Testimony Re: HB2368
Presented by Donna Nyght
House Committee on Health and Human Services
February 17, 2025

Chairperson Carpenter and honorable members of the Committee,

Re: Against the credentialing of AAs to practice in Kansas.

My name is Donna Nyght, and I have been a Kansas resident my entire life, growing up in rural Franklin County. I earned my Bachelor of Science in Nursing, Master of Science in Nurse Anesthesia, and Doctor of Nursing Practice from the University of Kansas. From January 2008 through June 2024, I served as Chair of the KU Nurse Anesthesia Education Program. My testimony today is a product of my Kansas residency, role as Department Chair, role as a KANA Board member, and my expertise in nurse anesthesia education. I want to emphasize that I am retired and no longer employed by the University of Kansas. I am also a veteran of the US Army Nurse Corps, having served as a CRNA.

The KU Nurse Anesthesia Program has existed for 58 years and admitted the first class in 1967. The Program has transitioned from awarding certificates from 1969-1981 to bachelor degrees in 1982 when the Program was granted full department status in the School of Allied Health. The degree changed again when the Program achieved graduate status and the first master's degrees were awarded in 1987. In 2015, the first cohort graduated with a clinical doctorate degree: every nurse anesthesia program in the US had to convert to a clinical doctorate degree by 2022 or close.

The Program has steadily grown over the decades: there were 11 graduates in my class of 1993. The KU NA Department had been admitting 24 RNs per cohort since 2011. About ten years ago, the Council on Accreditation of Nurse Anesthesia Programs (COA) instituted a policy that any increase in class size would require application and approval for expansion. KU hired a new Dean for the School of Health Professions, Dr. Abiodun Akinwuntan in 2016 and one of his primary goals has been to increase enrollment. In addition, demand for CRNAs continued and the KU Nurse Anesthesia Department Faculty members supported increasing enrollment to help meet the demand, especially in the state of Kansas. The COA granted the requested admittance for KU to 36 per cohort, a 50% increase.

The KU Program currently has 30 clinical sites, including the primary clinical sites of KU Hospital (KUH) and KU Medwest Surgery Center (KUMW). The increase in student numbers has presented challenges in securing clinical placements in every phase of training. The KU Program must meet COA requirements for mandatory case numbers for the 108 students enrolled in the clinical doctoral program.

The clinical sites include:

- Kansas: KUH, KUMW, Manhattan, Atchison, Ottawa, Winfield, Parsons, Salina, Hays, El Dorado, Hutchinson, St. Joseph and St. Francis in Wichita, Providence, Ascentist Healthcare-Merriam, Children's Mercy Kansas, Advent Shawnee Mission Medical Center, Overland Park Regional, Menorah, St. Francis and Stormont Vail in Topeka, and Lawrence Memorial Hospital

- Nebraska: Kearney
- Oklahoma: Tahlequah: Cherokee Nation Public Health Hospital
- Missouri: Clinton, Warrensburg, Centerpoint, Research, and Children's Mercy.

The KU NA Program provides a well-rounded clinical experience for SRNAs. All students are exposed to cases at a Level 1 academic trauma center (medical direction model), urban surgery center, pediatric hospital, urban community hospitals, federal facility Cherokee Nation public health hospital, small community CRNA only facilities, critical access facilities, and hospitals where CRNAs work with anesthesiologists but independently. For four months of the year, KUH has about 32 KU SRNAs in anesthetizing areas every day (this is during the novice phase for the first-year students) and the other eight months of the year KUH has 20-25 SRNAs scheduled each day.

It would be devastating to the KU Program if AAs are hired at KUH, forcing the KU program to reduce the number of SRNAs scheduled at KUH.

It would be impossible to find another hospital in Kansas City that is willing to take even four SRNAs per day and most sites take one or two students at a time. SRNAs cannot be placed with AAs for clinical training, so any facility that is utilized that hires AAs will take jobs away from CRNAs and cases away from SRNAs. KU has already felt the negative impact of AAs employed at CMH: KU SRNAs have been told to stay home on clinical days because there are no CRNAs to work with, and there have also been days when the KU and UMKC (Truman) SRNAs have been forced to share a room. This scenario will become common at any facility utilized by the KU Program in Kansas that hires AAs and will have many detrimental effects on Kansas SRNAs, CRNAs, and the public they serve.

The KU Program strives to admit as many Kansas residents as possible while maintaining the position of accepting the most qualified RNs. Early admission for 12 of the 36 RNs per cohort is open to Kansas residents only. The COA requires a minimum of one year of experience as an RN and it must be in a critical care unit. KU doubles that requirement and requires two years of experience as an RN with a minimum of one year of experience in critical care. RNs admitted to the KU Program usually have over two years of experience. Most years Kansas residents make up 50-60% of each class. Every year there are RNs who move to Kansas City for nurse anesthesia education and have nothing in common with Kansas, but like it so much that they stay in the area after graduation and work as CRNAs.

I **want to again emphasize that allowing AA licensure and practice in Kansas would have a devastating effect on the clinical education of SRNAs from KU, Newman, and Texas Wesleyan University.** Since AAs must work under direct medical direction by anesthesiologists, they would work solely in the urban hospitals and primarily in the Kansas City and Wichita metro areas where a majority of the SRNAs are training every day. Any cases that AAs perform would be unavailable to both SRNAs and anesthesiology residents. A good way to explain this is: at present KU has 36 juniors and 36 seniors that combined equals 72 full time clinical SRNAs. On average, 20 KU SRNAs are scheduled at CRNA only or non-medically directed CRNA sites each month, so 52 are assigned to facilities such as KUH or Menorah where AAs could replace CRNAs. If KU had to find clinical sites for half of the 52, most would be outside of the Kansas City area and students would be away from their homes even more than presently required. I think it would be impossible to find enough clinical sites for the Kansas nurse anesthesia programs if AAs take jobs away from CRNAs in the state, potentially forcing the programs to decrease class sizes.

If SRNAs must spend more time away from their homes in Kansas City and Wichita, the programs and students would have the additional cost of more apartment rentals and travel costs. Another factor would be the difficulty of attracting the best RNs to a program where they are required to move to Kansas City, only to spend most of their junior and senior years at affiliate sites away from the area.

If AA's are licensed, it would have a devastating *effect* on the academic programs for CRNA's in Kansas, and the result will be an inability to provide enough CRNA's for the state of Kansas.

Since approximately 85% of the facilities in the state utilize CRNA only practices (where AAs absolutely cannot work), it makes no sense to harm the nurse anesthesia programs by allowing anesthesiologists to hire AAs, which they say are the equal of CRNAs. This is obviously a false statement and has been refuted by the testimony today.

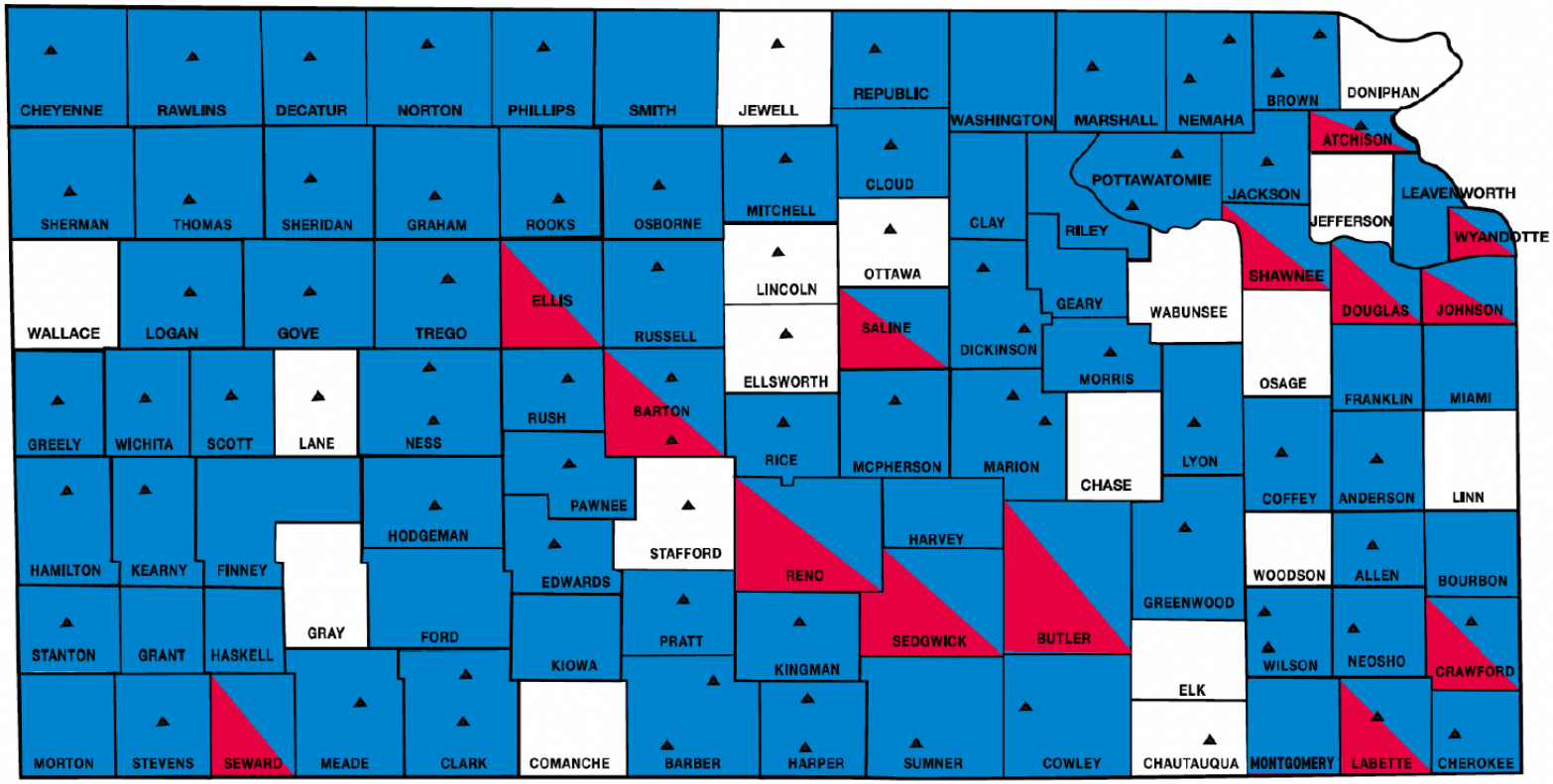
Thank you.

Dr. Donna Nyght, MS, DNP, CRNA

KANSAS ASSOCIATION OF NURSE ANESTHETISTS

KANSAS ANESTHESIA PROVIDERS

Coverage by Counties



Updated March 2024

Kansas Hospital Association Stat Book and
Blue Cross Blue of Kansas Shield Provider Directory

Map does not include Pain, Military, or VA Anesthesia Providers

CRNA only | CRNA and Anesthesiologist | No Anesthesia Providers | Critical Access Hospital

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