WRITTEN ONLY TESTIMONY

Dear Chairman Suellentrop and the Senate Public Health and Welfare Committee Members:

My name is Jessica Sweeney, and I am a physician practicing adult and pediatric anesthesiology at The University of Kansas Health System. I am writing to express my support for the licensure of Certified Anesthesiologist Assistants (CAAs) in the State of Kansas.

Currently in Kansas, anesthesiologists have only one choice for hiring physician extenders: CRNAs. This severely limits our options in recruiting qualified individuals to be a part of our anesthesia care teams. As a result of reduced workforce supply, healthcare costs are driven up by overtime/PRN (as-needed) coverage of CRNAs, and care shortages are a harsh reality in many areas of Kansas. All other physicians in Kansas have the choice of hiring Nurse Practitioners (NPs) or Physician Assistants (PAs) as midlevel providers. CAAs (the PA equivalent in anesthesia) have similar training as CRNAs (the NP equivalent in anesthesia) and are capable of covering all case types with similar safety records.

I had the privilege of training and working alongside CAAs and CRNAs as a medical student, resident, fellow, and eventually a staff anesthesiologist at Emory University in Atlanta, Georgia. Over those ten years, I gained experience within anesthesia care teams at Grady (a busy Level 1 Trauma Hospital), Egleston (a dedicated Level 1 pediatric hospital), the Atlanta VA, and numerous hospitals within the Emory Healthcare system including its main academic center, ambulatory surgery center, and affiliated community and specialty hospitals. In all those various settings, I saw how well physician-led teams worked, with either CAAs or CRNAs as the experienced in-room providers. In fact, during that time, I often had trouble distinguishing which of my teammates were CAAs vs CRNAs, but I could always be sure that whoever stood at that bedside with me had gone through rigorous training and certification to be there. What mattered most to us in the OR was coming together as a team with a well-coordinated plan of anesthesia care. I did not sense any tension or competition. Instead, what I felt was a camaraderie amongst all team members: CAAs working well with CRNAs, residents, students, and staff; everyone working to the best of their training and ability to improve patient care and safety.

In contrast, I spent a year at a Level 1 Trauma hospital in Chicago while my husband finished his surgical training. In Illinois, CAAs are NOT licensed to practice. I saw then how the high cost of CRNAs limited our options and availability of mid-level providers, and this crippled our ability to offer a care team model approach consistently to our patients. This often meant fewer trained "hands on deck" when a crisis situation arose. Just to give you an idea of what a crisis situation might entail: an anesthesiologist may need to rapidly diagnose and manage a sudden medical issue, while communicating with the surgeon about patient's status changes AND coordinating for additional equipment and resources AND managing the patient's airway AND pushing life-saving medications to stabilize a patient's hemodynamics... So you can see how having other in-room providers—specifically trained in managing basic anesthesia care— would be a valuable addition in these scenarios. From this experience, I am a firm believer that especially in higher-acuity cases with critically-ill or medically complex patients, or in off-site locations like radiology or cardiology where anesthesia services are increasingly being provided, our patients are best served with more well-trained anesthesia providers on-hand and available to safely deliver care together.

Just across the state line, we have CAA students training in Missouri, many of whom are residents of Kansas or bordering states. We are missing out on an excellent opportunity to recruit from a pool of qualified practitioners who are highly motivated to serve their home community. The introduction of CAAs into our state should not threaten the livelihood of our CRNAs. This is particularly important to us at the University of Kansas, since we have a thriving student nurse anesthetist program and a vested interest in seeing our own well-trained students successfully placed as CRNAs upon graduation. NPI data shows that when CAAs entered the marketplace in a particular state, they did not displace any nurse anesthetists. On the contrary, there is a higher percentage of nurse

anesthetist growth in states with CAAs versus states without CAAs. Reimbursement rates should not change, as CAAs are recognized by CMS, Tricare (the military's health insurance), the VA, and all major commercial payers. According to data from the Bureau of Labor and Statics, the **cost of anesthesia care decreases** in states with CAAs.

Since moving here to Kansas, I have felt so proud to be a part of the high-caliber anesthesia care teams at KU. I want Kansas health centers to be able to recruit from the best of the best so we can continue to improve the value of the excellent care we are already providing to the citizens of Kansas. So, please; consider welcoming CAAs into our wonderful state.

Please feel free to contact me if you need any further information or clarification.

Respectfully,

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