Memorandum

To: Senate Claire Ayer, Chair, Senate Health and Welfare Committee
Senate Health and Welfare Committee Members
From: Vermont Association of Nurse Anesthetists
Re: Response to Senate Health and Welfare Committee questions posed April 6, 2018
Date: April 11, 2018

In response to questions posed by the Senate Health and Welfare Committee on April 6, 2018, the Vermont Association of Nurse Anesthetists (VtANA) offer the following responses:

1. How can an APRN go into independent practice right out of school without additional hours and support?

Prior to entering an accredited CRNA program (all CRNA programs are accredited by the Council on Accreditation), a Bachelors prepared Registered Nurse must have worked in a critical care (ICU) environment (the average time spent in ICU is 3.5 years).
CRNAS complete rigorous clinical training during their programs (see supporting documents submitted) have Advanced Cardiac Life Support and Pediatric Advanced Life Support Certifications and have passed a National Board Certifying Exam before entering into practice. The nature of their work in the Operating Room is an ongoing collaboration with the other members the health care team: surgeon, registered nurses, scrub techs, xray personnel. All focused on the care of patient in front of them. That happens from the first case as you enter practice and continues for the rest of your career. Each facility in Vermont has rules and guidelines regarding how a provider is oriented and integrated to its' system of care. I have never had a fellow CRNA report not having adequate support or collaboration in entering the profession.

2. What is the data on adverse effects on states where there are requirements and in states where there aren't requirements?

I have solicited data on this question from the office of the American Association of Nurse Anesthetists (AANA) and will share it with you when I receive it.

3.If collaboration and supervision are already the defacto practice, why is it hard to meet the OPR standards?

Collaboration is de facto practice, but supervision is not at all de facto practice. A collaborative practice agreement, as required in current law, does not require any form of supervision whatsoever. It is not that it is hard to meet the OPR standards; it is, as OPR testified, an unnecessary and burdensome practice that is not needed to meet the public and patient safety threshold. This paperwork has no bearing in our real world practice in the operating room.

The reason we are so opposed to the House-passed language is that the language states that either the CPA will continue as is or, if an APRN works in a larger practice, essentially he or she must be overseen by a more-experienced provider (by either having the provider on site at all times, or available by other means) It is also unclear as to what this means – does the APRN need to

consult with that provider before acting independently, does the APRN need to call the provider when making decisions, etc. This has never been the case, to my knowledge, in the history of CRNA practice in VT. In fact, in VT, nurses provided anesthesia before physicians did, and the first Nurse Anesthetist at Mary Fletcher Hospital in Burlington, Maude Smith, began work there in 1927.

The House language was agreed to by VMS in the House, but the CRNAs were not a part of those negotiations. As soon as we became aware of the language, we notified OPR and VMS that we would oppose the language.

Sincerely,
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President VTANA