The New York State
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Just the Facts

OPPOSE S.9507/S7507

PART H Governor's Health Budget

Below we have detailed "Just the Facts" refuting NYSANA's (an association representing allied health professionals) misleading and false assertions presented in testimony and recent press releases. We work side by side in the Operating Room everyday with their members but they are not doctors and our society of Anesthesiologist Physicians we will not waiver from our insistence of PATIENT SAFETY!

NYSANA

More than 30 years of scientific study has demonstrated that CRNAs administer safe, quality care with patient outcomes equivalent to anesthesiologists.

Just the Facts

In Fact, Scientific Studies find the opposite:

"mortality and failure-to-rescue rates were higher for patients who underwent operations without medical direction by a physician anesthesiologist"

Studies referenced in the NYSANA press release of March 1, 2018, were prepared by consulting firms underwritten and paid for by the American Association of Nurse Anesthetists (AANA). The conclusions of the AANA-funded studies are not scientifically sound.

- The Negrusa study contains errors by using billing modifier QZ to define CRNA-solo practice despite that the QZ modifier is being commonly used when physician anesthesiologists are involved in the case.

- The Negrusa study uses classifications of state scope of practice laws based on “an analysis conducted by the AANA” and refers loosely to nursing or facility statutes and regulations. NYSSA submits that the classification does not accurately reflect state statutes and regulations and ignores state medical statutes and regulations.
- The Negrusa study contains a weak statistical model because it does not include hospital variables, which often confound differences in patient outcomes.
- The Health Affairs paper reflects the weaknesses of billing data when used to make an assessment of safety and quality. These billing data were not created for this purpose and do not distinguish between complications resulting from surgery or anesthesia, nor do they discriminate between conditions existing prior to surgery and those resulting from surgical or anesthetic care. Further, an insufficient number of cases was used to support any conclusions about mortality.
- Consider instead, an independent study published in the peer-reviewed journal *Anesthesiologist* found that mortality and failure-to-rescue rates were higher for patients who underwent operations without medical direction by a physician anesthesiologist *(Silber JH, Kennedy SK, Even-Shoshan O, Chen W, Koziol LFL, Showan AM, Longnecker DE: Anesthesiologist direction and patient outcomes. Anesthesiology 2000; 93: 152-63.)*

NYSANA

CRNAs practice in every setting where anesthesia is offered, for every type of procedure

Just the Facts

In Fact, they do every type of procedure but only under the supervision of a physician’s consistent with the State of New York’s Health Code

CRNA’s do practice in all these settings but only under the supervisions of a physician consistent with the State of New York’s Health Code. The physician-led anesthesia care team is the standard of care in each of the venues listed where the administration of anesthesia occurs. In fact, the Department of Veterans Affairs in January 2017, after extensive analysis and review of comments, announced that they rejected a collaborative relationship for nurse anesthetists (even after approving collaborative relationships for three other advance practice nurse specialties) because of significant questions raised about the safety of “solo” CRNA model of anesthesia. The outcome of this final rule was to maintain physician-led anesthesia care in all VA hospitals.

NYSANA

This geographic imbalance is no more pronounced than in our rural counties across Upstate, NY.

Just the Facts

In Fact, their own study found the opposite!

In 2014, NYSANA commissioned a survey of 46 upstate New York hospitals on what NYSANA suggested were a set of problems sometimes associated with the provision of anesthesia services [prepared by The Center for Health Workforce Studies' (CHWS), at SUNYAlbany]. The survey revealed that:

- Only 28 hospital administrators of the 203 hospitals in New York State (about 14%) responded to the CHWS survey and revealed further that less than 13% of the respondent hospital administrators had any serious problems providing anesthesia services (equating to less than 4 out of 203 hospitals across New York State); and
- For those hospitals having trouble attracting physician anesthesiologist, they also had difficulty attracting nurse anesthetists in essentially the same proportion. The first highlight of the CHWS 2014 study claims 40%-50% of anesthesia services were provided by nurse anesthetists in upstate/rural hospitals ignoring the fact, which they later acknowledge in the survey, that a physician anesthesiologist was also involved in 85% of those cases (an operative surgeon was supervising in the rest).

The current protocol in NYS is cost effective. Physician anesthesiologists avoid added consultations, screenings, and tests that drive up costs. According to a *New England Journal of Medicine* review, "pre-surgical assessment and preparation of patients for surgery by physician anesthesiologists significantly reduces unnecessary testing and preventable cancellations of surgery. Physician anesthesiologists reduced medical consultation requests by 75 percent, the cancellation of operations for medical reasons by 88 percent and the cost of laboratory tests by 59 percent." Under federal CMS guidelines, there is no reimbursement differential that favors nurse anesthetists over physician anesthesiologists and most commercial payers pay the same reimbursement. Finally, when nurse anesthetists' compensation is adjusted to the same number and types of hours worked by physician anesthesiologists, nurse anesthetists are 70% the cost of private practice anesthesiologists and 93% that of academic anesthesiologists.

NYSANA

Bottom line: removing restrictive barriers to practice including outdated, unnecessary supervision requirements translates into greater patient access to more efficient and cost-effective care for our hospitals at a time when they must fully utilize every resource they have.

Just the Facts

In Fact, the current physician supervision requirements for anesthesia save lives. New York's Patients deserve safe anesthesia.

- The current scope of practice for nurse anesthetists is under physician supervision; nurse anesthetists' training and education is based on the physician-led anesthesia care team model. The restrictive barriers characterized as being "outdated" are really a set of protections.

— Protection for patient safety.

— Protection from liability.

— Protection for the surgical team in the OR.

— Protection for nurse anesthetists from the undesired consequence of an emergency that would stretch their bounds of education and training.

- Most, if not all, of the "barriers" suggested are ones NY physician anesthesiologists would agree are true, but for different reasons:

— TRUE, nurse anesthetists lack the ability to prescribe medications and to write patient treatment orders – ***BECAUSE*** they lack the proper medical training to safely perform this important duty.

— TRUE, nurse anesthetists lack the ability to conduct patients' physical assessments – ***BECAUSE*** they lack the medical training to properly evaluate a patient's suitability to withstand surgery.

— TRUE, nurse anesthetists are not permitted under existing NYS Medicaid rules to bill independently – ***BECAUSE*** state law mandates a physician anesthesiologist medically direct a nurse anesthetist in the administration of anesthesia. This requires the physician to be responsible for the pre-operative, intra-operative, and post-operative care of the patient, a duty that requires the discipline of extensive medical training.

NYSANA

Regardless of who your anesthesia provider is, however, we administer anesthesia services in exactly the same way: our techniques are the same, the equipment, anesthesia agents and drugs we use are the same and most importantly our patient outcomes are the same. ...

Just the Facts

In Fact, physician anesthesiologists prevent more than six excess deaths per 1,000 cases in which an anesthesia or surgical complication occurred.

Anesthesiology remains a life-or-death matter.

- Physician anesthesiologists have improved anesthesia safety and delivery for the benefit of their patients but risks still remain.
- There has been a decrease in anesthesia-related deaths over the past three decades[1] :
  - — From the 1950's through the 1970's, there were approximately **two deaths per 10,000 anesthetics**.
  - — Today, there is approximately **one death per 200,000 to 300,000 anesthetics**.
- Physician anesthesiologists have designed safer anesthesiology medicines, devices, and methodologies and preventable mishaps have declined.
- A physician applies advanced medical knowledge to diagnosing and preventing factors that contribute to complications of patients receiving anesthesia.
- According to the Agency for Healthcare Research and Quality (AHRQ), physician anesthesiologists prevent more than six excess deaths per 1,000 cases in which an anesthesia or surgical complication occurred.
- American Society of Anesthesiologist's ("ASA") comprehensive patient safety efforts over the past three decades were designated a "gold standard" for medical specialties in the Institute of Medicine report on patient safety, *To Err is Human*.
- Physician anesthesiologists are involved in every type of anesthetic procedure from the most basic to the most complicated. Physician anesthesiologists, with increasing frequency, complete enhanced subspecialty training in: pain medicine, hospice and palliative care medicine, sleep medicine, pediatric anesthesiology, cardiac anesthesiology, neurological anesthesiology, and other subspecialties. This enhanced training clearly distinguishes physician anesthesiologists from nurse anesthetists.

[1] Source: Committee on Quality of Healthcare in America, IoM: To err is human, building a safer health system. Edited by Kohn L, Corrigan J, Donaldson M, Washington Academy National Press, 1999, p 32.