4, lines 22-25). This provision already exists for other nurses who are employed in federal service.

K.S.A. 65-1161 was revoked. In K.S.A. 65-1120, RNA's are listed specifically in this statute which refers to discipline on a license, certificate, or authorization.

In summary, most of the changes in the RNA statutes are merely an update. The most significant was to add to the RNA's scope of practice to decide what medications to utilize during surgical procedures. In almost every situation when a RNA administers the anesthesia, the surgeon will not prescribe the drugs to be used, but will depend on the RNA to provide safe anesthesia during the operation. Physicians review anesthesia practices as part of quality assurance. Substandard practice has to be reported to the licensing board under risk management.

I hope the committee will pass SB 152 favorably.

Thank you. I am available for questions.

65-1161. Denial, revocation, suspension or limitation of authorization to practice or refusal to renew such authorization; grounds; procedure. The board may deny, revoke, suspend, limit or refuse to renew the authorization to practice of a registered nurse anesthetist if the person so authorized has failed to comply with the requirements established under this act for initial authorization or renewal of authorization, has willfully or repeatedly violated any provision of this act or any rule and regulation adopted under any provision of this act or has committed any of the acts enumerated in K.S.A. 65-1120 and amendments thereto, as applicable. The procedure for denial, revocation, suspension, limitation or refusal to renew an authorization to practice as a registered nurse anesthetist under this act shall be the same as that provided under the Kansas nurse practice act for the denial, revocation, suspension, limitation or refusal to renew the license of a licensed professional nurse under that act.

History: L. 1986, ch. 183, § 11; July 1.

65-1120. Denial, revocation, limitation or suspension of license or certification of qualification; costs; professional incompetency defined. (a) Grounds for disciplinary actions. The board may deny, revoke, limit or suspend any license, certificate of qualification or authorization to practice nursing as a registered professional nurse, as a licensed practical nurse, as an advanced registered nurse practitioner or as a registered nurse anesthetist that is issued by the board or applied for under this act or may publicly or privately censure a licensee or holder of a certificate of qualification or authorization, if the applicant, licensee or holder of a certificate of qualification or authorization is found after hearing:

(1) To be guilty of fraud or deceit in practicing nursing or in procuring or attempting to procure a license to practice nursing;

(2) to have been guilty of a felony or to have been guilty of a misdemeanor involving an illegal drug offense, if the board determines, after investigation, that such person has not been sufficiently rehabilitated to warrant the public trust;

(3) to have committed an act of professional incompetency as defined in subsection (e);

(4) to be unable to practice with skill and safety due to current abuse of drugs or alcohol;

(5) to be a person who has been adjudged in need of a guardian or conservator, or both, under the act for obtaining a guardian or conservator, or both, and who has not be restored to capacity under the act;

(6) to be guilty of unprofessional conduct as defined by rules and regulations of the board;

(7) to have willfully or repeatedly violated the provisions of the Kansas nurse practice act or any rules and regulations adopted pursuant to that act, including K.S.A. 65-1114 and 65-1122 and amendments thereto; or

(8) to have a license to practice nursing as a registered nurse or as a practical nurse denied, revoked, limited or suspended, or to be publicly or privately censured, by a licensing authority of another state, agency of the United States government, territory of the United State or country or to have other

disciplinary action taken against the applicant or licensee by a licensing authority of another state, agency of the United States government, territory of the United States or country. A certified copy of the record or order of public or private censure, denial, suspension, limitation, revocation or other disciplinary action of the licensing authority of another state, agency of the United States government, territory of the United States or country shall constitute prima facie evidence of such a fact for purposes of this paragraph (8).

(b) Proceedings. Upon filing of a sworn complaint with the board charging a person with having been guilty of any of the unlawful practices specified in subsection (a), two or more members of the board shall investigate such charges, or the board may designate and authorize an employee or employees of the board to conduct such investigation. After investigation, the board may institute charges. In the event such investigation, in the opinion of the board, shall reveal reasonable grounds for believing the applicant or licensee is guilty of the charges, the board shall fix a time and place for proceedings thereon, which shall be conducted in accordance with the provisions of the Kansas administrative procedure act.

(c) Witnesses. No person shall be excused from testifying in any proceedings before the board under this act or in any civil proceedings under this act before a court of competent jurisdiction on the ground that such testimony may incriminate the person testifying, but such testimony shall not be used against such person for any prosecution for any crime under the laws of this state except the crime of perjury as defined in K.S.A. 21-3805 and amendments thereto.

(d) Costs. If final agency action of the board in a proceed pursuant to this section is adverse to the applicant or licensee, the costs of the board's proceedings shall be charged to the applicant or licensee as in ordinary civil actions in the district court, but if the board is the unsuccessful party, the costs shall be paid by the board. Witness fees and costs may be taxed by the board according to the statutes relating to procedure in the district court. All costs accrued at the instance of the board, when it is the successful party, and which the attorney general certifies cannot be collected from the applicant or licensee shall be paid out of any available moneys in the board of nursing fee fund.

(e) Professional incompetency defined. As used in this section, "professional incompetency" means:

(1) One or more instances involving failure to adhere to the applicable standard of care to a degree which constitutes gross negligence, as determined by the board;

(2) repeated instances involving failure to adhere to the applicable standard of care to a degree which constitutes ordinary negligence, as determined by the board; or

(3) a pattern of practice or other behavior which demonstrates a manifest incapacity or incompetence to practice nursing.

History: L. 1949, ch. 331, § 9; L. 1963, ch. 314, § 6; L. 1972, ch. 231, § 10; L. 1975, ch. 316, § 7; L. 1978, ch. 240, § 6; L. 1981, ch. 245, § 1; L. 1983, ch. 206, § 10; L. 1985, ch. 88, § 6; L. 1986 ch, 233, § 4; L. 1990, ch. 221, § 5; L. 1993, ch. 194, § 1, July 1.

KANSAS ASSOCIATION OF NURSE ANESTHETISTS

February 14, 1995

Senator Sandy Praeger
Chairperson, Senate Public Health and Welfare Committee
State Capitol Building
Topeka, Kansas 66612

Senator Praeger and members of the Committee

My name is Joseph P. Conroy, and I am a Certified Registered Nurse Anesthetist from Emporia, Kansas, representing the Kansas Association of Nurse Anesthetists.

Our Association strongly supports S.B. 152, where changes are made in the Registered Nurse Anesthetists' Statutes, including a definition of active practice, a refresher course requirement if inactive for more than 5 years, and modifications in the authorization language.

The changes made in 65-1158, scope of practice, were made as a result of discussion with the Board of Nursing, who indicated a need for language which reflected the actual practice of anesthesia in the state of Kansas by RNA's. The current language was felt to be ambiguous with regard to authorization.

I am going to address the practice of anesthesia by RNA's in Kansas who are non-medically directed, as opposed to medically directed, the terminology used by Medicare under its reimbursement schedules. Steve Clifton will speak for the medically directed in his testimony.

In 1992, the Kansas Department of Health and Environment amended the Hospital Rules and Regulations for anesthesia services in K.A.R. 28-34-17a,(c) whereby physician supervision language was removed for nurse anesthetists. On the national level, HCFA, which writes regulations for Medicare, is also removing supervision language for nurse anesthetists, which will be reflected in new JCAHO standards. The authorization language in 65-1158 will clarify the ability of the RNA to develop an anesthesia plan and administer anesthetics.

The change in language also reflects the intent of K.S.A. 40-3403(h), the Kansas Health Care Stabilization Fund. In 1991, this statute abolished vicarious liability involving providers qualified for coverage under the Fund. RNA's in Kansas are required by law to be covered under the Health Care Stabilization Fund.

Senate Public Health & Welfare
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KANSAS ASSOCIATION OF NURSE ANESTHETISTS

Finally, the Drug Enforcement Administration has stated in 21 C.F.R. 1306.02(f) that the direct administration or the ordering of controlled substances pre-, intra-, and post-operatively by a nurse anesthetist does not involve prescribing. This definition can also be found in the Pharmacy Act under K.S.A. 68-20-1(e). Once again, the authorization language reflects this and is not an expansion of scope of practice.

Of the approximately 132 hospitals in Kansas providing surgical services, 110 rely solely on C.R.N.A.'s for anesthesia services. These C.R.N.A.'s are classified as non-medically directed and work with the physician or dentist, while supplying safe and cost-effective anesthesia care. We hope that with your support for S.B. 152, the 430 CRNA's in Kansas can continue to provide quality anesthesia care to the people of Kansas.

I would like to thank Pat Johnson and the State Board of Nursing for their time and help in revising these statutes.

Thank you for your time.

Joseph P. Conroy, B.A., C.R.N.A., A.R.N.P.
President-Elect, Kansas Association of Nurse Anesthetists
2614 Apple Drive
Emporia, Kansas 66801-5910
316-342-0856

The Emporia Center for Women

ASSOCIATES IN GYNECOLOGY AND OBSTETRICS
A PROFESSIONAL ASSOCIATION
1127 CHESTNUT, SUITE 300 EMPORIA, KANSAS 66801
(316) 343-6565

DOUGLAS J. AMEND, M.D., FACOG

JOHN C. LLOYD, M.D., FACOG

February 13, 1995

Senator Sandy Praeger, Chairperson
Committee on Public Health and Welfare

RE: Senate Bill #151

Dear Dr. Praeger,

Please allow me this opportunity to speak in favor of the proposed changes to Section 5, KSA 65-1158 in which the revision states "a nurse anesthetist will be designated as a responsible person to develop an anesthesia plan including ordering appropriate medications and anesthetics for pre-operative, interoperative, and post operative administration."

As written, this language will designate the nurse anesthetist as the responsible person for these services as they pertain to operative procedures, be they outpatient or inpatient. Additionally, this language would make the appropriate person responsible for anesthetics for pre-operative, interoperative, and post operative administration as is actually the current standard of practice in many smaller health care institutions.

Previously the language of KS 65-1158 suggested that a physician or dentist was somehow responsible for the anesthetics which has never really been the case at all. My training in anesthesia was limited to several months on the anesthesia service during the second year of my OB/GYN residency. In general, most physicians-surgeons do not have any more, and in some cases, even less experience than that.

Therefore, the language of the law regarding this issue certainly should reflect the actual standard of practice. Furthermore, the language of this Senate Bill is such that a nurse anesthetist would not be able to practice anesthesia independent of dentists or physicians, as the language of this bill restricts their practice for pre-operative, interoperative, and post operative administration.

Thank you very much.

Sincerely yours,

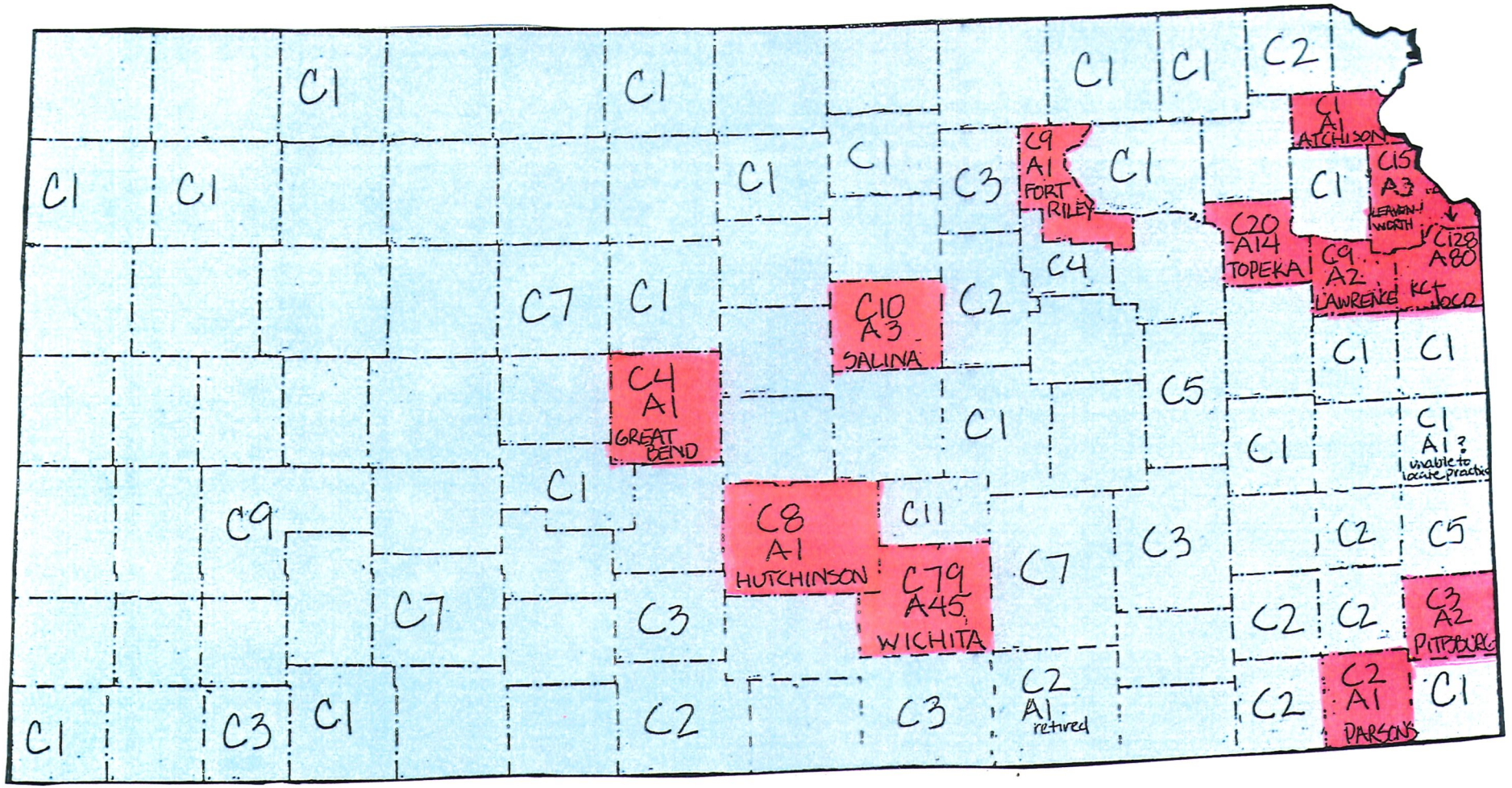
John C. Lloyd, M.D.

ANESTHESIA PROVIDERS IN KANSAS

CERTIFIED REGISTERED NURSE ANESTHETISTS (CRNAs) provide anesthesia for rural Kansas. CRNAs and Anesthesiologists provide anesthesia to urban Kansas areas.

= areas of Nurse Anesthesia coverage, by county

= areas of combined Nurse Anesthesia and Anesthesiologist coverage, by county



= Residences of CRNAs per county

= Residences of Anesthesiologists per county

Sources: American Association of Nurse Anesthetist Membership Databank May 1993

American Board of Medical Specialists Directory 1994

KANSAS MEDICAL SOCIETY
623 SW 10th Ave. • Topeka, Kansas 66612 • (913) 235-2383
WATS 800-332-0156 FAX 913-235-5114

February 14, 1995

To: Senate Public Health and Welfare Committee

From: C. L. Wheelen, KMS Director of Public Affairs

Subject: Senate Bill 152; Registered Nurse Anesthetists

Thank you for the opportunity to express our concerns about SB152. We are absolutely opposed to section 5 (page 3, at line 19). The amendments in section 5 would authorize CRNAs to practice anesthesia independent of any physician involvement whatsoever. We consider this an unacceptable departure from the established standard of care in Kansas.

We acknowledge that those Advanced Registered Nurse Practitioners who have achieved the necessary training to be certified by the Board of Nursing as CRNAs are quite knowledgable. They are valuable members of the surgery team and in some Kansas communities are essential. Without them, many Kansans would be forced to travel long distances to urban hospitals and some surgeons would perhaps relocate their medical practices. But this relationship between physicians and CRNAs is one that hinges on interdependence; the essential feature of current law which would be repealed by section 5 of SB152.

In 1986 a group of licensed nurses (RNs) who had acquired the necessary curriculum and clinical training to be certified by the American Association of Nurse Anesthetists organized themselves, hired a lobbying firm, and requested statutory authority to engage in independent anethesthesia practice. The initial proposal was not well received by the Legislature and probably would have died, but the Kansas Medical Society was willing to devote the time and other resources necessary to work out an acceptable bill that granted special recognition and statutory privileges to those nurses. The result was 1986 SB179; an innovative law that preserved collaboration between the CRNAs and physicians so that standards of care would be maintained while authorizing CRNAs to engage in advanced nursing practice.

We believe the 1986 compromise was a good one which should be honored. We urge you to **delete section 5 from SB152 prior to any action** on the bill. Thank you for the opportunity to testify.

Senate Public Health & Welfare
Date: 2-14-95
Attachment No. 3

for an additional 30 days but not to exceed a combined total of 120 days.

Sec. 4. K.S.A. 65-1154 is hereby amended to read as follows: 65-1154. Upon application to the board by any licensed professional nurse in this state and upon satisfaction of the standards and requirements established under this act, the board shall grant an authorization to the applicant to perform the duties of a registered nurse anesthetist. An application to the board for an authorization, for an authorization with temporary authorization, for biennial renewal of authorization, for reinstatement of authorization and for reinstatement of authorization with temporary authorization shall be upon such form and contain such information as the board may require and shall be accompanied by a fee to assist in defraying the expenses in connection with the administration of the provisions of this act. The fee shall be fixed by rules and regulations adopted by the board in an amount fixed by the board under K.S.A. 65-1118 and amendments thereto. The executive administrator of the board shall remit all moneys received pursuant to ~~K.S.A. 65-1151~~ to 65-1163, inclusive, and amendments thereto, to the state treasurer as provided by K.S.A. 74-1108 and amendments thereto.

Sec. 5. K.S.A. 65-1158 is hereby amended to read as follows: 65-1158. (a) Each registered nurse anesthetist shall *be authorized to*:

(1) Conduct a pre- and post-anesthesia visit and assessment with appropriate documentation;

(2) develop an anesthesia care plan with the physician or dentist which includes procedures for administration of medications and anesthetic agents *plan which includes ordering appropriate medications and anesthetics for pre-operative, intra-operative and post-operative administration*;

(3) induce and maintain anesthesia *or analgesia* at the required levels;

(4) support life functions during the peri-operative period;

(5) recognize and take appropriate action with respect to patient responses during anesthesia;

(6) provide professional observation and management of the patient's emergence from anesthesia; *and*

(7) participate in the life support of the patient;.

~~(8)~~ *(b) Each registered nurse anesthetist may* participate in periodic and joint evaluation of services rendered, including, but not limited to, chart reviews, case reviews, patient evaluation and outcome of case statistics; and

(9) participate in the joint reviews and revision of adopted protocols or guidelines.

(b) A registered nurse anesthetist shall perform duties and functions in an interdependent role as a member of a physician or dentist directed health care team.

delete a(1) and re-number

KMS
KANSAS MEDICAL SOCIETY

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Chip Wheelen
Director of Public Affairs

3-2

KANSAS STATE SOCIETY OF ANESTHESIOLOGISTS
Component society of
The American Society of Anesthesiologists, Inc.

Statement of
Gregory K. Unruh, M.D.
President, Kansas Society of Anesthesiologists
February 14, 1995

To the Honorable members of the Senate Public Health and Welfare Committee.

Madam Chairman and members of the Committee:

I want to thank you for this opportunity to provide testimony on Senate Bill 152. I am before you today wearing many hats. I am a Board Certified Anesthesiologist. I am an Associate Professor in the Department of Anesthesiology, School of Medicine, in the University of Kansas Medical Center and my title there is Director, Anesthesiology Residency Education. I also carry a teaching appointment in the School of Allied Health and I teach student nurse anesthetists in both operating room and formal didactic settings. In addition, I am also the President of the Kansas Society of Anesthesiologists and I represent over 140 anesthesiologists throughout the State of Kansas, all of whom are dedicated to excellent medical care for the citizens of Kansas.

It is that dedication to patient care that brings me before you today. We are **strongly opposed** to the changes in Senate Bill 152 that would remove the requirement that: "Each registered nurse anesthetist shall be authorized to develop an anesthesia care plan ***with the physician or dentist*** which includes procedures for administration of medications and anesthetic agents." [Emphasis added] We are also **strongly opposed** to the removal of Section (9)(b) that states: "A registered nurse anesthetist shall perform duties and functions in an interdependent role as a member of a physician or dentist directed health care team." We see no reason to change the current language.

Included in this discussion, we must also consider House Bill 2194 that seeks to grant independent prescriptive authority to Advanced Registered Nurse Practitioners. CRNAs are one class of Advanced Registered Nurse Practitioners and would be covered under that statute. We believe that CRNAs provide excellent service to the citizens of Kansas in their current mode of practice and many of us work closely with CRNAs on a daily basis. It is our opinion, however, that these changes in Senate Bill 152, along with House Bill 2194, attempt to provide independent practice for these health care providers. We believe that CRNAs are not educated or trained as independent practitioners nor are they qualified to practice medicine.

I would like to offer several reasons why we should not make these changes and then discuss each of them individually:

- We do not believe that removing the statutory requirement for interdependency will in any way improve the quality of care for Kansas patients undergoing an anesthetic.

- There is a vast difference in training between CRNAs and independent licensed practitioners, i.e. surgeons, dentists, and anesthesiologists.

- Anesthesia services are readily available to the citizens of Kansas. A change in this regulation would do nothing to enhance the availability of anesthesia services.

- The American Association of Nurse Anesthetists (AANA) recognizes the need for CRNAs to function interdependently and in a collaborative manner with independent health care practitioners in their own Guidelines and Standards for Nurse Anesthesia Practice.

- Maintaining interdependency and collaboration with a physician or dentist is consistent with the intent and standards of both JCAHO and HCFA.

- There is no need to make these changes to eliminate a presumed "Captain of the Ship" legal doctrine. Any question of legal liability is clearly dealt with in K.S.A. 40-3403 (h) and Kansas Administration Regulation 28-34-17a.

- Some states are revisiting independent practice rules and tightening them up.

To elaborate further:

We see no reason why a registered nurse anesthetist would **not <u>want</u>** to practice in an interdependent role with the physician or dentist. While it is true that physicians or dentists with whom the nurse anesthetists work in the interdependent role may not have taken formal training in anesthesia or anesthesia care, that is not the point. The physician or dentist brings to the care of the patient undergoing an anesthetic their **medical expertise**. They provide a thorough knowledge of the patient's medical history and physical findings, a knowledge of the patient's pathology and its interaction with the patient's physiologic state and surgical procedure, and the patient's medication history. Most importantly, they bring their **medical judgment** to the care of the patient developed by formal medical education, residency, and practice experience.

So that you may be entirely clear on the differences between an anesthesiologist and a CRNA, I have included Exhibit A that details those educational and training requirements. For the sake of brevity, I will not describe that at this time other than to say that an anesthesiologist's training totals twelve years after high school while a CRNA's training totals six to six and a half years after high school. This results in vast differences in skill and expertise in medical diagnostics and therapeutics. I would also like for you to consider what impact that training has on the development of an anesthetic plan. I have included Exhibit B that details what constitutes preoperative, intraoperative, and postoperative care by an anesthesiologist so which you may review at your convenience. I would also like for you to consider that surgeons follow the same course of training up to the

completion of internship at which time they branch off into an additional four to six years of surgical residency.

As you can see, the training for a nurse anesthetist is very different in both time and scope from a physician and has extremely different emphasis. CRNAs are trained in the technical delivery of anesthesia, not to practice anesthesiology. As one who daily participates in the training of both student nurse anesthetists and resident physicians, I can clearly attest to the differences in expertise between the two groups and the focus of each group's training.

Anesthesia care in this country is provided in three different modes: (1) anesthesiologists alone, (2) registered nurse anesthetists medically directed by anesthesiologists, and, (3) registered nurse anesthetists delivering anesthesia in an interdependent role as a member of a physician or dentist health care team.

As an anesthesiologist, I feel that every anesthetic should be administered by an anesthesiologist or provided under the medical direction of an anesthesiologist. In reality, however, this is not always possible, particularly in many rural settings. In many of those circumstances, registered nurse anesthetists provide anesthesia care in the operative setting and do a fine job of it. Their involvement, however, is to render anesthesia care. They do not practice medicine and, in particular, they do not practice anesthesiology.

It is difficult to conduct controlled studies on the quality of care delivered by CRNAs compared to anesthesiologists because of the large numbers of patients and the costs to study an issue such as this. Some studies, however, are beginning to be published suggesting that there may be fewer deaths or less severe morbidity in settings where the anesthesia was delivered in the care team setting involving nurse anesthetists medically directed by anesthesiologists. [1,2 & 3] Only time will tell whether these statistics will be borne out.

In my own residency program, we have had residents who were CRNAs in private practice. These individuals chose to go back to medical school, become physicians, and then take further training in anesthesiology. When I asked one of them about the differences in training, he shrugged his shoulders and said, "We don't have enough time to go over all the differences. I can't believe I was doing some of the things I did as a CRNA and I can't believe how 'on the edge I was.'" He also stated that he had not anticipated how much his skills and expertise had improved in taking histories and physicals since he went to medical school. Overall, he thought the single biggest change was in his approach to intraoperative management and how it had matured. Other former CRNAs who became anesthesia residents have related similar thoughts and they focused on the training, as well as the evaluation and certification process.

Despite my twelve years of formal training and over ten years of practice experience at the University of Kansas Medical Center, I often utilize my surgical and dental colleagues for their expertise, knowledge of the patient's medical and surgical history, and understanding of the patient's current pathology. Although not mandated by law, I feel obligated on behalf of my patients to do so in the pursuit of total quality care. When any of us work with a patient in the operative setting, we are part of the team. I do not understand why a nurse anesthetist would not want to maintain that relationship. The current legislation works effectively to continue that relationship.

The Nurse Anesthetists themselves feel the need for collaboration and interdependency. The American Association of Nurse Anesthetists in their Guidelines and Standards for Nurse Anesthesia Practice document states:

> "The scope of practice of the Certified Registered Nurse Anesthetist encompasses the professional functions, privileges and responsibilities associated with nurse anesthesia practice. These are performed in collaboration with qualified and legally authorized professional health care providers. CRNAs are prepared to recognize those situations where care requirements are beyond their individual

competencies and to seek consultation or referral when such situations arise."

Another section states:

"CRNAs are responsible for assessing their individual clinical capabilities and for determining and providing competent anesthesia services within their scope of practice and clinical privileges. CRNAs practice in collaboration with other health care professionals to achieve individual and common goals for care and to assure the patient's safety and welfare. While their primary responsibility is to the patient, CRNAs recognize the interdependency of all members of the health care team involved in the diagnostic or therapeutic interventions necessitating the anesthesia service and accept their responsibility to each member of the team based on identified roles and responsibilities."

The Health Care Financing Administration (HCFA) also recognizes the necessity of medical direction in its Medicare requirements for Rural Health Centers [Section 186](aa)(4)(6) where it defines collaboration as "a process in which a nurse practitioner works with a physician to deliver health care services within the scope of the practitioners professional expertise, with medical direction and appropriate supervision, as provided for in jointly developed guidelines or other mechanisms as defined by the law of the State."

In addition, elimination of medical direction, both in and as a result of prescription of the anesthesia plan, is entirely inconsistent with the standards both of the Joint Commission on Accreditation of Health Care Organizations (JCAHO) and HCFA. The JCAHO provides that delivery of anesthesia care is the responsibility of licensed independent practitioners (one who may provide care without direction or supervision), and that determination of the anesthesia plan for the individual patient must be made by a licensed independent practitioner, with appropriate privileges. The JCAHO also requires that organized anesthesia services be directed by a physician, and that prior to anesthesia, a licensed independent

practitioner with appropriate clinical privileges determine that the patient is an appropriate candidate to undergo the planned anesthesia. A licensed independent practitioner must also discharge the patient from the recovery room or hospital, as the case may require.

HCFA, which oversees Medicare, requires that a CRNA be supervised by the operating practitioner or an immediately-available anesthesiologist. (42 CFR 482.52) Commenting in the final rule for CRNA reimbursement a little over two years ago, HCFA stated that "it would not be appropriate to allow anesthesia administration by a non-physician anesthetist unless under supervision by either an anesthesiologist or the operating practitioner."

Some CRNAs will argue that "interdependent" implies a "Captain of the Ship" legal doctrine and exposes the surgeon or dentist to increased legal liability. This, however, is not the case. K.S.A. 40-3403 (h) establishes that a health care provider covered under the Kansas Health Care Stabilization Fund, "shall have no vicarious liability or responsibility for any injury or death arising out of the rendering of or the failure to render professional services inside or outside this state by another health care provider who is also qualified for coverage under the fund." Furthermore, Kansas Administrative Regulation 28 -34-17, which provided some underlying basis for the "captain of the ship" doctrine was replaced by Kansas Administrative Regulation 28-34-17(a) which contains the following provision in paragraph (d)(1):

> The governing body shall determine the extent of anesthesia services and shall define the degree of collaboration required for the administration of anesthesia. Certified registered nurse anesthetists shall work in an interdependent role with other practitioners.

There remains, then, little legal impetus to remove the interdependent role based on legal liability concerns.

Two states that have recently allowed some forms of independent prescriptive authority or other types of independent practice, Montana and

Vermont, have now tightened up those rules. They now require that a physician within the advanced nurse practitioner's specialty must provide collaboration or quality assurance review. Montana requires the physician providing that quality assurance review to examine five percent or thirty of the practitioners cases, whichever is larger. Vermont requires collaboration with a physician within that nurse practitioners specialty. In both cases, this tightening came from the State Boards of Nursing.

In summary:

We do not believe that removing the statutory requirement for interdependency will in any way improve the quality of care for patients undergoing an anesthetic. On the contrary, it could be detrimental. Taking the physician or dentist out of the development of the anesthetic plan only distances an individual with expertise, training, and experience from providing quality care for the patient.

There is a vast difference in training between CRNAs and independent licensed practitioners, i.e. surgeons, dentists, and anesthesiologists. CRNAs are trained to function in a **collaborative** and **interdependent** manner and practice experience does not make up for the extensive training necessary to function independently or practice medicine. CRNAs deliver anesthesia care, they do not practice anesthesiology.

Anesthesia services are readily available to the citizens of Kansas. A change in this regulation would do nothing to enhance the availability of anesthesia services.

The American Association of Nurse Anesthetists (AANA) recognizes the need for CRNAs to function interdependently and in a collaborative manner with independent health care practitioners in their own Guidelines and Standards for Nurse Anesthesia Practice.

Maintaining interdependency and collaboration with a physician or dentist is consistent with the intent and standards of both JCAHO and HCFA.

There is no need to make these changes to eliminate a presumed "Captain of the Ship" doctrine. Any question of legal liability is clearly dealt with in K.S.A. 40-3403 (h) and Kansas Administration Regulation 28-34-17a.

Some states are revisiting independent practice rules and tightening them up.

We currently have a system that works effectively to deliver quality care for the citizens of Kansas. We urge you not to make the proposed changes in Senate Bill #152. I thank you for taking time to hear my thoughts and the thoughts of the Kansas Society of Anesthesiologists on this important issue. I stand ready to entertain any questions you might have.

Respectfully submitted,

Gregory K. Unruh, M.D.
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Voice (913) 588-6670 FAX (913) 588-3365

1. Warner MA, Warner ME, Narr BJ: Perioperative mortality and major morbidity in ASA physical status I and II patients undergoing non-emergent procedures: 1985-87. Anesthesiology 69A721, 1988

2. Warner MA, Shields SE, Chute CG: Major morbidity and mortality within 1 month of ambulatory surgery and anesthesia. JAMA 270:1437, 1993

3. Silber JH, Williams SV, Krakauer H, et al: Hospital and patient characteristics associated with death after surgery. A study of adverse occurrence and failure to rescue. Medical Care 30:615, 1992.

Exhibit A

Anesthesiologist vs. CRNA Training

To become an anesthesiologist takes twelve years:

The education begins with a four year college degree which may be in any discipline but must include the pre-medical requisites of English, biology, general chemistry, organic chemistry, calculus, physics and biochemistry.

The education continues with four years of medical school. During the first two years there are required courses covering anatomy, embryology, cell biology and genetics, biochemistry, physiology, pathology, microbiology, pharmacology, and clinical sciences including physical diagnosis. The last two years are divided among the major specialties of medicine including Family Medicine, Internal Medicine, Obstetrics and Gynecology, Pediatrics, Psychiatry, and Surgery. All physicians also take electives in subspecialties of those major rotations and in other specialties of medicine such as anesthesiology. As I am sure you are aware, all students are required to pass two national medical licensing examinations prior to graduation and receiving the Doctor of Medicine degree.

Following medical school, all physicians are required to complete a one year internship in Internal Medicine, Surgery, Pediatrics or a Rotating Internship which comprises aspects of all of these fields. A third national qualifying examination (United States Licensing Medial Examination) must be passed to be certified and gain state licensure. To become an anesthesiologist then takes three years of Anesthesiology Residency. The training has heavy emphasis on pharmacology, physiology, pathophysiology, the interactions of anesthetics with the patient and their physical state, and the interactions of anesthetics and other drug interactions. Residents in anesthesiology complete rotations in obstetrical anesthesia, pediatric anesthesia, cardiovascular and thoracic anesthesia, neuroanesthesia, and post anesthesia care. There is extensive training in pre-operative evaluation, intraoperative management, postoperative management and management of acute and chronic pain. Anesthesiology residents also spend two or more months in Intensive Care Units under the supervision of Critical Care Specialists. The

training deals extensively with treatment of perioperative aberrations and emergencies including resuscitation.

Anesthesiologists are the primary care doctors of the operating room but the patients we care for and the procedures they undergo dictate that we practice critical care medicine.

The American Board of Anesthesiology defines anesthesiology as the practice of medicine dealing with but not limited to:

- The assessment of, consultation for and preparation of patients for anesthesia.
- The provision of insensibility to pain during surgical, obstetric, therapeutic, and diagnostic procedures, and the management of patients so affected.
- The monitoring and restoration of homeostasis during the perioperative period, as well as homeostasis in the critically ill, injured, or otherwise seriously ill patient.
- The diagnosis and treatment of acute and chronic pain syndromes.
- The clinical management and teaching of cardiac and pulmonary resuscitation.
- The evaluation of respiratory function and application of respiratory therapy in all its forms
- The supervision, teaching, and evaluation of performance of both medical and paramedical personnel involved in anesthesia, respiratory, and critical care.
- The conduct of research at the clinical and basic science levels to explain and improve the care of patients
- The administrative involvement in hospitals, medical schools, and outpatient facilities necessary to implement these responsibilities

The culmination of the process is the eight hour certifying examination conducted by the American Board of Anesthesiologists (ABA). Upon successful completion of that exam, an anesthesiologist

is then required to pass two oral examinations, also administered by the ABA, to be granted American Board of Anesthesiology Certification. We are then allowed to use the title, "Consultant in Anesthesiology." The ABA defines a Consultant in Anesthesiology as a physician who:

- Possesses knowledge, judgment, adaptability, clinical skills, technical facility and personal characteristics sufficient to carry out the entire scope of anesthesiology practice.

- Is able to communicate effectively with peers, patients, their families and others involved in the medical community.

- Can serve as an expert in matters related to anesthesiology, deliberate with others and provide advice and defend opinions in all aspects of the specialty of anesthesiology.

- Is able to function as the leader of the anesthesiology care team

A CRNA on the other hand, obtains an undergraduate nursing degree. Most nurse anesthesia programs require the applicants to obtain a Bachelor of Science in nursing followed by one year of critical care nursing experience. The formal nurse anesthesia training then involves a two to three year program of technique-oriented instruction and clinical experience, with some scientific underpinning. The first year consist of didactic training in subjects such as anatomy, physiology, and pharmacology; the second year is didactic and supervised clinical experience in most areas of the operating and labor and delivery suites. Many programs are now granting a Masters Degree program. A student becomes a CRNA upon passing a certification examination administered by the American Association of Nurse Anesthetists. This four hour certifying examination confers the title, "Certified Registered Nurse Anesthetist."

4-12

Exhibit B

Preoperative, Intraoperative and Postoperative Care of the Surgical Patient by an Anesthesiologist

Preoperative Preparation of the Patient includes the following:

History and physical examination particularly relating to anesthetic history and the cardiorespiratory systems.

Ordering and interpretation of appropriate tests other than the routine, such as blood gases, electrolytes, enzymes and pulmonary function parameters.

Diagnosing and treating pathologic aberrations such as pulmonary insufficiency, cardiac abnormalities, or fluid and electrolyte imbalances

Overall evaluation of the patient's anesthetic risk, including an independent decision regarding the patient's fitness for surgery at the proposed time

Ordering preoperative medications and evening sedation in conjunction with the patient's other medications or deciding not to prescribe those medications based on the patient's physical status

Obtaining informed consent

Consultation with physicians in other specialties as indicated to provide optimal preanesthetic evaluation and preparation

Intraoperative Care of the Patient includes the following:

Prescription of an anesthetic plan and carrying it out based on the preoperative evaluation and preparation of the patient

Managing fluid and blood replacement and diagnosing and treating electrolyte and coagulation abnormalities

Diagnosing and treating cardiac dysrhythmias, ischemia and failure

Obtaining and interpreting arterial blood gases and diagnosing and treating respiratory and gas exchange abnormalities

Using and interpreting other special monitoring devices including invasive monitors such as central venous pressure monitors and cardiac output catheters.

Diagnosing and treating intraoperative complications such as hypothermia, hyperthermia, hypotension, hypertension, insulin shock, and adrenal insufficiency

Administration of regional anesthesia by spinal, epidural, and nerve block techniques

Postoperative care includes the following:

Managing postoperative pain including the prescribing drugs and conduction anesthesia

Managing fluid balances and diagnosing and managing volume, osmolar and electrolyte abnormalities

Managing nausea and vomiting

Diagnosing and treating cardiac dysrhythmias, ischemia and failure as well as pulmonary insufficiency

Managing critically ill patients in Intensive Care Units

LEGISLATIVE UPDATE

ANESTHESIOLOGISTS ARE A BARGAIN FOR MEDICARE

The Clinton Health Care Plan encourages the use of allied health care professionals, including nurse anesthetists (CRNAs) to reduce medical costs. Allowing nurse anesthetists to practice independently is not in the patient's best interest and is not necessarily cheaper. In fact, a close examination of the Medicare reimbursement system reveals that anesthesiologists cost less than independent CRNA anesthesia services (see charts). NYSSA endorses the anesthesia care team, which consists of one or two nurse anesthetists who are medically directed by an anesthesiologist.

The anesthesiologist performs a number of medical functions on behalf of the patient and develops the anesthesia plan including:

PRE-OPERATIVE EVALUATION

Because anesthesiologists are physicians they can medically assess the patient and determine if specialized medical consultation is required. In most cases, the anesthesiologist performs the physical exam, evaluates laboratory data and interprets pulmonary function tests and blood gases at no charge to the patient.

PERI-OPERATIVE MANAGEMENT

When anesthesia is delivered by a physician directed anesthesia care team or is physician administered, the patient's medical condition during an operation is constantly monitored. Anesthesiologists are specially trained during medical school and in residency programs to handle any problems which may develop in cardiac, pulmonary, hepatic, neurologic or renal function. The lack of this training prevents CRNAs from diagnosing and treating these problems. During the operation, a patient has the services of a fully qualified anesthesiologist and the need for intra-operative specialty consultation is eliminated. The additional skills and services provided by the anesthesiologist are compensated by Medicare at the standard anesthesia reimbursement rate. This rate is the same for anesthesiologists and CRNAs.

PERI-OPERATIVE MONITORING

In certain patients it is necessary to use invasive monitoring, such as a pulmonary artery (Swan Ganz) catheter during surgery. If anesthesiologists insert this catheter they only charge for placement of the monitor. Most nurse anesthetists are not trained in the insertion of Swan-Ganz catheters and have varying degrees of experience with other monitoring modalities. Their use of these state of the art technologies, in the absence of an anesthesiologist, would require the services of other physicians with experience and training in this area. These physicians will charge Medicare for consultation, insertion of the catheter and monitoring.

POST-OPERATIVE CARE

In the recovery room, the diagnosis and treatment of pain, nausea, vomiting, blood pressure problems and chest pain can be complex. These services are provided at no charge to the patient in the recovery room by the anesthesiologist. This medical service must be provided by a physician. ■

Charles J. Assini, Jr., Esq
Scott B. Goudine, M.D.

4/15

The following chart would be a cost comparison of services between an anesthesiologist and a CRNA for a patient undergoing a routine colon resection if CRNAs were granted a license to practice independently.

Medicare Reimbursement Schedule
ROUTINE COLON RESECTION

Provided Service	Anesthesiologist M.D. Charge	Independent Nurse Anesthetist Charge
Preoperative evaluation to assess patient's ability to tolerate anesthesia and surgery.	No Additional Charge	$85.80 pre-op evaluation by M.D.
Anesthesia (90 minutes) 6 unit base value + 6 units time $14.65/unit	$175.80	$175.80
Total Reimbursed by Medicare	$175.80	$261.60

The second chart compares costs for the same patient with additional medical conditions.

COMPLICATED COLON RESECTION
(Patient with heart and/or lung disease)

Provided Service	Anesthesiologist M.D. Charge	Independent Nurse Anesthetist Charge
Preoperative evaluation to assess patient's ability to tolerate anesthesia and surgery.	No Additional Charge	$85.80 pre-op evaluation by M.D.
Anesthesia (90 minutes) 6 unit base value + 6 units time $14.65/unit	$175.80	$175.80
Interpretation of preoperative blood gases and other pulmonary function tests	No Additional Charge	Internist reimbursement for interpretation $44.60
Placement of appropriate monitors (eg Swan Ganz) catheter	$333.00	Cardiologist reimbursement $408.00
Treatment of intra-operative cardiac failure	No Additional Charge	Cardiologist reimbursement for complex visit intraoperatively $100.00
Total Reimbursed by Medicare	$508.80	$814.20

Anesthesiologist provided and / or directed anesthesia services will not cost Medicare more than CRNA anesthesia services; and, in many cases will cost substantially less.

4-16

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4-17

KANSAS BOARD OF HEALING ARTS

BILL GRAVES
Governor

LAWRENCE T. BUENING, JR.
Executive Director

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Topeka, KS 66603-3068
(913) 296-7413
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M E M O R A N D U M

TO: Senate Committee on Public Health and Welfare

FROM: Lawrence T. Buening, Jr.
Executive Director

DATE: February 14, 1995

RE: **SENATE BILL NO. 152 - FEBRUARY 14, 1995**

Thank you for the opportunity to appear as a conferee on Senate Bill No. 152. My name is Lawrence T. Buening, Jr. and I am the Executive Director of the Kansas State Board of Healing Arts.

The State Board of Healing Arts met on Saturday, February 11 and at that time reviewed the provisions of Senate Bill No. 152. The Board directed that I express to the Legislature the Board's concerns regarding the provisions of Senate Bill No. 152 and particularly Section 5 thereof.

Section 5 of the bill would enable nurse anesthetists to develop their own anesthesia plan without physician or dentist involvement. Further, this section removes the nurse anesthetist as a member of a physician or dentist-directed health care team.

The Board does not license nor register, certify or otherwise regulate any nurses, including those who have been authorized to practice as registered nurse anesthetists. This bill, if enacted, would enable nurse anesthetists to practice medicine and surgery and still be regulated by the Board of Nursing. It is the position of the State Board of Healing Arts that if the Legislature by statute wishes to authorize individuals to actively practice medicine and surgery in this state, that the statutory language should be such as to place the regulation of those individuals under the auspices of the State Board of Healing Arts which is the entity that presently licenses individuals to practice medicine and surgery. Further, the Board is concerned that authorizing individuals to practice medicine and surgery without having undergone the medical school and the residency training presently required under the Healing Arts Act does not serve to adequately protect the public health, welfare and safety of the citizens of this State.

Thank you for the opportunity to appear before you. I would be happy to respond to any questions.

Senate Public Health and Welfare
Date: 2-14-95
Attachment No. 5

KANSAS ASSOCIATION OF NURSE ANESTHETISTS

February, 14, 1995

Senator Sandy Praeger
Chairperson, Senate Public Health and Welfare Committee
State Capitol Building
Topeka, Kansas 66612

Senator Praeger and members of the Committee

My name is Steve Clifton. I am a Certified Registered Nurse Anesthetist from Topeka, and President of the Kansas Association of Nurse Anesthetists.

I am speaking today in support of S.B. 152.

I am employed by a group of anesthesiologists that work at Stormont Vail Regional Medical Center and Topeka Single Day Surgery. In my practice setting, I will conduct a pre- and post-anesthesia visit and assessment, develop an anesthesia plan, then induce and maintain the anesthetic intra-operatively and post-operatively.

Under Medicare reimbursement schedules, I am considered to be medically directed, although I still am responsible for the choice of the anesthetic and the techniques I will be using.

At hospitals in cities such as Topeka or Wichita, the by-laws of the hospital, as written by the Board of Trustees, require an anesthesiologist to be present in the building for all anesthetics. But even with their presence, I am in charge of that patient's anesthetic.

S.B. 152 will not change what I am doing now, but will more accurately reflect the management of an anesthetic for patients under my care.

Thank you for your time.

Stveve Clifton, B.S.N., C.R.N.A., A.R.N.P.
5690 SW 33rd Terrace
Topeka, Kansas 66614-4578
913-273-7935

Senate Public Health & Welfare
Date: 2-14-95
Attachment No. 6

KSNA
the voice of Nursing in Kansas

KSNA &
You
A Powerful Match

FOR MORE INFORMATION CONTACT:
Terri Roberts JD, RN
Executive Director
Kansas State Nurses Association
700 SW Jackson, Suite 601
Topeka, KS 6603-3731
913-233-8638
February 14, 1995

S.B. 152 Registered Nurse Anesthetists Statute Changes

Senator Praeger and members of the Senate Public Health and Welfare Committee, my name is Terri Roberts and I am the Executive Director of the Kansas State Nurses Association.

KSNA supports the changes embodied in S.B. 152, especially cleaning up the statute by removing dated language that applied to the initial implementation of this statute. The Board of Nursing is asking for additional language to permit authorizing temporary permits for RN's taking refresher courses to reactivate their RNA authorization, and langauge so that the Board of Nursing can require a refresher course in those cases where a CRNA has not been engaged in active anesthesia practice for a period of time within the past five years of their application.

CRNA's provide a vital service to more than 110 hospitals in the state of Kansas, that would otherwise be unable to offer surgical services. They should be commended for their commitment to providing services in these rural areas and supported through statutes that govern them with the necessary parameters to protect the public. These should be legislated without undue restrictions or prohibitions which interfere with their delivery of anesthesia services.

Senate Public Health and Welfare
Date: 2-14-95
Attachment No. 7