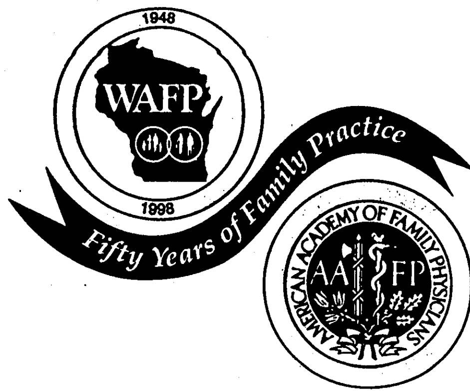

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Wisconsin Academy of Family Physicians Testimony Before the Senate Health Committee March 15, 2000

Members of the committee, thank you for the opportunity to address you today. I am speaking on behalf of the Wisconsin Academy of Family Physicians. We represent over 1400 doctors in the state, the largest single medical specialty in the state, also the most geographically dispersed group, providing cradle to grave primary health care to Wisconsin citizens in small towns and big cities, solo practices and large HMOs. We are Wisconsin's family doctors and in many settings, we work side by side with advanced practice nurses.

We oppose the proposed change in N 8.

First, we feel the wording of the rule before you is misleading. Despite saying "may not independently order," the rest of the rule goes on to effectively allow independent ordering. All test-ordering by any clinician should be related to his or her seeking an appropriate diagnosis to facilitate prescribing or providing other appropriate remedies. So actually, the current rule is like saying "You may not independently scratch your nose unless it itches." The awkwardness appears to be necessitated by the framework of N. 8. The purpose of N. 8 is to implement the prescribing privileges provided to advanced practice nurse prescribers in sec. 441.16 of the statutes. It is awkward to fit the proposed expanded scope into a rule with essentially a different purpose.

Second, and far more importantly than the awkwardness of the rule, the rule significantly expands the scope of APNP practice without any sort of required collaborative relationship with physicians. Why are we pushing for collaboration? Because we feel that the rule should codify what is actually happening in the real world and recognized by most practitioners in both professions as a crucial element of patient protection. Advanced practice nurses are working throughout the state in a variety of relationships with physicians, some very closely supervised, others essentially independent except for occasional collegial conferencing. We feel the rule should reflect this range of collaboration and can be written in such a way as to make nurses not feel and, in fact, not be under the thumb of physicians. For the most part, both professions appear to support the current relationships as being best for their patients, but cannot agree on how these relationships should be recognized or enforced.

Third, most patients assume their APNP is in a collaborative relationship with a physician and believe that their APNP will consult a physician colleague when the need arises. I believe it is fair to say that most patients do not realize the ramifications of the increasingly independent practice. For example, this independence is not accompanied by commensurate liability protection. We have resisted asking our colleagues in the trial bar to weigh in on this subject, but the committee should understand that citizens seeing advanced nurse practitioners who are not in collaborative relationships with physicians, do not have recourse to the same sorts of malpractice funds as those seeing physicians or nurses in collaboration with physicians.

A fourth issue which the proposed rule does not address is reimbursement. Part of the impetus for this rule change was to allow advance practice nurses to bill Medicare directly for their services. New Medicare statutes, the relevant excerpts of which you have before you as Exhibit 1, state that advance practice nurses may charge for their services if collaborating with a physician.

Since the original rule change was proposed last fall, the Academy has sought to find an alternative which would be acceptable to the nursing and medical establishments. At the end of January, representatives of the Wisconsin Nurses Association, our Academy and the State Medical Society came up with compromise wording, Exhibit 3. The Board of Nursing rejected this wording, apparently feeling it was too restrictive.

At the end of February, working closely with representatives of the Wisconsin Nurses Association and of the Advanced Practice Nurses Association, we developed a carefully constructed compromise which met all our criteria for collaboration and was initially acceptable to the representatives from Nursing as well, Exhibit 4. Our proposal included authorizing advanced practice nurse prescribers to order tests when they are in a collaborative relationship with a physician. The proposal also relied on a policy statement interpreting collaborative relationships to ensure the possibility of Medicare payment for APNP's as an interim step to a permanent rule. The policy statement and subsequent rule change were to clarify that APNP's should be practicing in collaborative relationships with MD's to prescribe, as well as to order tests. We were prepared to come to this committee to testify in support of that compromise.

What happened to it? The State Medical Society, which had a representative present at the meeting, felt they could not support the compromise, because they were concerned that a "policy statement" did not have the effect of law. Then, the Board of Nursing rejected it, apparently feeling it was still too restrictive.

It occurred to us that when a proposal leaves both sides slightly unhappy, perhaps you have found a good answer.

As I mentioned before, the wording of the proposed rule, with its double negative, seems unduly complex, and the alternative wording offered in Exhibit 3 does not solve this problem. The awkwardness apparently arises from attempting to expand the scope of practice with regard

to test-ordering within rule N. 8.06 (Exhibit 5) which has a different purpose, namely, to define prescribing limitations for advanced practice nurse prescribers.

WAFP would like to suggest, instead, amending N. 8.10 (Exhibit 6), which addresses case management and collaboration with other health care professionals. Our proposal is exhibit 7. This proposal

- Turns the double negative on test-ordering into a positive,
- Meets Medicare requirements on collaboration,
- Should satisfy most of our physician colleagues, and
- Still affords APNP's the independence they are seeking.

We realize this is new material for all involved and would be happy to participate in further discussions of this suggestion. Failing any willingness on the part of the Board of Nursing to consider this reasonable proposal, we will again state our support for the SMS wording and opposition to the rule. Thank you for the opportunity to address the committee on this important issue.

Calvin S. Bruce, Legislative Chair

Wisconsin Academy of Family Physicians
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EXHIBIT 1
MEDICARE STATUTES REGARDING REIMBURSEMENT FOR APNP'S:

The relevant statute which defines reimbursable services is Clause (ii) of section 1862(s)(2)(K) (42 U.S.C. 1395x(s)(2)(K)) which was amended to read:

(1) IN GENERAL - Clause (ii) of section 1862(s)(2)(K) (42 U.S.C. 1395x(s)(2)(K)) is amended to read as follows:

"(ii) services which would be physicians' services if furnished by a physician (as defined in subsection (r)(1)) and which are performed by a nurse practitioner or clinical nurse specialist (as defined in subsection (aa)(5)) working in collaboration (as defined in subsection (aa)(6)) with a physician (as defined in subsection (r)(1)) which the nurse practitioner or clinical nurse specialist is legally authorized to perform by the State in which the services are performed, and such services and supplies furnished as an incident to such services as would be covered under subparagraph (A) if furnished incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services."

Minus the verbiage, this says:

". . . services . . .which are performed by [an APN] working in **collaboration** . . . with a physician . . .which the [APN] is legally authorized to perform by the State . . ."

Collaboration is subsequently defined:

42 USCA §§ 1395x (6)

(aa)(6) The term "**collaboration**" means a process in which a nurse practitioner works with a physician to deliver health care services within the scope of the practitioner's professional expertise, with medical direction and appropriate supervision as provided for in jointly developed guidelines or other mechanisms as defined by the law of the State in which the services are performed.

EXHIBIT 2
WPS GUIDELINES REGARDING COLLABORATION:

*C. Collaboration:

1. Nurse practitioners and clinical nurse specialists must meet the standards for a collaborative process, as established by the State in which they are practicing. In the absence of State law governing collaborative relationships, collaboration is a process in which these

nonphysician practitioners have a relationship with one or more physicians to deliver health care services.

2. Such collaboration is to be evidenced by nurse practitioners or clinical nurse specialists documenting their scope of practice and indicating the relationships that they have with physicians to deal with issues outside their scope of practice.

3. Nurse practitioners and clinical nurse specialists must document this collaborative process with physicians. The collaborating physician does not need to be present with the nurse practitioner or clinical nurse specialist when the services are furnished or to make an independent evaluation of each patient who is seen by the nurse practitioner or clinical nurse specialist.

EXHIBIT 3
JANUARY COMPROMISE, CURRENT SMS PROPOSAL:

N. 8.06. The advanced practice nurse prescriber may not independently order or interpret laboratory testing, radiographs or electrocardiograms to assist with the issuing of a prescription order unless the advanced practice nurse prescriber collaborates with a physician.

For purposes of this section, collaborates means a process in which an advanced practice nurse prescriber works with a physician to deliver health care services within the scope of the advanced practice nurse prescriber's professional expertise, as provided for in jointly developed practice parameters.

EXHIBIT 4
FEBRUARY PROPOSAL:

First, that proposed administrative rule would be amended to read:

"An advanced practice nurse prescriber, working in a collaborative relationship with a physician, may order laboratory testing, radiographs or electrocardiograms to assist the advanced practice nurse prescriber in issuing a prescription order appropriate to the advanced practice nurse prescriber's areas of competence, as established by his or her education, training or expertise."

Second, that the BON and the MEB would issue a joint policy statement, published in the Administrative Register, that states:

"APNP's must meet the standards for a collaborative process as established by the Board of Nursing. Collaboration is a process in which APNP's have a relationship with one or more physicians to deliver health care services. Such collaboration is to be evidenced by the APNP's documenting their scope of practice and the relationships that they have with physicians to deal with issues outside their scope of practice." (This is taken from the language in the new version of the Medicare guidelines for reimbursement of NP's.)

Third, that the interested groups agree to work to have language similar to the above inserted into N. 8 probably in either 1.5 or 8.08 to give a definition of collaboration that includes a written relationship between the APNP and a physician.

EXHIBIT 5
CURRENT WISCONSIN ADMINISTRATIVE CODE N 8.06:

N 8.06 Prescribing limitations. The advanced practice nurse prescriber:

(1) May issue only those prescription order appropriate to the advanced practice nurse prescriber's areas of competence, as established by his or her education, training or experience.

(2) May not issue a prescription order for any schedule I controlled substance.

(3) May not prescribe, dispense or administer any amphetamine, sympathomimetic amine drug or compound designated as a schedule II controlled substance pursuant to the provisions of s. 161.16(5), Stats., to or for any person except for any of the following:

(a) Use as an adjunct to opioid analgesic compounds for the treatment of cancer-related pain.

(b) Treatment of narcolepsy.

(c) Treatment of hyperkinesis.

(d) Treatment of drug-induced brain dysfunction.

(e) Treatment of epilepsy.

(f) Treatment of depression shown to be refractory to other therapeutic modalities.

(4) May not prescribe, order, dispense or administer any anabolic steroid for the purpose of enhancing athletic performance or for other nonmedical purpose.

(5) Shall, in prescribing or ordering a drug for administration by a registered nurse or licensed practical nurse under s. 441.16(3)(cm), Stats., present evidence to the nurse and to the administration of the facility where the prescription or order is to be carried out that the advanced practice nurse prescriber is properly certified to issue prescription orders.

EXHIBIT 6
CURRENT WISCONSIN ADMINISTRATIVE CODE N 8.10:

N 8.10 Case management and collaboration with other health care professionals. (1) Advanced practice nurse prescribers shall communicate with patients through the use of modern communication techniques.

(2) Advanced practice nurse prescribers shall facilitate collaboration with other health care professionals, at least 1 of whom shall be a physician, through the use of modern communication techniques.

(3) Advanced practice nurse prescribers shall facilitate referral of patient health care records to other health care professionals and shall notify patients of their right to have their health care records referred to other health care professionals.

(4) Advanced practice nurse prescribers shall provide a summary of a patient's health care records, including diagnosis, surgeries, allergies and current medications to other health care providers as a means of facilitating case management and improved collaboration.

(5) The board shall promote communication and collaboration among advanced practice nurses, physicians and other health care professionals, including notification to advanced practice nurses of mutual educational opportunities and available communication networks.

<u>EXHIBIT 7</u>

WAFP SUGGESTION FOR AMENDING N.8.10 WOULD ADD:

(6) To promote case management, the advanced practice nurse prescriber may order laboratory testing, radiographs, or electrocardiograms appropriate to his or her area of competence as established by his or her education, training, or experience.

(7) Advanced practice nurse prescribers shall work in a collaborative relationship with a physician. The collaborative relationship is a process in which an advanced practice nurse prescriber works with a physician to deliver health care services within the scope of the practitioner's professional expertise. This relationship must be evidenced by a written agreement between the advanced practice nurse prescriber and a physician.

in each others presence when necessary

American Academy of Pediatrics

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WISCONSIN CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS

TESTIMONY ON MARCH 15, 2000, BEFORE THE WISCONSIN SENATE COMMITTEE ON HEALTH, UTILITIES, VETERANS AND MILITARY AFFAIRS

RELATING TO:
THE PROPOSED RULES GOVERNING ADVANCED PRACTICE NURSE PRESCRIBERS

Senator Moen and respected Committee members, it is an honor and privilege to address you.

I am Carl Eisenberg, MD, FAAP, a pediatrician, and the Vice President and Legislative Co-Chair of the Wisconsin Chapter of the American Academy of Pediatrics (WIAAP.) Today, I represent 733 pediatricians in the State of Wisconsin.

The Wisconsin Chapter of the American Academy of Pediatrics shares the concern of many about the problem of access to medical care for all the children of Wisconsin. Many of our members currently work in collaborative arrangements with Advanced Practice Nurses to provide parents increased opportunities to access quality medical care. I speak to foster and support these collaborative practices thereby increasing access to medical care for the children of Wisconsin.

Today, I would like to address the specific issue of interpretation of test results in children. Once a test is ordered something will need to be done with the result of that test. Interpretation of data in the pediatric population is complicated because normal values vary with age. This concept not only applies to <u>growth</u> (e.g., height and weight) and <u>development</u> (e.g., the age of acquisition of language skills), but also to the normal values for many <u>laboratory test</u>

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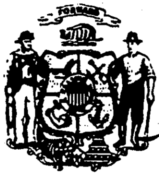
results as well as to findings on imaging tests and electrocardiograms. An Advanced Practice Nurse Prescriber will need skill to address these variables when interpreting test results, and the child's well being will depend upon the nurse's decisions. There are likely to be many times when the nurse will not need assistance or will know to ask for assistance with the interpretation. The collaboration this process implies needs to be codified at the time the Advanced Practice Nurse Prescribers are given the right by rule to order the tests. Any delay in codifying the requirement for this collaboration will potentially put Wisconsin children at risk because the nurse may not have a clear understanding of the circumstances when collaboration is appropriate. In this situation the Advanced Practice Nurse Prescriber may act on interpreted results without collaborating with a physician thereby putting the child-patient at higher risk. Furthermore, the collaboration agreement needs to be the product of joint negotiations between the physician(s) and the Advanced Practice Nurse Prescriber. A collaboration agreement drafted by one collaborator is not an agreement; agreements imply joint discussion and consensus.

In the view of the WIAAP, collaboration is critical in the relationship between the child-patient, the Advanced Practice Nurse Prescriber, and the physician. We believe language that defines a collaborative practice arrangement should be included in any rule adopted at this time. Further, we believe any rule adopted should specify that Advanced Practice Nurse Prescribers can only order and interpret tests, electrocardiograms, and imaging procedures if, and only if, there is a JOINTLY DEVELOPED, collaborative practice agreement in force between a physician or physicians and the Advanced Practice Nurse Prescriber.



State of Wisconsin \ DEPARTMENT OF REGULATION & LICENSING

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Testimony on Senate Clearinghouse Rule 99-126
Before The
Committee on Health, Utilities, Veterans and Military Affairs
Senator Rodney Moen, Chair
201 Southeast, State Capitol
Wednesday, March 15, 2000, 1:30 P.M.

Good afternoon, Chairman Moen, Committee Members, ladies and gentlemen. I am Ann Brewer, a registered nurse, and am here to represent the Wisconsin Board of Nursing as the chairperson of that body. I am here to speak in favor of the proposed Clearinghouse Rule 99-126 related to Prescribing Limitations for Advanced Practice Nurse Prescribers.

The Wisconsin Board of Nursing is assigned the responsibility of regulating the practice of professional nursing in order to protect and promote the general welfare of the citizens of the State of Wisconsin. It is with this responsibility in mind that we have proposed this rule change.

Advanced Practice Nurse Prescribers (APNP's) have been providing care and service to the citizens of the State of Wisconsin since this legislature had the foresight to enact **Chapter 441.16** in 1995. These nurses practice in areas of the state that are medically under-served, either due to the remoteness of the locale, or the perception that they are less desirable assignments i.e. inner cities and corrections. As noted in **N 8.10**, they must practice in collaboration with at least one physician. Collaboration is defined in **N 8.02** as "*2 or more health care professionals working together, in each other's presence* ***when necessary****, each contributing one's respective area of expertise to provide more comprehensive care than one alone can offer.*"

Chapter 441.16 and its associated references define an Advanced Practice Nurse's authority to prescribe devices, drugs and controlled substances, but it fails to address diagnostic test selection and interpretation. In **Chapter N8**, the educational preparation, qualifications for certification and continuing education required of an Advanced Practice Nurse Prescriber are detailed. Prior to certification, the applicant has to complete at least 45 contact hours in clinical pharmacology and therapeutics within 3 years of application. In **Section N 8.02,** "Clinical pharmacology / therapeutics" is defined as "*the identification of individual and classes of drugs, their indications and contraindications, their likelihood of success, their side effects and their interactions, as well as, clinical judgment skills and decision-making, based on thorough interviewing, history-taking, physical assessment, <u>test selection and interpretation</u>, pathophysiology, epidemiology, diagnostic reasoning, differentiation of conditions, treatment decisions, case evaluation and non-pharmacologic interventions.*" In addition, to the pre-certification educational requirements, **N 8.05** contains a provision for mandatory continuing education of at least 8 hours per year in clinical pharmacology / therapeutics in the APNP's area of practice.

Advanced Practice Nurse Prescribers are educationally and clinically prepared to prescribe and interpret the tests necessary to diagnose, treat and monitor their patients in their area of practice. APNP's have a professional and ethical responsibility to monitor their patients in relationship to the medications they prescribe. The legislature granted APNP's the privilege to prescribe medications and now we are asking that they be equally accountable to the public by

promulgating Clearinghouse Rule 99-126 that will protect these patients by allowing APNP's to order tests needed to diagnose, treat and monitor their patients' conditions.

In the five years that APNP's have been certified to practice in Wisconsin, there has never been a case of an APNP referred to the Wisconsin Board of Nursing due to the inappropriate choice of diagnostic tests or interpretation thereof. In addition, there has never been a case referred to the board where a nurse practicing as an APNP, has not had an established collaborative relationship with a physician. We have in fact received word that some certified Nurse Practitioners have not been able to work as APNP's, due to the unavailability of a physician willing to practice collaboratively.

In association with this proposed rule change, the Medical Society of Wisconsin has proposed a redefinition of "collaboration" from the language contained in **N. 8.02** adding restrictions to APNP practice. "Collaborator" is best defined by the individuals involved in the collaborative relationship. An individual APNP and their collaborative physician are currently free to define their scope of practice. They may choose or not choose to use protocols or guidelines for this purpose. The individuals who are best suited to evaluate the need for definition of practice, the mode and content there of, are the collaborators. The Wisconsin Board of Nursing opposes changing the current definition of collaboration.

In conclusion, the Board of Nursing acknowledges its responsibility to protect and promote the general welfare of the citizens of Wisconsin. This rule will acknowledge the capability and responsibility of APNP's to obtain appropriate tests to diagnose, treat and monitor their patients, thereby protecting the public. We strongly urge you to approve Clearinghouse Rule 99-126.

Thank you and I appreciate your attention and consideration in this matter.

Ann E. Brewer, RN BSN
Chairperson, Wisconsin Board of Nursing

Testimony-Ann Brewer/mls

NURSE ANESTHETISTS

Providing Anesthesia into the Next Century

American Association of Nurse Anesthetists

Wisconsin Association
Nurse Anesthetists

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CRNAs are key to resolving access problems associated with geographic distribution of anesthesia providers

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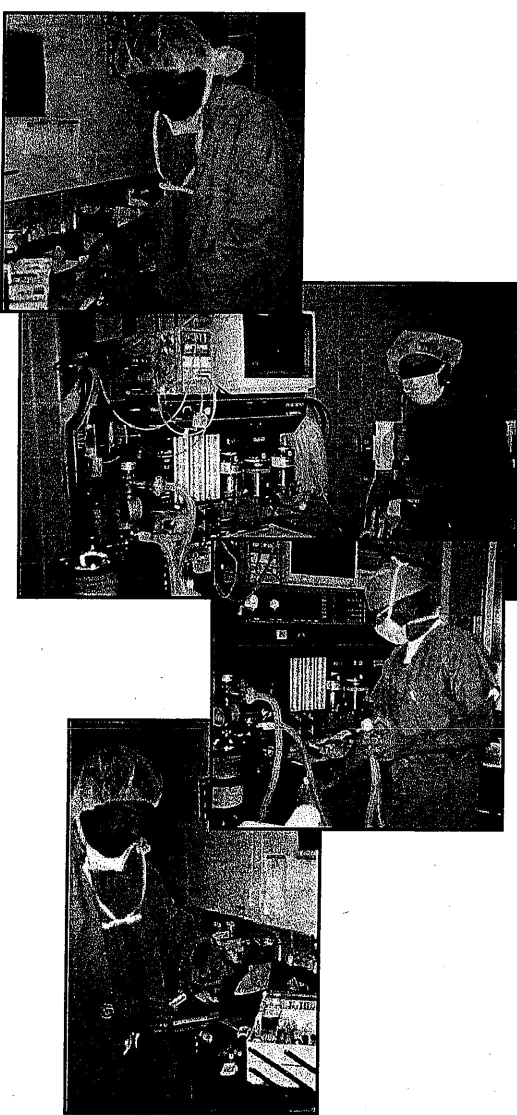
ANESTHESIA



CERTIFIED REGISTERED NURSE ANESTHETISTS

SCOPE OF PRACTICE

CRNAs administer more than 65 percent of the 26 million anesthetics given to patients each year in the U.S. They are the sole providers in 65 percent of rural hospitals, which allows those facilities to provide obstetrical, surgical and trauma stabilization services. More than 70 million Americans receive healthcare from CRNAs. CRNAs are key to resolving access problems associated with geographic distribution of anesthesia providers. As of 1999, there are over 28,000 CRNAs in the U.S.

CRNAs work in every setting in which anesthesia is delivered, including hospitals, offices of dentists, podiatrists, ophthalmologists and plastic surgeons; ambulatory surgical centers; U.S. military installations; and U.S. Public Health Service and Veterans Administration facilities.

Some states require CRNAs to work under the supervision of a physician, such as a surgeon, dentist, podiatrist or other health care provider. However, no state licensing statute requires nurse anesthetists to be supervised by an anesthesiologist, nor does the Joint Commission on Accreditation of Healthcare Organizations.

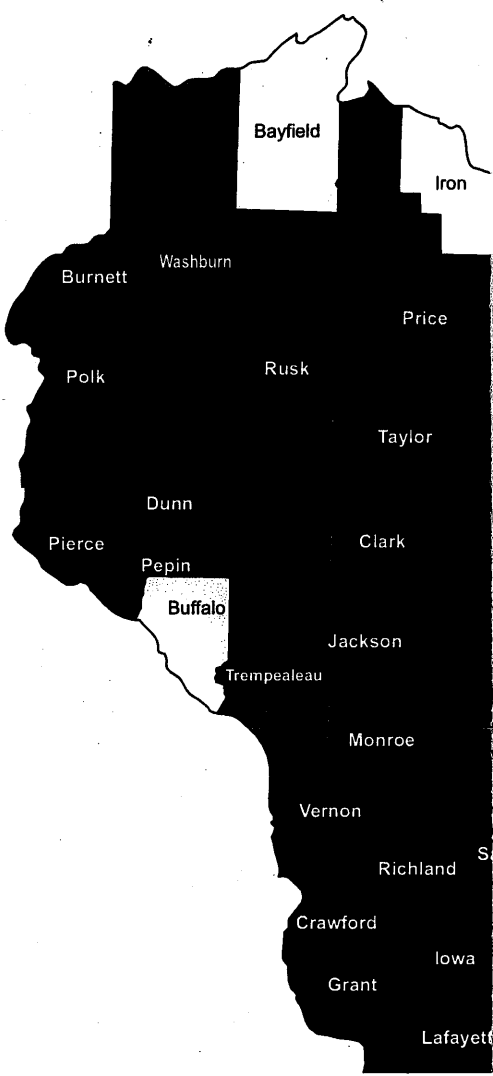
Is anesthesiologists' care superior to that given by anesthetists? No study exists that suggests that's the case. The only studies to address the issue show quality of care is not significantly different.

Are surgeons or obstetricians who work with CRNAs rather than anesthesiologists subject to greater liability? No. The principles governing surgeon liability are the same regardless of whether CRNAs or anesthesiologists give anesthesia. Potential surgeon liability depends on the facts of the case, not on the license of the anesthesia provider.

The practice of anesthesia has become safer in recent years due to better medications and advances in technology, such as patient monitoring techniques.

In 1990, the Centers for Disease Control (CDC) considered conducting a study on anesthesia-related morbidity (medical problems attributable to anesthesia) and mortality. After reviewing the data, CDC concluded anesthesia morbidity and mortality were too low to warrant a mutimillion-dollar study.

ANESTHESIA CARE PR



DATA COM

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- CRNA (Certified Register
- Anesthesiologist (Medical
- Care provided by CRNA,
- Non-service Area

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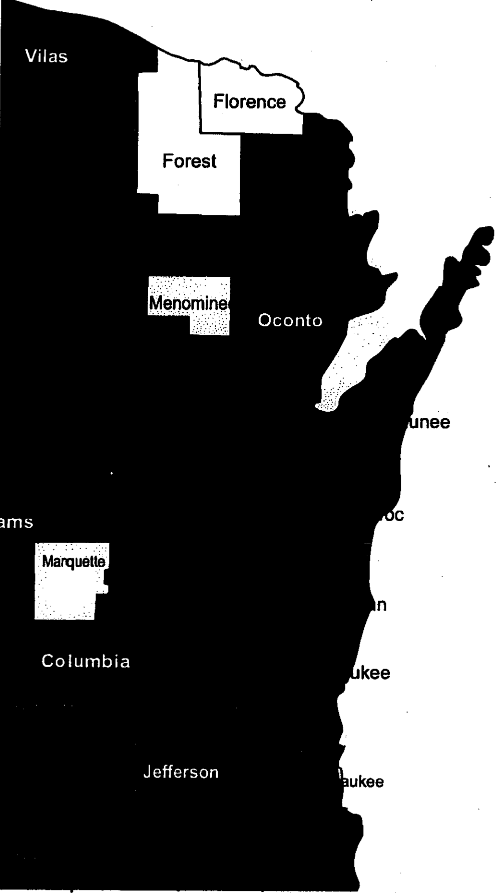


'ILED 2000

ND:

Nurse Anesthetist) Only

'octor of Anesthesiology) Only

nesthesiologist, or both

CRNA EDUCATION

Currently there are 83 AANA-accredited nurse anesthesia programs in the U.S. Starting in 1998, all programs offer master's degrees. Selected programs offer clinical nursing doctorate options for CRNAs pursuing further educztion. As of 1999, there are approximately 2,470 students in programs.

Requirements for admission to nurse anesthesia programs are:

- A bachelor of science in nursing (BSN) or other appropriate baccalaureate degree;
- Registered nurse licensure;
- A minimum of one year of critical care nursing experience

Programs are comprised of 24-36 months of classroom and clinical experiences. The curriculum emphasizes anatomy, physiology, pathophysiology biochemistry, chemistry, physics and pharmacology as they relate to anesthesia.

After successfully completing the program, candidates must pass the national certifying exam. CRNAs then must earn continuing education credits and be recertified every two years.

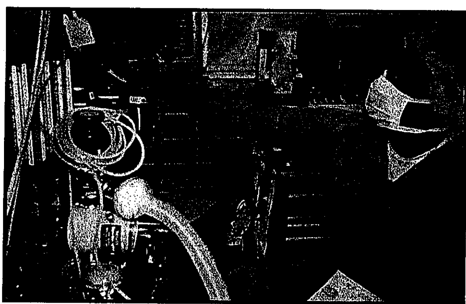
CRNA educational costs are significantly less than those for anesthesiologists. According to 1999 data from the federal Health Care Financing Administration (HCFA), the average educational cost to prepare each anesthesiology resident was greater than $85,000 a year. For nurse anesthetists, the average educational cost was $14,014 annually, according to a 1997 study by the AANA Council on Accreditation. From those studies, AANA concluded that at least 10 CRNAs can be trained for the cost of preparing one anesthesiologist. The CRNAs will also have entered the work force and provided services for several years by the time one anesthesiologist is ready to practice.

WHAT ARE CRNAS?

:ertified Registered Nurse Anesthetists are dvanced-practice nurses certified to dminister anesthesia in settings ranging :om medical offices to hospital surgical units. ı Wisconsin and many other states, CRNAs ave authority to independently prescribe ıedication used within the scope of their ractice. The practice of anesthesia is a ecognized specialty within both the nursing nd medical professions. In Wisconsin, pproximately 450 CRNAs provide nesthesia services. Members must be ertified by a national standards organization, n affiliate of the national organization, the merican Association of Nurse Anesthetists AANA).

nesthetists were the first clinical nurse pecialists and the first professionals to rovide anesthesia services in the United tates. Formal training programs started in ıe late 1800s and demand increased ramatically with the carnage of World War I. Vhile some doctors had also practiced nesthesia, the formalization of physician ducation in the field didn't become revalent until after World War II. The erception was that physicians should also pecialize in anesthesia, which had been a elatively untapped area for them.

Nurse anesthetists, the first providers of anesthesia, have been administering anesthesia for more than 100 years.



Anesthesiologists (doctors specializing in anesthesia) and CRNAs act in the same capacity in delivering anesthesia services. The difference between CRNAs and anesthesiologists is that prior to anesthesia education, anesthesiologists receive medical education, while CRNAs receive nursing education. However, the anesthesia part of the education is very similar for both providers. CRNAs and anesthesiologists are both educated to use the same procedures in the provision of anesthesia and related services.

In 25 of the 66 Wisconsin counties which provide anesthesia services, CRNAs work independently as sole practitioners of anesthesia care. In other instances, they work in conjunction with anesthesiologists as a team, or side by side as anesthesia care providers.

Nurse anesthetists have been the principal anesthesia providers in combat areas in all the armed conflicts the U.S. has engaged in since 1917. In World War II, the ratio was 17 nurse anesthetists to each physician anesthetist. In Vietnam, it was about 3:1, and in the Panama campaign, only CRNAs went abroad.

CRNAs were the first specialty nursing group to receive direct Medicare reimbursement for their services under the federal budget act of 1986. They accept mandatory assignment and do not bill patients for costs over Medicare limits. CRNAs are also recognized as providers and reimbursed through Medicaid in the state of Wisconsin.

Executive Summary

Nurse anesthetists have been providing quality anesthesia services in this country for more than a century. The longevity of their practice can be attributed directly to their commitment to excellence and patient safety, their willingness to provide services when and where needed, and the provision of those services at reasonable cost.

This series of documents was prepared to assist policymakers, health care administrators, health care insurers, and the public to better understand the role of nurse anesthetists and their potential to reduce health care costs while maintaining high quality health care. The following documents highlight important aspects of the nurse anesthesia profession.

History of Nurse Anesthesia Practice

Nurse Anesthesia Education

CRNA Scope of Practice

Quality of Nurse Anesthesia Practice

Cost Effectiveness of Nurse Anesthesia Practice

Nurse Anesthesia Reimbursement

Legal Issues in Nurse Anesthesia Practice

Nurse Anesthetists and Anesthesiologists Practicing Together

NURSE ANESTHESIA

Today, Certified Registered Nurse Anesthetists (CRNAs) working with anesthesiologists, physicians such as surgeons and, where authorized, podiatrists, dentists, and other health care providers, administer approximately 65% of all anesthetics given each year in the United States. CRNAs provide anesthesia for every age and type of patient, utilizing the full scope of anesthesia techniques, drugs, and technology which characterize contemporary anesthesia practice. They work in every setting in which anesthesia is delivered: tertiary care centers, community hospitals, labor and delivery rooms, ambulatory surgical centers, diagnostic suites, and physician offices. CRNAs are the sole anesthesia providers in more than 70% of rural hospitals, affording anesthesia and resuscitative services to these medical facilities for surgical, obstetrical, and trauma care.

Early in their history, nurse anesthetists were challenged by lawsuits claiming they were illegally practicing medicine. Landmark decisions in Kentucky (1917) and California (1936) established that they were, in fact, practicing nursing, not medicine. Today, more than 27,000 CRNAs practice in all 50 states, providing anesthesia services to all segments of the population including substantial numbers of Medicare, Medicaid, public employee, veteran, and indigent populations.

CRNAs are well versed in the health care trends sweeping this country including

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a restructured health care system of managed care. CRNAs strongly support comprehensive health care reform, increasing affordability, maximizing patient access, and promoting anesthesia payment reform which controls cost and maintains quality. CRNAs support patient choice. The nurse anesthesia profession advocates continued support for public and institutional policy which enables maximum utilization of CRNAs and their ability to work within their full and legal scope of practice. Their record of patient safety is excellent.

Nurse anesthetists are educated in the specialty of anesthesia at the graduate level that encompasses an integrated program of academic and clinical study. Based on their sophisticated body of knowledge, CRNAs are licensed and certified to practice anesthesia. In addition, they must meet the requirement of recertification every two years. As such qualified providers, CRNAs are eligible to receive reimbursement for their services directly from Medicare, nearly half of all Medicaid programs, Civilian Health and Medical Program of Uniformed Services (CHAMPUS), and a multitude of private insurers and managed care organizations.

The American Association of Nurse Anesthetists (AANA) is the sole professional association of the nation's nurse anesthetists. Founded in 1931, the AANA has issued educational and practice standards and guidelines, developed and implemented a certification and mandatory recertification program, and developed a nationally recognized program for accreditation of nurse anesthesia educational programs. Since 1975, credentialing of nurse anesthesia educational programs and the credentialing of nurse anesthetists has been a function of the AANA autonomous multidisciplinary councils. The AANA is actively involved in the development of federal and state health care policy and offers consultation and other data sources regarding CRNA practice to both public and private entities. Specific information on the practice of nurse anesthetists not found in this series of white papers is available from the American Association of Nurse Anesthetists, 222 South Prospect Avenue, Park Ridge, Illinois, 60068-4001. Phone: (847) 692-7050. Fax: (847) 692-6968.

History of Nurse Anesthesia Practice

Nurses were the first professional group to provide anesthesia services in the United States. Established in the late 1800s, nurse anesthesia has since become recognized as the first clinical nursing specialty. The discipline of nurse anesthesia developed in response to requests of surgeons seeking a solution to the high morbidity and mortality attributed to anesthesia at that time. Surgeons saw nurses as a cadre of professionals who could give their undivided attention to patient care during surgical procedures. Serving as pioneers in anesthesia, nurse anesthetists became involved in the full range of specialty surgical procedures, as well as in the refinement of anesthesia techniques and equipment.

The earliest existing records documenting the anesthetic care of patients by nurses were those of Sister Mary Bernard, a Catholic nun who assumed her duties at St. Vincent's Hospital in Erie, Pennsylvania in 1887. The most famous nurse anesthetist of the nineteenth century, Alice Magaw, worked at St. Mary's Hospital (1889), in Rochester, Minnesota. That hospital, established by the Sisters of St. Francis and operated by Dr. William Worrell Mayo, later became internationally recognized as the Mayo Clinic. Dr. Charles Mayo conferred upon Alice Magaw the title of "mother of anesthesia," for her many achievements in the field of anesthesiology, particularly her mastery of the open-drop inhalation technique of anesthesia utilizing ether and chloroform and her subsequent publishing of her findings.

Together, Dr. Mayo and Ms. Magaw were instrumental in establishing a showcase of professional excellence in anesthesia and surgery. Hundreds of physicians and nurses from the United States and throughout the world came to observe and learn their anesthesia techniques. Alice Magaw documented the anesthesia practice outcomes at St. Mary's Hospital and reported them in various medical journals between 1899 and 1906. In 1906, one article documented more than 14,000 anesthetics without a single complication attributable to anesthesia. (*Surgery, Gynecology and Obstetrics*, 3:795.)

In 1909, the first formal educational programs preparing nurse anesthetists were established. In 1914, Dr. George Crile and his nurse anesthetist, Agatha Hodgins, who became the founder of the American Association of Nurse Anesthetists (AANA), went to France with the American Ambulance group to assist in planning for the establishment of hospitals that would provide for the care of the sick and wounded members of the Allied Forces. While there, Hodgins taught both physicians and nurses from England and France how to administer anesthesia.

Since World War I, nurse anesthetists have been the principal anesthesia providers in combat areas of every war in which the United States has been engaged. During the Panama action, only nurse anesthetists were sent with the fighting forces. Nurse anesthetists have been held as prisoners of war, suffered combat wounds during wartime service, and have lost their lives serving their country. The names of two CRNAs killed in the Vietnam War are engraved on the Vietnam Memorial Wall in Washington, DC. Military nurse anesthetists have been honored and dec-

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orated by the United States and foreign governments for outstanding achievements, dedication to duty, and competence in treating the seriously wounded.

Although nurse anesthesia educational programs existed prior to World War I, the war sharply increased the demand for nurse anesthetists and, consequently, the need for more educational programs. Nurse anesthetists were often appointed as directors of anesthesia services in both the public and private sectors. In academic health centers, they were frequently responsible for the education of other nurses, medical interns, and physicians. Among the notable early programs of nurse anesthesia were: Johns Hopkins Hospital in Baltimore, the University Hospital of the University of Michigan in Ann Arbor, Charity Hospital in New Orleans, Barnes Hospital in St. Louis, and Presbyterian Hospital in Chicago. In 1922, Alice Hunt, a nurse anesthetist at Peter Bent Brigham Hospital in Boston, was invited by Dr. Samuel Harvey, professor of surgery, to join the Yale Medical School faculty as an instructor of anesthesia with academic rank. She accepted that position, eventually retiring from that institution in 1948.

Founded in 1931, the AANA is the professional association representing more than 27,000 nurse anesthetists nationwide. The AANA promulgates education, and practice standards and guidelines, and affords consultation to both private and governmental entities regarding nurse anesthetists and their practice. The AANA Foundation supports the profession through award of education and research grants to students, faculty, and practicing CRNAs.

The AANA developed and implemented a certification program in 1945 and instituted mandatory recertification in 1978. It established a mechanism for accreditation of nurse anesthesia educational programs in 1952, which has been recognized by the U.S. Department of Education since 1955. In 1975, the AANA was a leader among professional organizations in the United States by forming autonomous multidisciplinary councils with public representation for performing the profession's certification, accreditation, and public interest functions. Today, the CRNA credential is well recognized as an indicator of quality and competence.

The national office of the American Association of Nurse Anesthetists is located in Park Ridge, Illinois. The Association's federal affairs office is maintained in Washington, DC.

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Nurse Anesthesia Education

The educational preparation of Certified Registered Nurse Anesthetists (CRNAs) is conducted in approximately 90 accredited programs throughout the United States and Puerto Rico. These programs are offered at the graduate level in or in association with traditional institutions of higher education, most commonly in schools of nursing or health sciences. The American Association of Nurse Anesthetists (AANA) was at the forefront of the movement to require graduate education at the master's degree level for advanced practice nurses. The Council of Accreditation of Nurse Anesthesia Educational Programs (COA) has mandated that all programs offer a master's degree by 1998. Education programs are accredited by the COA, and it, in turn is recognized by the U.S. Department of Education.

Program curricula are governed by the accreditation standards of the COA. The specialty curriculum requires that students develop expert clinical judgment skills and critical thinking capabilities that prepare the nurse anesthetist to provide the full scope of anesthesia practice as defined by the profession. The educational curriculum in the anesthesia specialty ranges from 24 to 36 months in an integrated program of academic and clinical study. The academic curriculum consists of a minimum of 30 credit hours of formalized graduate study in those courses listed below (it should be noted, however, that most of the graduate programs range from 45 to 65 credit hours). The anesthesia component of the curriculum includes:

- Advanced anatomy, physiology, and pathophysiology
- Biochemistry and physics related to anesthesia
- Advanced pharmacology
- Principles of anesthesia practice
- Research methodology and statistical analysis
- Research or other scholarly endeavor

Clinical residencies afford supervised experiences for students during which time they are able to learn anesthesia techniques, test theory, and apply knowledge to clinical problems. Each graduate is required to complete a minimum of 450 cases. All programs provide around 1,000 hours of hands-on clinical experience for their students. Students gain experience with patients of all ages who require medical, obstetrical, dental, and podiatric interventions. Clinical experience provides the students with the use and application of a broad variety of anesthesia techniques and monitoring modalities.

Admission requirements to a nurse anesthesia educational program include:

- Bachelor of Science in Nursing (BSN) or other appropriate baccalaureate degree
- License as a Registered Nurse (RN)
- Minimum of one year of acute care nursing experience

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Graduates of accredited nurse anesthesia educational programs must meet all requirements prescribed by the Council on Certification of Nurse Anesthetists in order to write the national examination for certification as a nurse anesthetist. Those who successfully pass this rigorous examination are qualified to practice as a CRNA. Recertification, which includes a practice and continuing education requirement, must be met every two years. From the commencement of the professional education in nursing, a minimum of seven years of education and training is involved in the preparation of a CRNA.

Reference
Qualifications and Capabilities of the Certified Registered Nurse Anesthetist. Park Ridge, Illinois: American Association of Nurse Anesthetists. 1992.

CRNA Scope of Practice

Certified Registered Nurse Anesthetists (CRNAs) are licensed professional registered nurses who have obtained, through additional education and successful completion of a national examination, certification as anesthesia nursing specialists. CRNAs are qualified to make independent judgments relative to all aspects of anesthesia care, based on their education, licensure, and certification. The practice of anesthesiology by nurses has been recognized by the courts as the practice of nursing since 1917.

As anesthesia professionals, CRNAs provide anesthesia and anesthesia-related care upon request, assignment, or referral by a patient's physician (or other health care professional authorized by law), most often to facilitate diagnostic, therapeutic, or surgical procedures. In other instances, the referral or request for consultation or assistance may be for management of pain associated with obstetrical labor and delivery, management of acute or chronic ventilatory problems, or management of acute or chronic pain through the performance of selected diagnostic or therapeutic blocks or other forms of pain management.

The scope of practice of CRNAs includes, but is not limited to, the following:

- Performing and documenting a preanesthetic assessment and evaluation of the patient, including requesting consultations and diagnostic studies; selecting, obtaining, ordering, and administering preanesthetic medications and fluids; and obtaining informed consent for anesthesia.
- Developing and implementing an anesthetic plan.
- Initiating the anesthetic technique which may include: general, regional, local, and sedation.
- Selecting, applying, and inserting appropriate non-invasive and invasive monitoring modalities for continuous evaluation of the patient's physical status.
- Selecting, obtaining, and administering the anesthetics, adjuvant and accessory drugs, and fluids necessary to manage the anesthetic.
- Managing a patient's airway and pulmonary status using current practice modalities.
- Managing emergence and recovery from anesthesia by selecting, obtaining, ordering, and administering medications, fluids, and ventilatory support.
- Discharging the patient from a postanesthesia care area and providing postanesthesia follow-up evaluation and care.
- Implementing acute and chronic pain management modalities.
- Responding to emergency situations by providing airway management, administration of emergency fluids and drugs, and using basic or advanced cardiac life support techniques.
- Additional nurse anesthesia responsibilities which are within the expertise of the individual CRNA.

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In a survey of practice conducted among anesthesiologists and CRNAs in 1986 by the Center of Health Economics Research, it was found that CRNAs perform the same range of anesthesia tasks and activities as anesthesiologists.

CRNAs provide anesthesia, working with anesthesiologists, other physicians such as surgeons, and, where authorized, podiatrists, dentists, and other health care providers. The laws of every state permit CRNAs to work directly with a physician or other authorized health care professional without being supervised by an anesthesiologist. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) does not require anesthesiologist supervision of CRNAs nor does Medicare. In some cases, a provider or payor or a medical staff bylaw may require anesthesiologist supervision, however, these decisions are not based on legal requirements nor are they justified by concerns about the quality of care (see "Quality of Nurse Anesthesia Practice" paper). Regardless of supervision, the CRNA is legally responsible for the anesthesia care provided. Anesthesia has been a proper nursing function for more than 100 years, and nurse anesthetists practice in every state.

Clinical privileging is a form of credentialing utilized by hospitals and other facilities to authorize selected health care providers, including CRNAs, to provide specific patient care services. Having such privileges provides the health care provider with an opportunity to practice within that facility under the conditions specified in the privileges. Clinical privileging requirements are usually developed by the medical staff through bylaws.

JCAHO requires physician members of the medical staff to be credentialed and privileged. According to JCAHO, nurse practitioners, physician assistants, and CRNAs may be credentialed and privileged through the hospital's medical staff bylaw process or the institution's human resource credentialing process. It is the health care facility's choice to determine which credentialing and/or privileging process should be utilized for these practitioners.

Guidelines for granting clinical privileges to the CRNA and a prototype of an application for clinical privileges may be found in The *AANA Guidelines for Clinical Privileges* available from the American Association of Nurse Anesthetists, 222 South Prospect Avenue, Park Ridge, Illinois.

CRNAs practice in every clinical setting including tertiary care centers, major university medical centers, community hospitals, free-standing clinics, physician offices, surgicenters, as well as Veterans Administration Medical Centers and the U.S. Military. CRNAs are sole providers of anesthesia in more than 70% of rural hospitals in America. They administer approximately 65% of the 26 million anesthetics given in the United States annually, either as sole providers or working in collaboration with anesthesiologists.

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The American Association of Nurse Anesthetists Guidelines for Clinical Privileges. Park Ridge, Illinois: American Association of Nurse Anesthetists. 1996.
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Testimony before the Senate Health, Utilities, Veterans, and Military Affairs Committee
on CR 99-126: Clarification of Prescribing Limitations
for Advanced Practice Nurse Prescribers

Chairperson: Senator Rodney Moen
Committee Members:
Senator Roger Breske
Senator Judy Robson
Senator Jon Erpenbach
Senator Robert Welch
Senator Brian Rude
Senator Gary Drzewiecki

Hearing: State Capitol, Room 201 South East
March 15, 2000
1:30 p.m.

Presented by: Dennis Stalsberg, C.R.N.A., A.P.N.P.
President, Wisconsin Association of Nurse Anesthetists

Representing: Wisconsin Association of Nurse Anesthetists

March 15,2000

Good afternoon Senator Moen and members of the Committee. I thank the Committee for the opportunity to address the rule clarification proposed by the Wisconsin Department of Regulation and Licensing in conjunction with the Wisconsin Board of Nursing, CR 99-126.

My name is Dennis Stalsberg, and I am a practicing Certified Registered Nurse Anesthetist (CRNA) at Gundersen / Lutheran Medical Center in La Crosse, Wisconsin. Currently I am the President of the Wisconsin Association of Nurse Anesthetists (WANA). The objectives of WANA are to: (1) promote continual high quality patient care, (2) advance the science and art of anesthesiology, (3) promote educational standards in the field of nurse anesthesia, (4) promote standards of practice in the field of nurse anesthesia, and (5) facilitate effective cooperation between nurse anesthetists, anesthesiologists, and other members of the medical profession, hospitals, and agencies representing a community of interest in nurse anesthesia.

In Wisconsin, approximately 450 CRNAs provide anesthesia services in every clinical setting ranging from medical offices and small rural hospitals, to large university based medical centers. In 64 of the 65 Wisconsin counties offering anesthesia services, CRNAs are participating anesthesia providers. In 25 of these counties, CRNAs are the sole anesthesia providers. CRNAs are licensed professional registered nurses who have obtained, through additional education and successful completion of a national examination, certification as anesthesia advanced practice nursing specialists. CRNAs, by nature of their education, licensure and advanced certification, are qualified to make judgements and decisions relative to all aspects of anesthesia care.

Today, I appear before this committee to speak in support of the proposed language of the Wisconsin Department of Regulations and Licensing and Wisconsin Board of Nursing regarding the clarification of the scope of practice for Advanced Practice Nurse Prescribers (APNPs) to order laboratory, radiographic, EKG and other tests to validate the prescribing of medication.

It has been seven years since the process to grant advanced practice nurses independent prescriptive authority initially moved through the Legislature. During this process, the issues of authority, intent, qualifications, continuing education, application procedures, prescription issuance and limitations, and definitions within this Administrative Code were arduously discussed and agreed upon by all the interested and involved parties. With the existing rules in effect, APNPs have been performing these test ordering functions as part of their prescribing process. The intent to provide access to high quality, safe care in a cost effective manner has been demonstrated and accomplished with the current law. Collaboration agreements, as defined in the Codes are already in place and functioning as intended.

The WANA requests your support for this rule clarification. Maintain access. Maintain quality. Maintain the safe, cost effective care afforded by the APNPs in Wisconsin. Please support the proposed rule, CR 99-126 as offered by the Department of Regulation and Licensing and the Board of Nursing, and maintain the level of care the citizens of Wisconsin deserve and expect.

Sincerely,

Dennis Stalsberg, CRNA, APNP

Dennis Stalsberg, C.R.N.A., A.P.N.P.

Quality of Nurse Anesthesia Practice

Nurse Anesthetists have provided high quality anesthesia care for more than a century. Certified Registered Nurse Anesthetists (CRNAs) have the legal authority to practice anesthesia in the United States, administering and managing every aspect of the anesthetic process, from preanesthesia assessment and evaluation through the recovery phase of care.

Studies have shown a dramatic reduction in anesthesia mortality rates to approximately 1 per 240,000 anesthetics. In 1990, the Centers for Disease Control and Prevention (CDC) proposed to undertake research on morbidity and mortality in anesthesia; however, after review of preliminary data, the CDC concluded that the morbidity and mortality rates in anesthesia were too low to warrant a multi-million dollar study. Further, no studies to date have demonstrated that there is a difference in anesthesia patient care outcomes based on type of anesthesia provider, that is, a nurse anesthetist or anesthesiologist. This conclusion was recently confirmed in 1994 by the Minnesota Department of Health, which completed a legislatively mandated study concerning anesthesia care in that state. The department concluded that "there are no studies, either national in scope or Minnesota-specific, which conclusively show a difference in patient outcomes based on type of provider."

The American Association of Nurse Anesthetists (AANA) has been at the forefront of establishing clinical practice standards. The AANA was the first professional organization to endorse the Harvard Minimal Monitoring Standards on Anesthesia Care. Subsequently, AANA has issued even more explicit patient monitoring standards for anesthesia. In its capacity as the professional organization representing CRNAs, the AANA has developed standards of nurse anesthesia practice and postanesthesia care, as well as guidelines for obstetrical analgesia and anesthesia, waste gas management, and infection control. These documents are acknowledged by other nursing, medical, and allied health specialty groups.

The AANA fosters the participation and support of CRNAs in continuing education programs and practice advances and improvements relating to quality of care, patient safety research, patient satisfaction surveys, and technology development. The AANA also affords guidance to its members for developing and/or participating in peer review and risk management activities within health care institutions. A risk management guide for nurse anesthetists is published by the AANA. The AANA is a patron member of the Anesthesia Patient Safety Foundation (APSF) and has representatives appointed that serve on the Board of Directors and Editorial Board of APSF. The AANA holds membership on the Hospital Professional Technical Advisory Committee of the Joint Commission on Accreditation of Healthcare Organizations.

St. Paul Fire and Marine Insurance Company is the largest writer of medical malpractice insurance in the country and is also the largest provider of professional liability insurance for CRNAs as well. The St. Paul insurance company has advised AANA that, to its knowledge, there is no evidence that physicians (such as

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surgeons) working with CRNAs have a higher rate of claims made against insurance companies than physicians working with anesthesiologists. In 1995, the St. Paul insurance company reported that medical professional liability insurance rates for its insured nurse anesthetist policyholders decreased, on an average, countrywide basis, between 6 to 13% each year from 1988 to 1993 and have been stable through 1996.

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U.S. House of Representatives, Committee on Armed Services Report on H.R. 1748, *Department of Defense Authorization Act for Fiscal Year 1988-89*, pages 208-209.

Cost Effectiveness of Nurse Anesthesia Practice

The expanded utilization of Certified Registered Nurse Anesthetists (CRNAs) in the provision of anesthesia services makes financial sense especially as patients, carriers, purchasers and employers demand cost-effective services of high quality. This fact holds true regardless of whether the CRNA anesthesia service is provided in collaboration with an anesthesiologist or as a CRNA service alone.

According to the fiscal year 1996 American Association of Nurse Anesthetists (AANA) membership survey, the employment and practice arrangements of CRNAs are: hospital employed (39%); anesthesiologists group employed (36%); CRNA group or self employed (15%); and university, military, office, or surgery center/clinic employed (10%). CRNAs working with anesthesiologists, other physicians such as surgeons and (where authorized) podiatrists, dentists and other health care providers, administer approximately 65% of all anesthetics administered to patients each year in the United States. CRNAs are the sole anesthesia providers in more than 70% of rural hospitals, affording anesthesia and resuscitative services to these medical facilities for surgical, obstetrical, and trauma care.

In relation to the utilization of CRNAs in the provision of anesthesia services, substantial cost savings are realized when salary comparison between CRNAs and anesthesiologists are considered. While CRNA salaries have risen in recent years, they have not increased as dramatically as those of anesthesiologists. The median annual salary in 1994 for a CRNA was $84,000 based on the 1995 AANA membership survey. In contrast, the median salary for an anesthesiologist was approximately $244,600 based on 1994 data reported by the Medical Group Management Association (MGMA).

The educational costs of preparing CRNAs are significantly less than those needed to prepare anesthesiologists. Becoming a CRNA usually takes seven to eight years (including a year of acute care nursing experience); becoming an anesthesiologist usually takes a minimum of 12 years. According to a correspondance from the director of Hospital Payment Policy, Health Care Financing Administration (HCFA) dated July 27, 1992, to Kathleen A. Michels, RN, JD, director of Federal Government Affairs at the AANA, the average cost to prepare one anesthesiology resident, per year, is estimated to be $84,837. According to 1992 data obtained from the AANA, the average cost to prepare one nurse anesthetist, per year, is estimated to be $11,741. Considering the average costs for preparing nurse anesthetists, it becomes apparent that approximately eight CRNAs can be prepared for the cost of preparing a single anesthesiologist. In addition, those eight CRNAs will have entered the work force and cumulatively provided anesthesia services for a number of years by the time the one anesthesiologist is ready to practice.

According to Jerry Cromwell, PhD, a health care economist and president of Health Economics Research in Waltham, MA, in a paper published in *The U.S. Health Workforce: Power, Politics and Policy,* he noted that, "Anesthesia is an excellent

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laboratory for studying [workforce] substitutions." He further observed that anesthesia in the United States was historically performed by nurses and only in the past 25 years have the numbers of physicians entering the field begun to change the statistics significantly concerning the CRNA contribution to the total anesthesia workload. Additionally Dr. Cromwell noted that there are significant cost implications to having the wrong input mix in anesthesia based on the tremendous differences in practice earnings of CRNAs versus anesthesiologists, and stated his belief that: "Anesthesia, therefore, provides an excellent example of what can go wrong with the workforce mix when you pay for inputs (i.e., types of providers) rather than outputs (i.e., the services delivered). Federal and third-party reimbursement have paid for anesthesia inputs rather than outputs. This major flaw in the reimbursement system explains the inefficient mix we've developed in anesthesia (Cromwell and Rosenbach 1988)."

CRNA services are reimbursed directly by Medicare, state and federal programs, and a number of commercial carriers. When both a CRNA and an anesthesiologist are participating in the same case, the services of both anesthesia providers should be recognized for the extent of their involvement and appropriate payment methodologies should apply. Independently billing CRNAs provide savings for other government programs and for private payers either on the basis of their payment methodologies or because they typically charge less than their physician counterparts. For example, a Texas survey recently indicated that CRNA charges to private payers were between 10 and 25% less than those of the anesthesiologists. With the significant entry of managed care in the health care market, these CRNAs have been required to compete for contracts with many of these entities, as have physicians.

For hospitals which employ the CRNAs who work in collaboration with anesthesiologists, the financial viability of a CRNA/MD service is clearly dependent upon a cost-effective mix of providers as well as hospital competency in appropriately billing CRNA services. Hospitals which claim to lose money on CRNA services are likely billing inappropriately and therefore not receiving the revenue to which they are entitled. Failure to bill correctly may lead to divestment of hospital employed CRNAs to physician groups. That position weakens control of the facility's hospital-based revenue sources and limits the potential for hospitals to include anesthesia services when negotiating comprehensive managed care contracts.

The trend to align physician and hospital incentives to control costs is accelerating. HCFA has been studying an all-medical staff diagnosis-related grouping (DRG) payment system that would include all physicians. This all-inclusive payment arrangement would have obvious and profound implications for the kinds and numbers of inpatient consulting services. Undoubtedly, this force will accelerate in the near future as the health care system moves steadily toward higher levels of capitated payment in conjunction with the continued decrease in health care reimbursement from all payers.

With respect to the growth of managed care and its impact on anesthesia, Dr. Cromwell stated in a presentation to the 1995 Annual Meeting of the Association for Academic Health Centers, "A simple example of the arbitrage potential between managed care HMOs and more expensive private fee-for-service medicine is anesthesia. In Southern California Kaiser hospitals, there are about 0.4 anesthesiologists for every full-time CRNA. In the rest of California, excluding the Kaiser System, the ratio is 2.6 anesthesiologists for every CRNA. There is no reason to believe that the mix of operations in non-Kaiser hospitals is dramatically different than experienced in Southern California Kaiser, implying tremendous opportunities for cost-saving arbitrage through the greater penetration of managed care."

Cost efficiency of anesthesia services is dependent on avoidance of high MD to CRNA working ratios that cannot be justified on the basis of quality of care or cost effectiveness. Patient care needs should dictate appropriate personnel resources rather than predetermined numerical ratios. As an illustration, Kaiser Permanente Medical Centers, in an inter-regional examination of operating room best practices, conducted an internal benchmarking process to identify the best operating room practices in 42 Kaiser Permanente facilities. Kaiser found that the productivity of the anesthesia care team is increased by each anesthesiologist directing four operating rooms staffed with CRNAs, and CRNAs exercising an expanded practice.

CRNAs have traditionally made high quality anesthesia services accessible to underserved populations despite the cost constraints and/or isolation of many geographic locations. For any service location, CRNAs are highly cost-effective, quality anesthesia providers on the basis of educational costs, cost of service, productivity, and substitutability for more expensive providers. Whether working with or without anesthesiologists, they serve as the key to cost savings in the provision of anesthesia and anesthesia related services, whether within operating rooms or in expanded service areas such as pain management clinics, postoperative suites and critical care units.

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Nurse Anesthesia Reimbursement

Nurse Anesthesia

Medicare

Enacted in 1965, Medicare (Title XVIII of the Social Security Act) reimbursed hospitals under Part A for "reasonable costs" of anesthesia services provided by hospital-employed Certified Registered Nurse Anesthetists (CRNAs). Anesthesiologists who employed and supervised CRNAs could bill under Part B as if they personally performed the case. Anesthesiologists who supervised CRNAs who were employed by a hospital could bill the same base units as if they did the case themselves, but their time units were halved.

- The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) established conditions that anesthesiologists must fulfill in order to be paid for medically directing CRNAs. In addition, TEFRA limited to four the number of concurrent cases physicians could medically direct and gain reimbursement.
- The Social Security Amendments of 1983 created the Prospective Payment System (PPS). Under PPS, all hospital Part A payments were bundled into diagnosis-related groupings (DRGs). Hospitals would have been required to pay for their CRNA employees from the fixed DRG payment, jeopardizing their ability to recoup actual costs, and creating a disincentive for hospitals to employ CRNAs. In addition, PPS precluded the unbundling of services and anesthesiologists who employed CRNAs would have been forced to contract with hospitals to get the CRNA portion of the DRG.
- The Deficit Reduction Act of 1984 established a pass-through provision for hospital-employed CRNA costs for a three-year period, assuring hospitals that they would not lose money by employing CRNAs. It also allowed an exception to the unbundling provisions in PPS to accommodate anesthesiologists billing for their CRNA employees. However, due to the temporary nature of the pass-through provision, the American Association of Nurse Anesthetists (AANA) immediately sought legislative remedy that would provide for direct Medicare reimbursement.
- The Omnibus Budget Reconciliation Act of 1986 established direct reimbursement for CRNAs under Medicare Part B, effective January 1, 1989. It also continued the existing forms of hospital and anesthesiologist billing for CRNA services under Medicare until December 31, 1988.
- The Omnibus Budget Reconciliation Act of 1987 imposed reductions in base units for anesthesiologists who medically directed CRNAs. Anesthesiologists' base units were reduced by 10% when medically directing CRNAs in two concurrent procedures, 25% for three procedures, and 40% for four procedures. The Health Care Finance Association (HCFA) also adopted the 1988 American Society of Anesthesiologists (ASA) *Relative Value Guide* (RVG) as its Uniform RVG for services provided on or after March 1, 1989.
- The Omnibus Budget Reconciliation Act of 1989 created the Resource-Based

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Relative Value Scale (RBRVS) system. During this time, anesthesiologists' services were found to be overvalued, resulting in decreased conversion factors beginning in 1991.

- The Omnibus Budget Reconciliation Act of 1990 statutorily established higher Medicare conversion factors for CRNAs, effective January 1, 1991. The nonmedically directed CRNA conversion factors would begin in 1991 at $15.50 and eventually reach $16.75 by 1996. The medically directed CRNA conversion factors were set at 70% of the nonmedically directed CRNA rate. Therefore, the medically directed CRNA conversion factors would begin in 1991 at $10.50 and eventually reach $11.70 by 1996. However, nonmedically directed CRNA conversion factors could not exceed the anesthesiologist conversion factors in the same carrier locality.

- The Omnibus Budget Reconciliation Act of 1993 included cuts in payment for the anesthesia care team (when a CRNA is medically directed by an anesthesiologist). It was determined that the cost of the team was as much as 140% of the cost of a solo provider. Consequently, as of January 1, 1994, the payment for the anesthesia care team was capped at 120% of what a solo anesthesiologist would be paid, split 50/50 between the CRNA and the anesthesiologist. There was an additional 5% cut in the cap each year over a four-year period, ending in 1998 with a permanent 100% cap, split 50/50 between the CRNA and anesthesiologist. The law also repealed the 10%, 25%, and 40% reduction in base units when as anesthesiologist would medically direct two, three, and four CRNAs, respectively, as well as the use of 30-minute time units in medical direction cases. Anesthesiologists could still be paid for medically directing CRNAs in up to four cases.

Medically Directed CRNAs: There is no separate Medicare conversion factor for medically directed CRNA services. The medically directed CRNA and the anesthesiologist are each paid 50% of the case. The case is paid under the following formula: base units + time units × anesthesiologist conversion factor × 110% rate (decreasing to 105% in 1997 and 100% in 1998 and thereafter) = $$, which is split 50/50 between the CRNA and the anesthesiologist. Although a CRNA can only be paid 50% of one case, an anesthesiologist can be paid 50% for each concurrently medically directed case up to four cases.

Medical Supervision of CRNAs by Anesthesiologists: When an anesthesiologist is involved in furnishing more than four procedures concurrently or is performing other services while directing the concurrent procedures, Medicare allows the anesthesiologist to be reimbursed for three base units per procedure. An additional time unit can be recognized if the anesthesia record can document that the physician was present at induction.

Nonmedically Directed CRNAs: The participating physician anesthesia conversion factor and the nonmedically directed CRNA conversion are the same.

The anesthesia conversion factor by Medicare is based upon a number of variables: the anesthesia update for that year, any decrease in anesthesia fees for a given year due to continued phase-in of anesthesiologist cuts under HCFA payment reforms, and geographic adjustments. Since HCFA does not support long-range predictions, these variables are re-calculated by HCFA on a year-to-year basis.

Reasonable Cost Payments to Hospitals for Qualified Anesthetists' Services: A rural hospital can qualify and be paid on a reasonable cost basis for one full-time employed CRNA providing 500 or fewer inpatient and outpatient anesthesia procedures without anesthesiologist services provided at the hospital. Participation in this program must be requested after September 30 and before January 1 for the coming year. The hospital and/or CRNA receiving pass-through funding is prohibited from billing a Medicare Part B Carrier for any anesthesia services furnished to patients of that hospital.

Medicaid

- There are 36 states that directly reimburse CRNAs under Medicaid.

Civilian Health and Medical Program of Uniformed Services (CHAMPUS)

- CRNAs and anesthesiologists are both directly reimbursed under CHAMPUS.

Federal Employee Health Benefit Program (FEHB)

- CRNAs are directly reimbursed for their services under FEHB.

State Mandates

- There are approximately 22 states which mandate direct private insurance payment to CRNAs.

Blue Cross/Blue Shield Plans

- There are approximately 38 Blue Cross/Blue Shield entities providing direct reimbursement to CRNAs.

Managed Care Plans

- Numerous managed care plans provide direct reimbursement to CRNAs in all states. For instance, a significant number of managed care organizations in the states of Arkansas, Iowa, Kentucky, Minnesota, New Mexico, Oregon, South Dakota, Tennessee, and Wisconsin reimburse CRNAs for their services.

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Legal Issues in Nurse Anesthesia Practice

This document was prepared to assist policymakers, health care administrators, health care insurers, and the public to obtain an understanding of nurse anesthesia practice issues, including legal matters affecting the practice of anesthesia by Certified Registered Nurse Anesthetists (CRNAs). It is not intended to be comprehensive, but rather to serve as a brief overview and summary of selected legal and regulatory issues. A more extensive exploration of legal issues in nurse anesthesia practice can be found in the publication titled: "Professional and Legal Issues of Nurse Anesthesia Practice" listed as a reference at the end of this document.

Early legal challenges to nurse anesthesia practice were based on whether nurse anesthetists were illegally practicing medicine. Landmark decisions in Kentucky (1917) and California (1936) established that nurse anesthetists were practicing nursing, not illegally practicing medicine.

CRNAs are professional registered nurses licensed to practice nursing who have become anesthesia specialists by taking a graduate curriculum which focuses on the development of clinical judgment and critical thinking. CRNAs are qualified to make independent judgments relative to all aspects of anesthesia care based on their education, licensure, and certification. Nurse anesthetists are legally responsible for the anesthesia care they provide.

CRNAs provide anesthesia, working with anesthesiologists, other physicians such as surgeons, and, where authorized, podiatrists, dentists, and other health care providers. The laws of every state permit CRNAs to work directly with a physician or other authorized health care professional without being supervised by an anesthesiologist. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) does not require anesthesiologist supervision of CRNAs nor does Medicare.

Some states require that nurse anesthetists be supervised or directed by a physician (such as a surgeon), dentist or podiatrist. Those who seek to discourage physicians from working with nurse anesthetists have incorrectly asserted that a supervising physician becomes liable for the negligent acts of the CRNA. A physician or authorized provider is not automatically liable when working with a CRNA, nor is the physician immune from liability when working with an anesthesiologist.

The principles governing the liability of a surgeon or obstetrician when working with a CRNA are the same as those governing the liability of a surgeon or obstetrician when working with an anesthesiologist. Whether or not a surgeon or obstetrician will be held liable for the negligence of the anesthetist depends on the facts of the case, not on the nature of the license of the anesthesia provider. Generally, the courts do not look at the status of the anesthesia provider, but at the degree of control the physician exercises over the anesthetist — whether that anesthetist is a CRNA or an anesthesiologist. The issue in each case is the extent

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to which the physician has control over the anesthesia administrator. Thus, a court may render different conclusions for cases that involve a physician working with a CRNA— or, for that matter, a physician working with an anesthesiologist — if the physician controlled the CRNA in one case but not in another.

Even where state laws require physician supervision of CRNAs, there is no requirement that a supervising physician control the acts of a CRNA. State laws do not require control, and mere supervision is insufficient to make the supervisor legally responsible for the negligence of a CRNA. The CRNA is the expert in anesthesia and supervising physicians, other than anesthesiologists, are not expected to have as much knowledge of anesthesia as the CRNA.

Medical staff bylaws which prevent CRNAs from being able to practice to the full extent of their professional authority as granted by state laws or regulations are traps for unwary hospitals. Such restrictions have denied some patients access to the full scope of anesthesia techniques which should be made available to them, ultimately increasing the cost of anesthesia services. These restrictions have no basis in practice and are sometimes not followed when patient interests or operating room efficiency demand it. Should there be a problem during a procedure when these policies were not followed, the patient may claim that the hospital or institution was negligent for failing to follow its own requirements, creating a basis for a lawsuit for what may have been an otherwise non-negligent and unavoidable incident.

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Nurse Anesthetists and Anesthesiologists Practicing Together

Anesthesia is a recognized specialty in both medicine and nursing. Approximately 80% of Certified Registered Nurse Anesthetists (CRNAs) work as partners in care with anesthesiologists, while the remaining 20% function as sole anesthesia providers working and collaborating with surgeons and other licensed physicians. The American Association of Nurse Anesthetists (AANA) supports both practice models and believes that quality outcomes are excellent in both.

The AANA supports mutual respect and open, forthright relations between CRNAs and anesthesiologists working in a collaborative fashion.

When CRNAs and anesthesiologists work together to provide patient care, the following are key concepts:

1. CRNAs are responsible for their actions in the care of patients and in the provision of anesthesia services.
2. CRNAs practice according to their licensure, certification and expertise.
3. The anesthesiologist is the medical specialist who provides perioperative services and functions collaboratively with the CRNA in the provision of anesthesia and related services.
4. Patient care needs should dictate appropriate personnel resources of both anesthesiologists and CRNAs, rather than predetermined numerical ratios.

The anesthesia and related services provided by either the CRNA or the anesthesiologist when working together include, but are not limited to:

- Performing and documenting a preanesthetic assessment and evaluation of the patient, including ordering and administering preanesthetic medications, and requesting consultations and diagnostic studies.
- Developing and implementing the anesthesia care plan.
- Selecting and initiating the planned anesthetic technique which may include general, regional, or local anesthesia, or sedation.
- Selecting and administering anesthetics and adjunct drugs and monitoring the patient's responses to surgery or anesthesia.
- Selecting, applying, and inserting appropriate non-invasive and invasive monitoring modalities for continuous evaluation of the patient's physical status.
- Managing the patient's airway and pulmonary status.
- Managing emergence and recovery from anesthesia.
- Providing postanesthesia follow-up evaluation and care, including discharge of patients from a postanesthesia care area.

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- Ordering, initiating or modifying pain relief therapy.

- Responding to emergency situations by providing airway management, administration of emergency fluids or drugs, and advanced cardiac life support techniques.

Reference

Nurse Anesthetists and Anesthesiologists Practicing Together. In: *Professional Practice Manual for the Certified Registered Nurse Anesthetist.* Position Statement No. 1.9. Park Ridge, Illinois: American Association of Nurse Anesthetists. Adopted August 1996. Revised November 1996.