REPORT OF RECOMMENDATIONS AND FINDINGS

By the Anesthesiologist Assistants
Technical Review Committee

To the Nebraska State Board of Health, the
Director of the Division of Public Health, Department of Health and
Human Services, and the Members of the Health and Human
Services Committee of the Legislature

January 10, 2023

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Part One: Preliminary Information

Introduction

The Credentialing Review Program is a review process advisory to the Legislature which is designed to assess the need for state regulation of health professionals. The credentialing review statute requires that review bodies assess the need for credentialing proposals by examining whether such proposals are in the public interest.

The law directs those health occupations and professions seeking credentialing or a change in scope of practice to submit an application for review to the Department of Health and Human Services, Division of Public Health. The Director of this Division will then appoint an appropriate technical review committee to review the application and make recommendations regarding whether or not the application in question should be approved. These recommendations are made in accordance with statutory criteria contained in Section 71-6221 of the Nebraska Revised Statutes. These criteria focus the attention of committee members on the public health, safety, and welfare.

The recommendations of technical review committees take the form of written reports that are submitted to the State Board of Health and the Director of the Division along with any other materials requested by these review bodies. These two review bodies formulate their own independent reports on credentialing proposals. All reports that are generated by the program are submitted to the Legislature to assist state senators in their review of proposed legislation pertinent to the credentialing of health care professions.

LIST OF MEMBERS OF THE ANESTHESIOLOGIST ASSISTANTS TECHNICAL REVIEW COMMITTEE

Dan Vehle (Chair)

David Deemer, Nursing Home Administrator

Rebecca Docter, BS, MA

Mark Malesker, RP, PharmD

Susan Meyerle, PhD, LIMHP

Mary Sneckenberg, BAE, Bachelor of Arts in Education

Larry Hardesty, PhD

Part Two: Summary of Committee Recommendations

The committee members recommended against approval of the applicants' proposal by a vote of four against and two in favor with one abstention.

Part Three: Summary of the Applicants' Proposal

Proposed Credential

This application proposes to create education, training, certification, supervision, and scope of practice requirements for individuals to be eligible for licensure in Nebraska to practice as a Certified Anesthesiologist Assistant (CAA).

Education and Training

Education and training are addressed in Question 11 in detail. This application proposes to require CAAs seeking credentialing/licensing in Nebraska to have graduated from an anesthesiologist assistant program accredited by the Commission on Accreditation of Allied Health Education Programs or its predecessor or successor organization and to have satisfactorily completed a certification examination administered by the National Commission for the Certification of Anesthesiologist Assistants or another national certifying agency that has been reviewed and approved by the board and that is currently certified.

Scope of Practice

Under the direction of a physician anesthesiologist, in agreement with the American Society of Anesthesiologists (ASA) Statement on the Anesthesia Care Team, (ACT) and in accordance with the AAAA Statement on the ACT, the scope of practice for a CAA includes:

- developing and implementing an anesthesia care plan for a patient;
- obtaining a comprehensive patient history and performing relevant elements of a physical exam;
- performing preoperative and post-operative anesthetic evaluations and maintaining patient progress notes;
- ordering and performing preoperative patient consultations;
- ordering preoperative medications, including controlled substances;
- changing or discontinuing a medical treatment plan after consulting with the supervising physician anesthesiologist;
- obtaining informed consent for anesthesia or related procedures;
- ordering the perioperative continuation of current medications;
- pretesting and calibrating anesthesia delivery systems and obtaining and interpreting information from the systems and from monitors;
- implementing medically accepted monitoring techniques;

- performing basic and advanced airway interventions, including, but not limited to, endotracheal intubation, laryngeal mask insertion and other advanced airways techniques;
- establishing peripheral intravenous lines, including subcutaneous lidocaine use;
- performing invasive procedures including but not limited to arterial lines, central lines, and Swan Ganz catheters;
- performing general anesthesia, including induction, maintenance, emergence and procedures associated with general anesthesia, such as gastric intubation;
- administering anesthetic drugs, adjuvant drugs, and accessory drugs;
- administering vasoactive drugs and starting and titrating vasoactive infusions to treat patient responses to anesthesia;
- performing, maintaining, evaluating and managing epidural, spinal and regional anesthesia including catheters;
- performing monitored anesthesia care;
- obtaining venous and arterial blood samples;
- administering blood, blood products, and supportive fluids;
- performing, ordering and interpreting appropriate preoperative, point of care, intra-operative or postoperative diagnostic tests or procedures;
- obtaining and administering perioperative anesthesia and related pharmaceutical agents, including intravenous fluids and blood products;
- managing the patient while in the preoperative suite, recovery area, or labor suites;
- ordering postoperative sedation, anxiolysis or analgesia, postoperative respiratory therapy and medicines to treat patient responses to anesthesia and ordering postoperative oxygen therapy, including initial ventilator therapy;
- initiating and managing cardiopulmonary resuscitation in response to a lifethreatening situation;
- participating in administrative, research and clinical teaching activities including supervising student anesthesiologist assistants and other students involved in anesthesia education; and
- performing such other tasks not prohibited by law that an anesthesiologist assistant has been trained and is proficient to perform.

Administered

This application proposes to grant the State Board of Medicine the power to oversee and regulate CAAs. Currently the Board of Medicine regulates physician assistants in addition to physicians and osteopathic physicians. Like CAAs, physician assistants do not have independent practice and must be supervised by a physician. States where CAAs currently practice typically follow the requirements promulgated by the Center for Medicare and Medicaid Services (CMS) that allow physician anesthesiologists to supervise up to four CAAs concurrently and this application proposes to require the board of medicine to adhere to CMS

rules relating to CAA supervision. The State Board of Medicine would have the power to promulgate rules and regulations regarding the education and training requirements of CAAs and impose disciplinary measures against license holders on the typical grounds that such discipline can be imposed in the Uniform Credentialing Act.

The full text of the applicants' proposal can be found under the appropriate subject area of the credentialing review program link at
https://dhhs.ne.gov/Licensure/Pages/Credentialing-Review.aspx

Part Four: Discussion on issues by the Committee Members

Richard Evans, AAAA, came forward to present a power point on the Anesthesiologist Assistant profession. Mr. Evans informed the Committee members that the Anesthesiologist Assistant profession was created fifty years ago to address matters pertinent to service shortages in the provision of anesthesia services. Today, these professionals work under Federal Medicare rules which state that an Anesthesiologist is allowed to supervise up to four Anesthesiologist Assistants. By rule the supervising Anesthesiologist must be "immediately available" to his supervisees.

Mr. Evans went on to show the Committee members that there are nineteen states and two other types of jurisdictions that credential Anesthesiologist Assistants in some manner, or, which allow physicians to use their delegatory authority to allow Anesthesiologist Assistants to provide their services. Nebraska currently does not allow for the use of a physician's delegatory authority for this purpose, nor does Nebraska credential these professionals. This means that the members of this profession cannot practice in Nebraska under the current statutory situation. The applicant group seeks to eliminate this restrictive situation by pursuing licensure for Anesthesiologist Assistants. Mr. Evans went on to state that the applicant group believes that licensure is the best way to get practice rights for these professionals because it provides for accountability, discipline, and continuing education.

Regarding supervision Mr. Evans delineated the components of the supervision process for Anesthesiologist Assistants which involve: 1) Pre-examination, 2) Prescription, 3) Monitoring, and 4) Physician availability.

Pertinent to education and training Mr. Evans stated that all Anesthesiologist Assistant training is at a Masters-Degree level, and that it provides for the following: 1) Pre-Med, 2) 600 classroom didactic hours, and 3) 2500 clinical practicum hours. Medical schools offer these courses.

Mr. Evans went on to inform the Committee members that there are thirteen accredited Anesthesiology Assistant training programs around the USA. At this juncture, Jennifer Stevers, CAA, came forward to comment on the lab component of this education. Ms. Stevers stated that the goal of this education and training is to balance and coordinate didactic and clinical elements to maximize clinical competency. The didactic portion occurs first followed by 2500 hours of clinical training. Ms. Stevers went on to describe the overall training / post-training sequence for Anesthesiology Assistants which proceeds from: 1) the certification examination, 2) CE, and later, 3) recertification. Fifty hours of CE would be required every 10 years.

At this juncture Richard Evans resumed his comments by informing the Committee members that studies have shown that Anesthesiology Assistants are as safe as CRNAs, adding that CRNAs and Anesthesiology Assistants are virtually interchangeable when it comes to patient safety.

Dr. Cale Kassel came forward to comment on the reasons why Nebraska needs the Anesthesiologist Assistants proposal. Dr. Kassel stated that the proposal would increase the availability of anesthesia care providers and that any increase in services in this area of care is a good thing. Dr. Kassel added that current restrictions on the ability of members of the applicant group to practice their profession in Nebraska constitutes a limitation on access to care and that these restrictions need to be removed. Dr. Kassel went on to state that no new harm would be created by passing this proposal. He added that this is a profession for which

the public would benefit from an assurance that its members possess high-quality education and training, adding that there is no doubt that these professionals, in fact, do possess such education and training. Dr. Kassel concluded his remarks by stating that there is no other way of addressing the concerns raised about current practice restrictions in Nebraska than passing the proposal.

Tiffany Wenande, MS, CRNA, speaking on behalf of CRNA professionals in Nebraska, came forward to present comments opposing the Anesthesiology Assistants proposal. Holly Chandler, CRNA, stated that there are serious concerns about the proposal and identified these concerns as follows:

- The fact that applicant professionals are not independent practitioners raises serious questions about applicant group assertions that these professionals would provide services that are equivalent to those provided by CRNAs.
- Currently, there are no members of the applicant profession in Nebraska. How can we be assured that if the proposal were to pass that sufficient numbers of the profession under review would come to Nebraska to have an impact on the availability of the services in question?
- Evidence of service shortages under the current practice situation has not been provided.
- Could oversight as defined in the proposal be effectively maintained? Or, would there be a constant risk of non-compliance?
- There is no peer review evidence pertinent to the safety of the professionals under review.
- There is no peer review evidence pertinent to the need for the proposal.

Marty Fattig, CEO, Nemaha County Hospital, commented that the most acute issue facing healthcare today is personnel shortages, and one of the major problems in attempting to resolve such shortages is the lack of clinical sites to train students. CRNA students are required to have a pre-set number of specialty cases which can only be attained in large urban medical centers. If AA training were to be added to this mix they would be competing with CRNAs for access to such clinical training sites which is likely to result in CRNAs receiving less access to such training than they have now and this in turn could result in a decrease in the number of CRNAs being trained in our state. Rural Nebraska relies on CRNAs for most of its anesthesia care. It would be rural areas that would suffer the most if this scenario were to play out as feared in real time.

Karen Wade, Vice President of NNA, came forward to make comments on behalf of her organization. Ms. Wade characterized the proposal as offering a “double-provider model” for the provision of services given that under the terms of the proposal the applicant group cannot provide services without an Anesthesiologist being “immediately available” for direction or consultation. Ms. Wade went on to state that this is not an efficient model for providing outreach services to underserved areas, and as such would not be cost-effective outside of urban areas, for example.

Dan Vehle asked the applicants if this approach to oversight would always be the way it would be done, and if so, how would this work in rural areas of our state. Richard Evans responded that this is how oversight would be accomplished and added that the applicant group is not saying that this proposal is a solution or access to care problems in rural Nebraska but that it would work well in urban areas of our state.

Chairperson Vehle asked Committee members if they had any follow-up questions or information requests for the applicant group to address at the next meeting of the Committee.

Committee member Meyerle asked the applicants to provide a map of anesthesiology care services in Nebraska pursuant to the identification of underserved areas in our state. Committee member Meyerle also asked for information pertinent to reimbursement for the services of the professionals under review. She also asked for tuition estimates for the education and training of Anesthesiologist Assistants.

Committee member David Deemer asked the applicants to provide information from other states pertinent to the extent to which credentialing Anesthesiologist Assistants has had an impact on staffing shortages in other states. He then identified the states of Colorado, Kansas, and Missouri as examples of such states, adding that it would be good to know how many openings for positions there were prior to the passage of CAA credentialing in these states.

Later in the review process on the CAA proposal, Richard Evans, AAAA, came forward to present a power point on the Anesthesiologist Assistant profession. Mr. Evans informed the Committee members that there are 15 training programs for CAA's around the USA and that these programs are approximately 24-months in duration culminating in a certificate following completion of all requirements including passing a certifying examination. Those who complete the process and become licensed would be required to complete 50-hours of CE over a two-year period in order to renew their license. Tuition for the two-year training program varies from 64-thousand dollars to around 95-thousand dollars per student. Regarding supervision Mr. Evans stated that typically supervision is provided by an Anesthesiologist who is required to be on the premises of the facility wherein the CAA in question is working, though not necessarily in the same room as the CAA in question.

At this juncture Dr. Deborah Rusy, MD, came forward to make comments comparing AA's and CRNAs pertinent to their respective skills and abilities. Dr. Rosen stated that CRNAs and CAAs are virtually interchangeable in terms of their respective skills and abilities.

Dr. Cale Kassel, MD, came forward to comment on employment opportunities and job openings for CAAs around the USA and provided a map showing communities wherein there are job openings for CAAs. He also commented on the reimbursement situation of CAAs. He went on to state that evidence indicates that there is as demand for CAA services around the USA even though CRNAs are a well-established profession in remote rural areas, adding that there is plenty of room out there for the members of both professions. Dr. Kassel went on to state that CAAs education and training is similar to that of CRNAs, that the quality of their care is similar, and that data shows that CAA services are safe and effective.

Dr. Kassel commented that work force data shows that there is a real need for more anesthesia providers in Nebraska and that CAAs could play a major role in filling this void. He added that billing for CAA services would be via a team model, and that insurance costs for CAA services are not higher than for CRNAs.

Tiffany Wenande, CRNA, and Holly Chandler, CRNA, presented a power-point presentation opposing the Anesthesiology Assistants proposal. Holly Chandler, CRNA, stated that CAAs and CRNAs are not interchangeable in any way. She went on to state that CAAs are not legal in Nebraska, while CRNAs are members of an independently licensed profession that are trained and educated to exercise independent judgement in their treatment of their patients, whereas CAAs are not trained or educated to practice independently of their supervising physicians. This

means that CRNAs are capable of working alone in remote rural areas of our state whereas CAAs are not. Access to care in remote rural areas is maximized by the services of CRNAs. This is not the case vis-à-vis the services of CAAs.

Holly Chandler went on to state that licensing CAAs would lessen access to quality anesthesia care in rural areas of our state because of the fact that CAAs are not able to practice independently and would require the presence of an anesthesiologist on the premises wherever CAA services would be provided. This would significantly raise the costs of anesthesia care in rural areas of our state.

Tiffany Wenande, MS, CRNA, commented on patient safety concerns raised by the CAA proposal stemming from the inability of CAAs to exercise independent judgement or to manage emergent situations on their own without the presence of their physician supervisor to advise them. Ms. Wenande went on to state that any lapse in oversight in such a situation holds the potential for a delay in receiving competent care, or, worse yet, could result in a disastrous patient outcome.

Holly Chandler commented that NMA information pertinent to the available supply of anesthesia services and the supposed need for more providers is not accurate and is not based on real need. This information identifies vacancies for certain facilities pertinent to anesthesia but does not account for the fact that many of these facilities do not utilize the “medical direction” model upon which the current CAA proposal depends. Holly went on to state that even in some so-called “delegation states” there are few if any CAAs because facilities within these states do not allow for the utilization of the “delegation model” required for the CAA proposal to get underway. She added that only eight states have situations wherein the CAA model outlined by the current Nebraska CAA proposal would be able to function as designed.

Tiffany Wenande commented that in Indiana—which has passed a similar proposal—they are losing as many as 100 CRNA grads a year due to lost education and training hours stemming from having to share time and space for such education and training with CAAs. She went on to state that in that state they are losing their frontline nursing people because of the demands on the education and training system for anesthesia care.

Dr. Matt Mormino, MD, argued that including CAAs in the mix of professionals allowed to provide anesthesia services slows down the process because they are not able to provide such services or render judgements on such services without the input of an anesthesiologist, whereas CRNAs are fully capable of exercising such judgement. He added that in this sense CAAs would actually lessen access to anesthesia care in Nebraska.

Troy Anderson, CRNA, commented that CAA licensure / employment in health care facilities would not only lessen access to care but would actually be a source of potential danger to the public in emergency situations wherein independent judgement is required to save someone’s life if things for whatever reason go wrong. CRNAs are much better prepared to handle emergencies because they are trained to work independently and exercise independent judgement.

Rachael Lupak-Bayer, AAA, responded to concerns about independent judgement by CAAs by stating that CAAs are sufficiently well trained to act in emergencies without input from their supervisor and do so without delays.

Dr. Angela Mund, CRNA, stated that in one facility in a state that licenses CAAs large numbers of CRNAs left their employment to work elsewhere after hearing that CAAs had been hired to work at this facility. Dr. Cale Kassell responded that blocking CRNA access to their training is not the intent of the applicant group. Dr. Richard Evans, AAAA, responded to Dr. Mund's remarks by stating that under the terms of the proposal no facility is going to be required to employ CAAs, and that if such employment is determined not to be in the interest of service to the public dealing with such a situation is simple, "just don't do it!" Dr. Rosenquist commented by stating that the applicant group is not trying to undermine CRNAs. They are trying to provide another option / alternative for addressing service shortages in the provision of anesthesia services in Nebraska. He added that an overview of how things have worked in states wherein CAAs have become licensed shows that CAA services have been safe and effective and that there has been no indication of any negative impacts on CRNAs or their services. Dr. Cale Kassell commented that he too has found no evidence of any harm to CRNAs from CAA licensure in such states and added that CAAs have enhanced access to anesthesia services without harming the services of other anesthesia service providers wherever they have been allowed to practice.

All sources used to create Part Four of this report can be found on the credentialing review program link at
https://dhhs.ne.gov/Licensure/Pages/Credentialing-Review.aspx

Part Five: Formulation of Recommendations on the Applicant's Proposal

Committee action on the Four Statutory Criteria as They Pertain to this Proposal

Criterion one: Unregulated practice can clearly harm or endanger the health, safety, or welfare of the public.

Voting aye were: Malesker, Sneckenberg, and Meyerle
Voting nay were: Hardesty, Doctor, and Deemer
Chairperson Dan Vehle abstained from voting.

Criterion two: Regulation of the profession does not impose significant new economic hardship on the public, significantly diminish the supply of qualified practitioners, or otherwise create barriers to service that are not consistent with the public welfare and interest.

Voting aye were: Malesker and Sneckenberg
Voting nay were: Hardesty, Meyerle, Doctor, and Deemer
Chairperson Dan Vehle abstained from voting.

Criterion three: The public needs assurance from the state of initial and continuing professional ability.

Voting aye were: Malesker, Sneckenberg, and Meyerle
Voting nay were: Deemer, Doctor, and Hardesty
Chairperson Dan Vehle abstained from voting.

Criterion four: The public cannot be protected by a more effective alternative.

Voting aye were: Sneckenberg,
Voting nay were: Meyerle, Doctor, Malesker, Hardesty, and Deemer
Chairperson Dan Vehle abstained from voting.

Action taken on the proposal as a whole:

The Committee members took action on the proposal as a whole via an up/down roll call vote as follows:

Mark Malesker, RP, Pharm D: Voted **"Yes"** to recommend approval of the proposal

His Comments were that there is a great need in Nebraska for additional anesthesia care providers and that this proposal would provide much needed help in that regard.

Mary Sneckenberg, BA: Voted **"Yes"** to recommend approval of the proposal

Her Comments were that she voted for the proposal not only for today's understanding of what was said earlier about most AA's now being in the urban areas, and the attraction to remain in the urban areas, but colleges like UNMC are making a significant commitment to rural Nebraska with the building of a rural medical school expansion at the Kearney campus. There will be more opportunities not only for today, but for the near future in rural Nebraska.

Larry Hardesty: Voted **"No"** to recommend against approval of the proposal

His Comments were that the proposal would do nothing to address service needs vis-à-vis anesthesia care in rural areas of Nebraska, adding that it is doubtful that it would do anything to improve access to anesthesia care in urban areas either. Indeed, it might even have a negative impact even on urban areas because it might restrict the training opportunities of nurse anesthesia practitioners based on the experiences of Colorado and Missouri, for example.

Susan Meyerle: Voted **"No"** to recommend against approval of the proposal

Her Comments were that the proposal would not only fail to enhance anesthesia services in Nebraska but would likely have a major negative impact on current anesthesia services in our state. She went on to state that the applicants provided no viable alternatives to their proposal, adding that the proposal seems to be motivated by a political agenda as opposed to being motivated by a sincere desire to address services shortages in the area of anesthesia care.

Rebecca Doctor: Voted **"No"** to recommend against approval of the proposal

Her Comments were that the supervisory situation for members of the applicant group would create a cumbersome and complicated situation for the delivery of anesthesia care in Nebraska and would lessen the efficiency and effectiveness of anesthesia services in our state.

David Deemer: Voted **"No"** to recommend against approval of the proposal

His Comments were that the supervisory situation for members of the applicant group would create a cumbersome and complicated situation for the delivery of anesthesia care in Nebraska and would lessen the efficiency and effectiveness of anesthesia services in our state.

Chairperson Dan Vehle abstained from voting.

The result of this roll call vote was two committee members voting to support the proposal and four committee members voting against the proposal. This means that the members of the Anesthesiologist Assistants Technical Review Committee recommended against recommending approval the Anesthesiologist Assistants proposal.