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Just the Facts – Answering NYSANA
A7100 (Bichotte) / S5885 Gaughran
Equal Access to Safe Anesthesia Bill

What they have said: This bill purports to codify the practice of nurse anesthesia. It does not. It was written by doctors to protect the practice and employment of doctors at the expense of nurses. This bill was written and introduced by special interests—the New York State Society of Anesthesiologists and the Medical Society of the State of New York—and intends to allow physicians to exert control over nurses.

Just the Facts: NYSSA did not write the bill. MSSNY did not write the bill. The Legislators wrote the bill.

This bill grants title to nurse anesthetists and defines the scope of practice of a nurse anesthetist wholly consistent with existing standards set forth in the NYS Health Code Part 405.13 and Part 755.4. The NYS Health Code mandates that a nurse anesthetist be supervised by a physician. For a comparison of the provisions contained in A7100/S5885 and the NYS Health Code, see attached chart. The operating room is a unique environment; every surgery and procedure has risks. When seconds count, when a life hangs in the balance, when medical emergencies or other complication occur, it is imperative that the roles of the physician-anesthesiologist and nurse anesthetist are clear. Enactment of the A7100 (Bichotte) / S5885 (Gaughran) bill achieves this clarity.

What they have said: Doctors cannot be allowed to control the profession of nursing. That's why the New York State Association of Nurse Anesthetists (NYSANA), the professional association of nearly 1,400 Certified Registered Nurse Anesthetists (CRNAs) practicing in New York State, STRONGLY OPPOSES this bill.

Just the Facts: A predominant method of delivery of anesthesia to patients in NYS is through the **physician-led anesthesia care team** wherein the physician-anesthesiologist supervises nurse anesthetists (or resident physicians) in the provision of anesthesia care. The physician-anesthesiologist may delegate monitoring and appropriate tasks to the nurse anesthetist while retaining overall medical and legal responsibility for the patient. As such, it is not possible to define the scope of practice of a nurse anesthetist without also defining the roles of both the physician-anesthesiologist and operative physician.

What they have said: CRNAs have been providing anesthesia care in New York for more than 150 years. Today, New York CRNAs work in hospitals, military facilities, ambulatory surgery centers, physicians'

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offices, pain clinics, universities, dental offices, ophthalmologists' offices, oral surgeons' offices, plastic surgery centers, pain management clinics, prisons, and for the Veterans Administration.

Just the Facts: 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.

What they have said: CRNAs are masters and doctoral-prepared nurses with national certification who practice across healthcare settings, administering approximately 65 percent of all anesthetics provided in the U.S. CRNAs provide anesthesia care to all categories of patients, for all types of procedures, in every setting where anesthesia is administered. They are also the primary anesthesia providers in the majority of rural hospitals throughout New York State.

Just the Facts: Anesthesiology is the practice of medicine. No matter how many doctoral degrees nurses have, those degrees are in NURSING not in medicine. In New York State 100% of anesthetics are supervised by physicians because the New York State Health Code mandates supervision. In New York State, there are approximately 3,417 physicians who specialize in the field of anesthesiology and pain medicine; there are approximately 1,244 nurse anesthetists. 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.

What they have said: New York is home to some of the strongest CRNA graduate programs in the country. The existing requirements CRNAs must meet to receive their advanced degree have resulted in the high quality, professional standard of care exhibited by CRNAs today. CRNA education programs range from 24-36 months, result in masters or doctoral degrees, and have been certified by the New York State Education Department (NYSED) as nurse practitioner programs. CRNAs acquire over 1,800 total patient care hours including research and clinical residency, and most have several years of advanced critical care nursing experience as well. Finally, CRNAs must pass a national certification examination and obtain 40 hours of approved continuing education every two years for re-certification.

Just the Facts: There are significant differences in the education, training, and responsibilities of physician-anesthesiologists and nurse anesthetists. Physician-anesthesiologists are highly trained medical specialists; physicians who complete 12,000-16,000 hours of clinical training in anesthesia and in pain and critical care medicine. Nurse anesthetists complete only 1,651 hours of clinical training. A doctorate in nursing is not equivalent to a doctorate in medicine. New York State is also the home of the strongest physician-anesthesia programs in the U.S.A.

What they have said: This bill would restrict the practice of CRNAs by only allowing them to practice in the presence of an anesthesiologist. This does not reflect national standards of anesthesia practice or current practice in New York State.

Just the Facts: This bill would simply maintain the current anesthesia delivery rules that already exist in New York State and does not require nurse anesthetists to administer anesthesia only under the supervision of an anesthesiologist. At the same time, it would grant the long sought after title the nurse anesthetists claim to be seeking. The verbatim language in this bill is:

> Section 1, Paragraph 4(b)(i): ... only under the supervision of an anesthesiologist who is immediately available; **or under the supervision of the operating physician who is physically present; or under the supervision of a dentist, oral surgeon or podiatrist who is physically present** ...

What they have said: The language in this bill reflects conditions of participation in the Medicare reimbursement system under the federal Tax Equity and Financial Reimbursement Act (TEFRA). It has been clearly stated by the federal Health Care Financing Administration (currently the Center for Medicare and Medicaid Services) that these TEFRA conditions do not constitute a standard of care in the delivery or administration of anesthesia. Rather, they constitute a method of reimbursement.

In other words, the conditions set forth in this bill specify what an anesthesiologist must do in order to be paid when a CRNA administers the anesthetic. These provisions do not pertain to the scope of practice of CRNAs and do not belong in an act codifying their practice.

Just the Facts: The standard of care contained in the bill is wholly consistent with NYS Health Code Part 405.13 and incorporates language to define terms contained in the Health Code, including "supervision" and "physically present" to clarify the existing standard and not create a new standard. In other words, the A7100 (Bichotte) / S5885 (Gaughran) bill do not restrict the practice of nurse anesthetists.

What they have said: Rising healthcare costs coupled with fewer providers in underserved areas have had a severe impact on our healthcare system. Nationally, CRNAs make up almost half the total anesthesia-provider workforce, but they represent only one quarter of New York State's total anesthesia workforce, leading to limited access and increased cost.

Just the Facts: 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.

What they have said: Presently, many of New York State nurse anesthesia graduates are relocating to other states where they can practice to the full extent of their education and training. New York cannot afford to lose any more of its nursing workforce.

Just the Facts: The number of nurse anesthetists practicing in New York State has steadily increased over the past several years. Now at 1,244 in New York State, in 2001 they numbered approximately 800.

What they have said: NYSANA supports the removal of barriers that prevent nurses from practicing to the full extent of their education and training. We believe that allowing nurses to practice to their fullest extent improves the quality of and access to healthcare for all New Yorkers. This bill does just the opposite.

Just the Facts: 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 2014 NYSANA commissioned survey mentioned above outlined a "set of problems" or barriers to a nurse anesthetist's practice. The set of problems presented is 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 in the survey 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.

What they have said: On behalf of rural hospitals and the underserved, the practice of CRNAs needs to be preserved. This bill creates a disincentive for CRNAs to practice to the full scope of their education and ability, which could severely limit anesthesia services in rural and underserved areas of New York State.

Just the Facts: The enactment of this bill A7100 (Bichotte) / S5885 (Gaughran) will preserve the existing and long-standing NYS Health Department regulations mandating the physician-led anesthesia care team. Nurse anesthetists have been administering anesthesia in all venues where anesthesia may be administered in accordance with this standard of care.

Attachment: Comparison chart

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COMPARISON OF BICHOTTE (A.7100) / GAUGHRAN (S.5885) BILLS AND NEW YORK STATE HEALTH CODE

Legislative Session 2019-2020

Bichotte/Gaughran Bills Are Consistent With Existing Statewide Minimum Standards Which Have Contributed To Unprecedented Safe Anesthesia Delivery in New York State

	Bichotte (A.7100) / Gaughran (S.5885) Bills	NYS Health Code (adopted 1989)
Important Sections of Bills	4(b) The practice of professional nursing by a registered nurse anesthetist, certified under section sixty-nine hundred twelve of this article, shall (i) include the administration of anesthesia to a patient but only under the supervision of an anesthesiologist who is immediately available; or under the supervision of the operating physician who is physically present; or under the supervision of a dentist, oral surgeon or podiatrist who is physically present and who is authorized by law to administer anesthesia, to the extent such person is qualified by law, regulation or hospital appointment to perform and supervise the administration of anesthesia; and (ii) include the execution of medical regimens prescribed by the supervisory physician, dentist, oral surgeon or podiatrist who is authorized by law to prescribe; and (iii) be consistent with policies and procedures approved by the medical staff and governing body of the health care facility, or free standing ambulatory surgical center defined under article twenty-eight of the public health law, where applicable, and as legally authorized under this title and in accordance with applicable regulations of the commissioner of health.	10 NYCRR §405.13(a)(1) (Hospitals): ...Anesthesia shall be administered in accordance with their credentials and privileges by the following: (i) anesthesiologists; (ii) physicians granted anesthesia privileges; (iii) dentists, oral surgeons, or podiatrists who are qualified to administer anesthesia under State law; and (iv) certified registered nurse anesthetists (CRNA's) under the supervision of an anesthesiologist who is immediately available as needed or under the supervision of the operating physician who has been found qualified by the governing body and the medical staff to supervise the administration of anesthetics and who has accepted responsibility for the supervision of the CRNA; or (v) a student enrolled in a school of nurse anesthesia accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs may administer anesthesia as related to such course of study under the direct personal supervision of a certified registered nurse anesthetist or an anesthesiologist. 10 NYCRR §405.22(l)(6)(vi) (Critical Care and Special Care Services; Live Adult Liver Transplantation Services): Anesthesia Requirements: (c) These teams shall each be directed by a separate attending anesthesiologist for the live donor and the recipient procedure. In addition to the attending anesthesiologist who shall be present as specified in clause (a) above, at least one member of the anesthesia team who is an anesthesiologist, chief resident, fellow (postgraduate year 3, 4, or 5), and/or qualified certified registered nurse anesthetist shall be present and responsible, under the direction of the attending anesthesiologist, for the evaluation and care of the patient through all phases of the procedure pertaining to the administration of, and recovery from, anesthesia. All team members shall have ongoing education and training in liver and/or cardiac surgery and have had anesthesia responsibility for major liver resections. 10 NYCRR §755.4 (Free-Standing Ambulatory Surgery Centers): The operator shall ensure that: (a) an anesthesiologist, licensed by and currently registered with the New York State Education Department, and who meets the definition of a qualified specialist, is responsible for the anesthesia services and may fulfill the requirement for medical director;

	Bichotte (A.7100) / Gaughran (S.5885) Bills	NYS Health Code (adopted 1989)
		(b) administration of anesthesia is in accordance with current standards of professional practice; (c) anesthesia is administered by only a qualified anesthesiologist, or a physician or dentist qualified to administer anesthesia, or a certified registered nurse anesthetist; (d) when nonphysicians administer anesthesia, the anesthetist must be under the direct personal supervision of a qualified physician, who may be the operating surgeon; (e) the person administering the anesthesia, other than local anesthesia, is not the operating surgeon; and (f) a physician examines each patient immediately prior to surgery to evaluate the risk to anesthesia and the procedure to be performed.
Definitions		
"Administration of Anesthesia"	(i) "Administration of anesthesia" in the hospital or ambulatory surgical center means anesthesia services shall be directed by a physician who has responsibility for the clinical aspects of organization and delivery of all anesthesia services provided by the hospital or ambulatory surgical center. That physician or another individual qualified by education and experience shall direct the administrative aspects of the service, and shall be responsible, in conjunction with the medical staff, for recommending to the governing body privileges to those persons qualified to administer anesthetics, including the procedures each person is qualified to perform and the levels of required supervision as appropriate. Administration of anesthesia in office based surgery venues means the anesthesia component of the medical or dental procedure shall be supervised by an anesthesiologist, physician, dentist or podiatrist qualified to supervise the administration of anesthesia who is physically present and available to immediately diagnose and treat the patient for anesthesia complications or emergencies, and nurse anesthetists with the appropriate training and experience may be permitted to administer unconscious or deep sedation, and/or general	10 NYCRR §405.13(a) (Hospitals): Organization and direction. Anesthesia services shall be directed by a physician who has responsibility for the clinical aspects of organization and delivery of all anesthesia services provided by the hospital. That physician or another individual qualified by education and experience shall direct administrative aspects of the service. 10 NYCRR §405.13(a)(1) (Hospitals): The director shall be responsible, in conjunction with the medical staff, for recommending to the governing body privileges to those persons qualified to administer anesthetics, including the procedures each person is qualified to perform and the levels of required supervision as appropriate. 10 NYCRR 405.13(b): Operation and service delivery. Policies governing anesthesia services shall be designed to ensure the achievement and maintenance of generally accepted standards of medical practice and patient care.

	Bichotte (A.7100) / Gaughran (S.5885) Bills	NYS Health Code (adopted 1989)
	anesthesia, regional anesthesia, and/or monitor the patient.	
"Supervision"	(xiii) "Supervision" means that a physician, dentist, oral surgeon or podiatrist shall perform a pre-anesthetic examination and evaluation, prescribe the anesthesia, including post-operative medications as needed for pain and discomfort, including nausea and vomiting, remain physically present during the entire peri-operative period and immediately available for diagnosis, treatment, and management of anesthesia related complications or emergencies, and assure the provision of indicated postanesthesia care.	10 NYCRR §405.13(a)(1) (Hospitals): ...Anesthesia shall be administered in accordance with their credentials and privileges by the following: (iv) certified registered nurse anesthetists (CRNA's) under the supervision of an anesthesiologist who is immediately available as needed or under the supervision of the operating physician who has been found qualified by the governing body and the medical staff to supervise the administration of anesthetics and who has accepted responsibility for the supervision of the CRNA; or... 10 NYCRR §755.4 (Free-Standing Ambulatory Surgery Centers): The operator shall ensure that: (d) when nonphysicians administer anesthesia, the anesthetist must be under the direct personal supervision of a qualified physician, who may be the operating surgeon; Additionally, the Health Department takes the position that, in the hospital and ambulatory surgical center settings, if the operative physician is supervising the delivery of anesthesia, that physician must satisfy the following basic requirements: (1) Appreciate the risks of anesthesia; (2) Possess the medical knowledge and judgment with respect to the administration of anesthesia required to supervise the process; and (3) Accept legal and medical responsibility for the supervision and for the patient.
"Physically Present"	(x) "Physically present" by a physician means the ability to react and respond in an immediate and appropriate manner so as to make possible the continuous exercise of medical judgment throughout the administration of the anesthesia. "Physically present" by a dentist, oral surgeon or podiatrist means the ability of such person who is performing the procedure requiring the administration of anesthesia to react and respond in an immediate and appropriate manner so as to make possible the continuous exercise of professional judgment throughout the administration of the anesthesia.	10 NYCRR §405.13(a)(1)(iv) (Hospitals): ...certified registered nurse anesthetists (CRNA's) under the supervision of an anesthesiologist who is immediately available as needed or under the supervision of the operating physician...