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The Kansas State Nurses Association Provides our Support for Senate Bill 112 for Certified Registered Nurse Anesthetists (CRNAs)

Statement of the Kansas State Nurses Association

The Kansas State Nurses Association supports the adoption of Senate Bill 112 providing CRNAs ability to practice to the fullest extent of their training and licensure. We believe full practice authority (FPA) is critical to the continued advancement of high quality, consistent, accountable, cost-effective, and accessible advanced health, and nursing care to the residents of Kansas.

Introduction

Lack of full practice authority (FPA) for Certified Registered Nurse Anesthetists (CRNAs) is a barrier to the provision of efficient, cost-effective, high-quality, and comprehensive health care services for some of our most vulnerable citizens (Bosse et al., 2017, p. 761). The US continues to have the highest cost of healthcare services per capita while achieving worse clinical outcomes, lower life expectancy, and higher infant mortality rates (Papanicolas et al., 2018). The causes of these inequalities are varied and prevalent in research.

One evidence-based approach to addressing access to care, and therefore potentially improving health outcomes, is granting full practice authority (FPA) to CRNAs. That is why we present support for Senate Bill 112 granting Kansas CRNAs the ability to practice to the full extent of their education and training without a required written protocol or collaborative practice agreement with a physician. By adopting SB 112 you are expanding healthcare to the citizens of Kansas, and in turn protecting the public's access to care.

What is a CRNA?

CRNAs are highly skilled and trained clinicians who can deliver all types of anesthesia in inpatient and outpatient settings, as well as provide ventilator support, pain management, and critical care (Callan et al., 2021). CRNAs are required to have a minimum of seven to eight years of education, training, and experience before they can become a CRNA. While the profession is over 150 years old, CRNAs today enter the workforce with a master's or doctoral degree. In addition, CRNAs have an average of 3.5 years of critical care experience before they even begin a nurse anesthesia program (https://www.aana.com/membership/become-a-crna).
On November 13, 2001, the Centers for Medicare & Medicaid Services (CMS) published in Federal Register a final rule amending the federal Medicare and Medicaid physician supervision requirement for CRNAs. The amendment gave state governors the ability to "opt-out" of the federal supervision requirement. The "opt-out" does not permit a CRNA to practice outside of

the scope of practice or licensure requirements. Recognizing the important role of CRNAs in the provision of healthcare to the state's residents, Kansas became an opt-out state in 2003, however barriers to CRNAs practicing to the full extent of their licensure and training remain.

CRNAs Provide Safe, High-Quality Healthcare

Multiple studies and systematic analyses have concluded that anesthesia care provided by CRNAs is safe and that patient outcomes are no different between anesthesiologists and CRNAs (Dulisse & Cromwell, 2010; Hoyem et al., 2019; Needleman & Minnick, 2009; Negrusa et al., 2016; Pine et al., 2003; Vitale & Lyons, 2021). In fact, a Cochrane Collaborative review concluded that no definitive statement could be made for anesthesiologists over CRNAs (Lewis et al., 2014). A study by Silber and colleagues (2000) is often cited as evidence that certain patient outcomes are better under direction of an anesthesiologist. However, that study has been criticised for its inadequate risk adjustment (i.e., assuming hospital size could explain differences in mortality) and a comparison group that was not cared for by an independent CRNA (McCleery et al., 2014).

CRNAs Increase Healthcare Access

CRNAs provide vital access to healthcare, specifically anesthesia care, in rural and underserved areas. Nationally, 55% of rural counties have no surgeon, 81% have no anesthesiologist, and 58% have no CRNA (Cohen et al., 2021). In Kansas, 16% of counties (n=17) have no anesthesia providers, 14% (n=15) have a mix of CRNAs and anesthesiologists, and 70% (n=73) have only CRNAs providing anesthesia services (derived from data from https://www.kana.org/). Of the more than 900 CRNAs in Kansas, over 80% work in non-metropolitan areas (https://www.kana.org/). This is similar to multiple national studies that show CRNAs provide the majority of anesthesia services in rural areas (Cohen et al., 2021; Feyereisen et al., 2018; MacKinnon, 2021; Martsolf et al., 2019; Mills et al., 2020). Facility leaders have stated that CRNAs are crucial to rural hospitals because physician anesthesiologists often see rural areas as less desirable, making recruitment difficult. In addition, CRNA salaries are seen as more cost-effective, which can be especially important to rural hospitals that tend to have lower reimbursement rates and high charity care (Mills et al., 2020).

Without a doubt you will hear arguments before you that by adopting these provisions you are allowing CRNAs to practice outside of their scope of practice, allowing them to practice medical anesthesiology, citing statutory requirements pursuant to the healing arts act. This could not be further from the truth. These provisions do not apply because persons practice advanced practice nursing within their scope of practice and licensure, are specifically "not engaging in the practice of the healing arts" pursuant to K.S.A. 65-2872(m). Thus, when CRNAs are performing services within their scope of practice, they are specifically NOT practicing medicine and surgery.

65-2872. **Persons not engaged in the practice of the healing arts.** The practice of the healing arts shall not be construed to include the following persons: (m) Nurses practicing their

profession when licensed and practicing under and in accordance with the provisions of article 11 of chapter 65 of the Kansas Statutes Annotated, and amendments thereto, and any interpretation thereof by the supreme court of this state. History: L. 1957, ch. 343, § 72; L. 1976, ch. 273, § 33; L. 1976, ch. 276, § 2; L. 2005, ch. 117, § 1; L. 2007, ch. 42, § 2; L. 2014, ch. 131, § 30; L. 2016, ch. 92, § 30; July 1.

National Bipartisan Support and Advocacy

National Academy of Medicine. In 2011, the Institute of Medicine of the National Academies (now the National Academy of Medicine) published a landmark report on nursing: The Future of Nursing: Leading Change, Advancing Health. The first key message from the National Academy of Medicine was nurses should practice to the full extent of their education and training, noting that a variety of historical, regulatory, and policy barriers have limited nurses' ability to generate widespread transformation" (Institute of Medicine of the National Academies [IMNA], 2011, p. 4-5). The key message goes to report "some states have regulations to allow nurse practitioners to see patients and prescribe medications without a physician's supervision or collaboration… what nurse practitioners are able to do once they graduate varies widely for reason that are related not to their ability, education or training, or safety concerns but to the political decisions of the state in which they work (IMNA, 2011, p. 5).

Federal Trade Commission. In 2014, the Federal Trade Commission (FTC) released a report commenting on the regulation of APRNs entitled "Policy Perspectives: Competition and the Regulation of Advanced Practice Nurses." The executive summary of this report states "effective collaboration between APRNs and physicians do not necessarily require any physician supervision, much less any particular model of physician supervision" (Federal Trade Commission [FTC], 2014, p. 3). The report additionally states "… APRNs play a critical role in alleviating provider shortages and expanding access to health care services for medically underserved populations. For these reasons, the FTC staff has consistently urged state legislators to avoid imposing restrictions on APRN scope of practice unless those restrictions are necessary to address well-founded patient safety concerns. Based on substantial evidence and experience, expert bodies have concluded that APRNs are safe and effective as independent providers of many health care services within the scope of their training, licensure, certification, and current practice. Therefore, new, or extended layers of mandatory physician supervision may not be justified" (FTC, 2014, p.2).

Summary

The extensive list of reference below is only a glimpse into the extensive knowledge surrounding CRNA practice, regulation, quality, and cost. The Covid-19 pandemic has highlighted weaknesses in our healthcare delivery system, one of which is the widespread mistrust in science. The science surrounding CRNA practice, regulation, quality, and cost must be acknowledge and translated into state and federal regulations as called upon by the National

Academy of Medicine in 2011, and numerous other bodies, and continuously supported by emerging research.

It is with that research and passage of SB 112 that the Kansas State Nurses Association respectfully ask for KSBN to pass SB 112 allow CRNAs to practice as independent advanced practice registered nurses to the full extent of their education and qualifications so that all Kansans will have access to safe, high-quality healthcare..

Best regards,

KANSAS STATE NURSES ASSOCIATION BOARD OF DIRECTORS

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