Testimony Re: HB 2295
House Health and Human Services Committee
February 18, 2019
Presented by Donna Nyght

Madame Chairman and honorable members of the committee,

Re: Opponent to HB 2295 licensure of AAs 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. Since 2008 I have been Chair of the KU Nurse Anesthesia Education Program. My testimony today is a product of my Kansas residency, my role as Department Chair, and my expertise in nurse anesthesia education: it does not reflect the views of 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 51 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 must 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 has been admitting 24 RNs per cohort since 2011. About five years ago, the 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. Dr. Akinwuntan fully supported growth in the Nurse Anesthesia Department, and the COA increased the allowed admittance for KU to 36 per cohort, a 50% increase. The class admitted in 2018 is 30 and the Department plans to admit the full 36 in 2019. There are two reasons for the admission of 30 rather than 36 students this year: financial constraints and need for additional clinical sites.

About four to five years ago, Dr. Talal Khan, Chair of KU Anesthesiology Department, asked me in a meeting if our Department could increase enrollment. I explained to him that programs must apply to the COA to increase the accredited number of spots in a program and we could not simply take more RNs. This was in a meeting to discuss increasing reimbursement to the NA Department for faculty CRNA work: it had been at the same level since 1993 when the program had half the number of students and faculty. The desire to increase enrollment was never brought up again, but a discussion

was initiated in a different meeting and an anesthesiologist stated that the NA Department should reimburse the Anesthesiology Department because staff CRNAs and anesthesiologists supervise KU SRNAs in clinical. The Anesthesiology Department was reminded that KU is a Board of Regents institution and that there is no money from the State of Kansas allocated to pay anesthesia providers for clinical supervision. The KU NA Department has always used many clinical sites in Kansas City, across Kansas, and in neighboring states: CRNAs and anesthesiologists at these sites have never asked for money to supervise SRNAs, and most view it as an appropriate means of recruiting and hiring future CRNAs as well as giving back to the profession.

The KU Program currently has 17 clinical sites, including the primary clinical sites of KU Hospital (KUH) and KU Medwest Surgery Center (KUMW). For basic requirements, our Program utilizes KUH, KUMW, two OB sites in Tahlequah, OK and Fort Riley, Children's Mercy (CMH) for pediatrics, and various sites for peripheral nerve blocks and additional cardiothoracic cases. The clinical sites include:

- Kansas: KUH, KUMW, Fort Riley, Ottawa, Winfield, Ark City, Salina, Lakin, Providence, Shawnee Mission Medical Center, Overland Park Regional, Menorah, and working on contracts with Hays and St. Francis in Topeka
- Nebraska: Kearney
- Oklahoma: Tahlequah and working on contract with Hillcrest in Tulsa
- Missouri: Clinton, Centerpoint, and CMH.

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 facilities on an Army base and a Cherokee Nation public health hospital, small community CRNA only facilities, and hospitals where CRNAs work with anesthesiologists but independently. For four months of the year, KUH has about 30 of our 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 18-20 SRNAs scheduled each day.

It would be devastating to our Program if AAs are hired at KUH, forcing us 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 we utilize that hires AAs will take jobs away from CRNAs and cases away from SRNAs. We have already felt the negative impact of AAs employed at CMH: KU SRNAs have been told to stay home on more than a few 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 our 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 our position of accepting the most qualified RNs. 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. In last May's graduating class, four graduates accepted jobs out of state in Texas, Oklahoma, Missouri, and Nebraska. The other 19 or 83% stayed in Kansas, with two of them taking jobs in Salina.

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 24 juniors and 24 seniors that combined equals 48 full time clinical SRNAs. On average, 11 KU SRNAs are schedule at CRNA only or non-medically directed CRNA sites each month, so 37 are assigned to facilities such as KUH or Menorah where AAs could replace CRNAs. If I had to find clinical sites for half of the 37, 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 our increasing class size (24 to 36) if AAs take jobs away from CRNAs in Kansas, potentially forcing KU to decrease the class size. If SRNAs must spend more time away from their homes in Kansas City, the KU Program 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. Certainly, this information alone is sufficient evidence that Criterion 6 is not met by this application.

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