**From:** "Harmeyer, Don W." <Don.Harmeyer@uvmhealth.org>
**Date:** Wednesday, April 4, 2018 at 10:29:17 AM
**To:** "Jeanette White" <JWhite@leg.state.vt.us>
**Subject:** H.684 APRNs and CRNAs

Dear Senator,

I am a Certified Registered Nurse Anesthetist/Advanced Practice Registered Nurse (CRNA/APRN) and constituent of yours practicing for over 21 years in the state of Vermont. I am concerned about H.684 and the provision in the bill related to regulation of APRNs. I am most concerned by the Vermont Society of Anesthesiologists (VSA) presentation of misleading false data to the legislature in an attempt to inhibit the practice of CRNAs within the state of Vermont. An amendment placed in the bill because of this false data is now up for consideration by your committee.

I support the bill as introduced, eliminating collaborative agreements for new CRNAs/APRNs. The data used by the Vermont Society of Anesthesiologist has already been discredited by both Medicare and the CDC not to mention it is 20 years old. Unfortunately our political landscape at the national level no longer relies on the truth but this should not be the case in Vermont. For example, the VSA statement that this bill will result in 2.5 excess deaths per 1000 anesthetics is absolutely not true and recent well done studies noted below prove that CRNA administered anesthesia is very safe and cost effective. CRNAs have been providing high quality needed services throughout Vermont for decades, especially in rural hospitals and clinics. It is important for your committee to return the bill to the format that it was introduced to ensure that Vermonters continue to have access to these services. It is also important to note that the work to discredit the study reference by the VSA has already been done by Medicaid and the CDC. Making false statements of an excess 2.5 deaths per 1000 before the legislature should not be tolerated.

Pleased take a moment to review the statement below from the Vermont Association of Nurse Anesthetists.

Thank you for your time,

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VANA statement:

VSA myth:
"Nurse anesthetists practicing outside of the team-based model are rare, as evidenced by 46 states plus the District of Columbia requiring nurse anesthetists to practice in a team-based relationship for the delivery of anesthesia services. House Bill 684 would move Vermont far away from nearly all states that value the team-based model of anesthesia care."

Reality:
Current Vermont law allows CRNAs to collaborate with a physician (not limited to any particular specialty) or an APRN. CRNAs have been included in this APRN requirement since its inception, with no adverse effects on patient care. There have been no disciplinary actions by the Board of Nursing that justify separating CRNAs out from the provisions that apply to all APRNs in Vermont.

Current Vermont law, and the changes proposed in House Bill 684, are consistent with CRNA practice in the vast majority of states. Forty states, and the District of Columbia, have no supervision requirement concerning certified registered nurse anesthetists in state nursing laws/rules, medical laws/rules, or their generic equivalents.

VSA myth:
VSA cites the following studies in a mistaken and unfortunate attempt to show that CRNA care is inferior to that of anesthesiologists:

- Silber JH, Kennedy SK, Evan-Shoshan O et al. Anesthesiologist direction and patient outcomes. Anesthesiology. Jul 2000;93(1):152-163.
- Memtsoudis SG, Ma Y, Swmidoss CP et al. Factors influencing unexpected disposition after orthopedic ambulatory surgery. J Clin Anesth 2012;24(2):89-95.

Reality:
Claims about the outcomes shown by the Silber (2000) and Memtsoudis (2012) studies are uncorroborated by the evidence and should be rejected. The Silber study, based on data gathered more than two decades ago (between 1991-94), was critiqued extensively and independently by the Medicare agency, which stated that the article "did not study CRNA practice with and without physician supervision." Medicare also stated, "One cannot use this analysis to make conclusions about CRNA performance with or without physician supervision."

The Memtsoudis paper suffers from numerous methodological flaws that invalidate the faulty deductions. The Centers for Disease Control and Prevention, the source of the data grounding this paper, specifically addresses the unreliability of these data elements in its survey highlights. Moreover, the study did not adjust for major factors common in health services research, including race, comorbidity, insurance status, and metropolitan statistical area. In short: garbage in, garbage out.

In contrast, the studies cited below have found that:

- There are no differences in patient outcomes when anesthesia services are provided by CRNAs, physician anesthesiologists, or CRNAs supervised by physicians.
- When CRNAs practice to their full authority, there was no measurable impact on anesthesia-related complications.
- A CRNA acting as the sole anesthesia provider is the most cost-effective model of anesthesia delivery.

Study citations:

Hogan, Paul F., Rita Furst Seifert, Carol S. Moore, and Brian E. Simonson. Cost Effectiveness Analysis of Anesthesia Providers. Nursing Economics 28(3), 2010: 159.

The Lewin Group (2016). Update of Cost Effectiveness of Anesthesia Providers. Lewin Publications, May 13, 2016.

Dulisse B, Cromwell J (2010). No Harm Found When Nurse Anesthetists Work Without Supervision by Physicians, Health Affairs, 29:1469-1475.

If House Bill 684 is enacted with APRN provisions that include CRNAs, there will be no negative impact on patient safety. The quality care that surgeons and CRNAs currently provide to patients will not change. Surgeons and CRNAs will maintain the close cooperation that currently occurs throughout the surgical or diagnostic portions of patient care. Determining what policies best serve a facility's particular patient population should be a local facility decision, and Vermont facilities will continue to be able to adopt their own policies regarding anesthesia practice as they do today.