Report to the General Assembly

Scope of Practice Review Committee Report on
Certified Registered Nurse Anesthetists

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State of Connecticut

Department of Public Health

Report to the General Assembly

Scope of Practice Review Committee on Certified Registered Nurse Anesthetists

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Executive Summary

In accordance with Connecticut General Statutes (CGS) Section 19a-16d through 19a-16f, the Connecticut Association of Nurse Anesthesiology (CTANA) submitted a scope of practice request to the Department of Public Health (DPH) seeking to revise the Certified Registered Nurse Anesthetist (CRNA) scope of practice 20-87a(b)(2) governing the profession. Certified Nurse Anesthetists are licensed as Advanced Practice Registered Nurses (APRNs) and regulated under Chapter 378 of the CT General Statutes.

According to CTANA the current language in their scope of practice aligns with the provisions for all other Advanced Practice Registered Nurses (APRNs) licensed and practicing in Connecticut except that CRNAs are not permitted to work without a physician directing their activities. CTANA's request sought to remove this requirement for physician direction. In addition, CTANA sought to replace all references to the American Association of Nurse Anesthetists with the current certifying and recertifying body for CRNAs, the National Board of Certification and Recertification for Nurse Anesthetists (NBCRNA).

A scope of practice review committee was established to review and evaluate the request as well as subsequent written responses to the request and additional information gathered throughout the review process. The review committee met on three occasions and focused on assessing potential health and safety benefits associated with the request, whether the request enhances access to quality and affordable health care, the potential economic impact of the request, and how the request might enhance the ability of the profession to practice to the full extent of the profession's education and training.

The review committee recognized and acknowledged the important role that CRNAs play in the health care system. The physician organizations and individual physicians that participated on the committee acknowledged their supervisory role included a great deal of collaboration. However, these participants did not feel the supervisory relationship between physicians and CRNAs was burdensome or that it needed to be changed. In addition, the Physician organizations and individual physicians cited the education and training of CRNAs, patient safety, access to care, billing, and hospital policies related to federal and state requirements as reasons to maintain the existing requirement.

No committee members objected to the request to update the CRNA scope of practice to accurately reflect the current certifying and recertifying body.

Background

Connecticut General Statute Section 19a-16d through 19a-16f establishes a process for the submission and review of requests from health care professions seeking to revise or establish a scope of practice prior to consideration by the General Assembly. Under the provisions of these statutes, persons or entities acting on behalf of a health care profession that may be directly impacted by a scope of practice request may submit a written impact statement to DPH. The Commissioner of Public Health then selects from the timely scope of practice requests received by the department the requests on which DPH will act and, within available appropriations, establish and appoint members to a scope of practice review committee. Committees shall consist of the following members:

1. Two members recommended by the requestor to represent the health care profession making the scope of practice request.
2. Two members recommended by each person or entity that has submitted a written impact statement, to represent the health care profession(s) directly impacted by the scope of practice request; and
3. The Commissioner of Public Health or the commissioner's designee, who shall serve as ex-officio, non-voting member of the committee.

Scope of practice review committees shall review and evaluate the scope of practice request, subsequent written responses to the request and any other information the committee deems relevant to the scope of practice request. Such review and evaluation shall include, but not be limited to, an assessment of any public health and safety risks that may be associated with the request, whether the request my enhance access to quality and affordable health care and whether the request enhances the ability of the profession to practice to the full extent of the profession's education and training. Upon concluding its review and evaluation of the scope of practice request, the committee shall provide its findings to the joint standing committee of the General Assembly having cognizance of matters relating to public health. DPH is responsible for receiving requests and for establishing and providing support to the review committees, within available appropriations.

Scope of Practice Request

The CTANA submitted a request for the DPH to convene a scope of practice review committee to consider updating the profession's scope of practice to remove the requirement for physician direction. In addition, CTANA requested that all references to the American Association of Nurse Anesthetists by changed to the National Board of Certification and Recertification (NBCRNA) to reflect the current certifying and recertifying body for CRNAs.

Impact Statements and Response to Impact Statements

Written impact statements in response to the scope of practice request submitted by the CTANA were received from the following:

- Connecticut Hospital Association (CHA)
- Connecticut Advanced Practice Registered Nurse Society
- Connecticut Nurses Association
- American Association of PeriOperative Registered Nurses
- Connecticut State Society of Anesthesiologists
- Connecticut Society of Plastic Surgeons
- Connecticut State Medical Society
- Connecticut Anesthesia Professionals
- Connecticut Association of Nurse Anesthesiology
- Northwest Nurse Practitioner Group

The impact statements expressed a desire to serve on the scope of practice review committee to better understand the impact of the request as it relates to the access and utilization of health care in Connecticut. The impact statements acknowledged the valuable role the CRNA has within the healthcare team. However, a significant number of the impact statements expressed concern that the training that CRNAs receive and expertise they possess do not prepare CRNAs to practice without physician supervision. These impact statements expressed that permitting CRNAs to practice without supervision could lead to quality-of-care issues for some patients in Connecticut.

Scope of Practice Review Committee Membership

In accordance with Connecticut General Statute Section 19a-16e, a scope of practice review committee was established to review and evaluate the scope of practice request submitted by the CTANA. Membership on the scope of practice review committee included representation from:

- Connecticut Association of Nurse Anesthesiology,
- CT Nurses Association,
- CT State Medical Society,
- CT APRN Society,
- CT Hospital Association,
- CT Society of Plastic Surgeons,
- CT State Society of Anesthesiologists,
- Association of PeriOperative Registered Nurses,

- Nurse Practitioners,
- Individual Plastic Surgeons,
- Individual Anesthesiologists, and
- Commissioner's designee (chairperson and ex-officio, non-voting member)

Scope of Practice Review Evaluation of Request

CTANA's scope of practice request included all the required elements as outlined below.

Health and Safety Benefits

According to the requestors, removing the requirement of physician direction for CRNA practice will expand the settings in which CRNA services can be provided, such as the dental and podiatric setting. The requestors believe poor outcomes can be avoided with the utilization of qualified providers, including CRNAs.

Access to Healthcare

The requestors believe removing the requirement for physician direction for CRNAs will expand the practice settings in which CRNA services can be provided, such as the dental and podiatric setting. Eliminating restrictive scope of practice regulations will allow Connecticut to unlock the full potential of the anesthesia workforce and increase access to anesthesia services.

Laws Governing the Profession and State's Regulatory Oversight of the Profession

The profession of CRNAs is regulated by Chapter 378 of the Connecticut General Statutes. Other State and Federal laws that govern the profession include Connecticut Telehealth laws, State-Federal Medicaid regulations, Federal Privacy Laws such as the Health Insurance Portability and Accountability Act and the Connecticut Board of Examiners for Nursing.

Current Requirements for Education and Training and Applicable Certification Requirements

The Council on Accreditation of Nurse Anesthesia Educational Programs (COA) is the sole accrediting body for nurse anesthesia programs in the United States and Puerto Rico. All accredited nurse anesthesia programs are full time, at least 36 months in duration, offer a Doctor of Nursing Practice (DNP) or Doctor of Nurse Anesthesia Practice (DNAP) degree. Clinical experiences include a minimum of 2,000 clinical hours with 650 cases, 100 geriatric cases, 40 pediatric cases, 30 obstetrical, 15 pain management, intracranial, intrabdominal, intrathoracic heart 15 cases, intrathoracic lung 5 cases, general anesthesia, sedation, major regional anesthesia, peripheral nerve blocks and trauma/emergency care and successful completion of the National Certification Exam.

Summary of Scope of Practice Changes

The CRNAs previously sought a scope of practice change for CRNAs in Connecticut in 2007 but House Bill 7161, An Act Revising the Definition of Advanced Nursing Practice, did not advance out of committee. In 2014, Senate Bill 36, An Act Concerning the Governor's Recommendations to Improve Access to Health Care, focused on other advanced practice nurses and not scope of practice expansion for nurse anesthetists. At that time, the CT Association of Nurse Anesthesia submitted written testimony regarding this bill stating that anesthesia delivery provided by nurse anesthetists serves patients well. Senate Bill 36 passed and was signed into law on May 8, 2014. The current scope of practice review committee is based on the first scope of practice request by CTANA to DPH.

Impact on Existing Relationships within the Health Care Delivery System

The requestors believe changes to the CRNA scope of practice will have a positive impact on the health care delivery system in Connecticut and that existing relationships will be enhanced. The requestors asserted that the proposal would not change the way in which anesthesia is provided in practice locations, but it would allow CRNAs the ability to practice to the full scope of their academic and clinical training and education. With the removal of the requirement for physician direction, CRNAs claim they will be able to fill the gaps and reduce the anesthesia provider shortages.

Economic Impact

The requestors believe the restrictive physician involvement in CRNA practice raises several competitive concerns for patients. CTANA stated that physician requirement creates barriers that can increase the cost of care, restrict provider innovation in healthcare delivery, and create provider shortage and access problems, particularly for rural and underserved populations that lack adequate cost-effective healthcare. The CRNAs also asserted that without the physician requirement, institutional health care providers would be better able to deploy CRNAs that can practice to the full extent of their training and education, health care consumers/patients are likely to benefit from improved access to health care, lower costs, and additional innovation.

Regional and National Trends

Twenty-four states, the District of Columbia, and Guam have opted out of the Centers for Medicare & Medicaid Services (CMS) requirements for physician supervision allowing CRNAs to practice to the full extent of their academic and clinical education. The most recent state to opt out of the CMS requirements for physician supervision was Delaware in June of 2023, and independent practice has been recognized in the state of New Hampshire. Massachusetts removed prescriptive supervision for CRNAs, which grants CRNAs independent practice authority to issue written prescriptions and medication orders, order tests, and order therapeutics without supervision.

Other Health Care Professions that may be impacted by the Scope of Practice Request as identified by the Requestor

The requestors identified several healthcare professions that may be impacted by the request to remove the requirement for physician direction including physician anesthesiologists, dentists, podiatrists, and surgeons. Allowing CRNAs to practice to the full scope of their academic and clinical education may allow some of these practitioners to provide services in settings previously restricted.

Description of How the Request Relates to the Profession's Ability to Practice to the Full Extent of the Profession's Education and Training

The requestors believe removing the requirement for physician direction will allow CRNAs to practice autonomously in the health care system which will decrease the cost of care, improve provider innovation in health care delivery, and reduce provider shortage. CRNAs are trained to be full scope providers able to care for patients across the lifespan, in all practice settings, undergoing any type of surgery or procedure.

Findings/Conclusions

The scope of practice committee met on October 31, November 14, and December 13, 2023, to discuss the proposed request. The committee's evaluation of the proposal focused on assessing potential health and safety benefits associated with the request, whether the request enhances access to quality and affordable health care, the potential economic impact of the request, and how the request might enhance the ability of the profession to practice to the full extent of the profession's education and training.

The committee members did not object to the section of the scope request outlining an update to the current certifying and recertifying body for CRNAs. With regard to removing the requirement for physician supervision, the committee members were split, with the physicians, anesthesiologists, and physician groups in opposition. The primary concerns included patient safety and the belief that independent CRNA practice would lower the standard of care. In addition, the physicians, anesthesiologists, and physician groups cited the extensive training required to become an anesthesiologist, including 8 years post graduate training with 12,000 to 16,000 clinical hours of medical practice before being independently licensed. The physician groups asserted that this training and education ensures patients continue to receive safe, high quality and cost-effective health care. In contrast, becoming a nurse anesthetist requires a nursing degree, one year of nursing experience and two to three years of nurse anesthetist school with an average of 1,600 to 2,500 hours of nursing practice. A large percentage of applicants have two to three years of nursing experience by the time they are admitted to begin CRNA school.

While the requestors state a CRNA acting as the sole anesthesia provider is the most cost-effective model of anesthesia delivery and no risk to patients, other committee members argued nurse only anesthesia does not increase access to care and jeopardizes the safety of patients without providing any benefits.

The Connecticut Hospital Association (CHA) provided additional information from its membership regarding this scope of practice request. One level of concern is the Medicare conditions of participation. CHA informed the committee that even if the law changed, hospitals would generally continue to rely on physician anesthesiologists on staff, much like hospitals do presently. If there is a change in the scope and the law, there would still need to be alignment with Medicare and the conditions of participation. CHA stated that it difficult for a hospital to opt out of Medicare conditions of participation. Doing so requires a letter to CMS from the Governor stating they have consulted with the state boards of medicine and nursing and concluded it is in the best interest of state citizens to opt out of the current physician requirement. If that opt out is consistent with state law, then a hospital may permit CRNAs to administer anesthesia without physician supervision.

It should also be noted that while the requestors suggested this request would expand access to care by allowing CRNAs to provide services in other settings, such as dental and podiatry practices, DPH clarified for the committee that current laws and regulations do not allow for sedation services to be performed in a dental setting by anyone other than a dentist with either a conscious sedation permit and/or a dental anesthesia permit.

The final meeting adjourned with the two sides remaining in disagreement as to whether CRNAs could provide care and services without physician supervision.

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Appendix A

Scope of Practice Law

Sec. 19a-16d. Submission of scope of practice requests and written impact statements to Department of Public Health. Requests for exemption. Notification and publication of requests. (a) Any person or entity, acting on behalf of a health care profession that seeks to establish a new scope of practice or change a profession's scope of practice, shall submit a written scope of practice request to the Department of Public Health not later than August fifteenth of the year preceding the commencement of the next regular session of the General Assembly.

(b) (1) Any written scope of practice request submitted to the Department of Public Health pursuant to subsection (a) of this section shall include the following information:

(A) A plain language description of the request;

(B) Public health and safety benefits that the requestor believes will be achieved should the request be implemented and, if applicable, a description of any harm to public health and safety should the request not be implemented;

(C) The impact that the request will have on public access to health care;

(D) A brief summary of state or federal laws that govern the health care profession making the request;

(E) The state's current regulatory oversight of the health care profession making the request;

(F) All current education, training and examination requirements and any relevant certification requirements applicable to the health care profession making the request;

(G) A summary of known scope of practice changes either requested or enacted concerning the health care profession in the five-year period preceding the date of the request;

(H) The extent to which the request directly impacts existing relationships within the health care delivery system;

(I) The anticipated economic impact of the request on the health care delivery system;

(J) Regional and national trends concerning licensure of the health care profession making the request and a summary of relevant scope of practice provisions enacted in other states;

(K) Identification of any health care professions that can reasonably be anticipated to be directly impacted by the request, the nature of the impact and efforts made by the requestor to discuss the request with such health care professions; and

(L) A description of how the request relates to the health care profession's ability to practice to the full extent of the profession's education and training.

(2) In lieu of submitting a scope of practice request as described in subdivision (1) of this subsection, any person or entity acting on behalf of a health care profession may submit a request for an exemption from the processes described in this section and section 19a-16e. A request for exemption shall include a plain language description of the request and the reasons for the request for exemption, including, but not limited to: (A) Exigent circumstances which necessitate an immediate response to the scope of practice request, (B) the lack of any dispute concerning the scope of practice request, or (C) any outstanding issues among health care professions concerning the scope of practice request can easily be resolved. Such request for exemption shall be submitted to the Department of Public Health not later than August fifteenth of the year preceding the commencement of the next regular session of the General Assembly.

(c) In any year in which a scope of practice request is received pursuant to this section, not later than September first of the year preceding the commencement of the next regular session of the General Assembly, the Department of Public Health, within available appropriations, shall: (1) Provide written notification to the joint standing committee of the General Assembly having cognizance of matters relating to public health of any health care profession that has submitted a scope of practice request, including any request for exemption, to the department pursuant to this section; and (2) post any such request, including any request for exemption, and the name and address of the requestor on the department's Internet web site.

(d) Any person or entity, acting on behalf of a health care profession that may be directly impacted by a scope of practice request submitted pursuant to this section, may submit to the department a written statement identifying the nature of the impact not later than September fifteenth of the year preceding the next regular session of the General Assembly. Any such person or entity directly impacted by a scope of practice request shall indicate the nature of the impact taking into consideration the criteria set forth in subsection (b) of this section and shall provide a copy of the written impact statement to the requestor. Not later than October first of such year, the requestor shall

submit a written response to the department and any person or entity that has provided a written impact statement. The requestor's written response shall include, but not be limited to, a description of areas of agreement and disagreement between the respective health care professions.

(P.A. 11-209, S. 1; P.A. 22-58, S. 16, 55.)

History: P.A. 11-209 effective July 1, 2011; P.A. 22-58 amended Subsec. (a) by replacing "may" with "shall", amended Subsec. (c) by replacing "September fifteenth" with "September first" and making a technical change and amended Subsec. (d) by replacing "October first" with "September fifteenth" and "October fifteenth" with "October first", effective May 23, 2022.

Sec. 19a-16e. Scope of practice review committees. Membership. Duties. (a) On or before October fifteenth of the year preceding the commencement of the next regular session of the General Assembly, the Commissioner of Public Health shall select from the timely scope of practice requests submitted to the department pursuant to section 19a-16d the requests on which the department will act and, within available appropriations allocated to the department, establish and appoint members to a scope of practice review committee for each such request. Committees established pursuant to this section shall consist of the following members: (1) Two members recommended by the requestor to represent the health care profession making the scope of practice request; (2) two members recommended by each person or entity that has submitted a written impact statement pursuant to subsection (d) of section 19a-16d to represent the health care professions directly impacted by the scope of practice request; and (3) the Commissioner of Public Health or the commissioner's designee, who shall serve as an ex-officio, nonvoting member of the committee. The Commissioner of Public Health or the commissioner's designee shall serve as the chairperson of any such committee. The Commissioner of Public Health may appoint additional members to any committee established pursuant to this section to include representatives from health care professions having a proximate relationship to the underlying request if the commissioner or the commissioner's designee determines that such expansion would be beneficial to a resolution of the issues presented. Any member of such committee shall serve without compensation.

(b) Any committee established pursuant to this section shall review and evaluate the scope of practice request, subsequent written responses to the request and any other information the committee deems relevant to the scope of practice request. Such review and evaluation shall include, but not be limited to, an assessment of any public health and safety risks that may be associated with the request, whether the request may enhance access to quality and affordable health care and whether the request enhances

the ability of the profession to practice to the full extent of the profession's education and training. The committee, when carrying out the duties prescribed in this section, may seek input on the scope of practice request from the Department of Public Health and such other entities as the committee determines necessary in order to provide its written findings as described in subsection (c) of this section.

(c) The committee, upon concluding its review and evaluation of the scope of practice request, shall provide its findings to the joint standing committee of the General Assembly having cognizance of matters relating to public health. The committee shall provide the written findings to said joint standing committee not later than the February first following the date of the committee's establishment. The committee shall include with its written findings all materials that were presented to the committee for review and consideration during the review process. The committee shall terminate on the date that it submits its written findings to said joint standing committee.

(P.A. 11-209, S. 2; P.A. 22-58, S. 17.)

History: P.A. 11-209 effective July 1, 2011; P.A. 22-58 amended Subsec. (a) by replacing "November first" with "October fifteenth", adding provision re selection of timely scope of practice requests and made technical and conforming changes, effective May 23, 2022.

Sec. 19a-16f. Report to General Assembly on scope of practice review processes. On or before January 1, 2013, the Commissioner of Public Health shall evaluate the processes implemented pursuant to sections 19a-16d and 19a-16e and report to the joint standing committee of the General Assembly having cognizance of matters relating to public health, in accordance with the provisions of section 11-4a, on the effectiveness of such processes in addressing scope of practice requests. Such report may also include recommendations from the committee concerning measures that could be implemented to improve the scope of practice review process.

(P.A. 11-209, S. 3.)

History: P.A. 11-209 effective July 1, 2011.

APPENDIX B

CRNA Statute

Sec. 20-87a. Definitions. Scope of practice. (a) The practice of nursing by a registered nurse is defined as the process of diagnosing human responses to actual or potential health problems, providing supportive and restorative care, health counseling and teaching, case finding and referral, collaborating in the implementation of the total health care regimen, and executing the medical regimen under the direction of a licensed physician, dentist or advanced practice registered nurse. A registered nurse may also execute orders issued by licensed physician assistants, podiatrists and optometrists, provided such orders do not exceed the nurse's or the ordering practitioner's scope of practice. A registered nurse may execute dietary orders written in a patient's chart by a certified dietitian-nutritionist.

(b) (1) Advanced nursing practice is defined as the performance of advanced level nursing practice activities that, by virtue of post-basic specialized education and experience, are appropriate to and may be performed by an advanced practice registered nurse. The advanced practice registered nurse performs acts of diagnosis and treatment of alterations in health status, as described in subsection (a) of this section.

(2) An advanced practice registered nurse having been issued a license pursuant to section 20-94a shall, for the first three years after having been issued such license, collaborate with a physician licensed to practice medicine in this state. In all settings, such advanced practice registered nurse may, in collaboration with a physician licensed to practice medicine in this state, prescribe, dispense and administer medical therapeutics and corrective measures and may request, sign for, receive and dispense drugs in the form of professional samples in accordance with sections 20-14c to 20-14e, inclusive, except such advanced practice registered nurse licensed pursuant to section 20-94a and maintaining current certification from the American Association of Nurse Anesthetists who is prescribing and administrating medical therapeutics during surgery may only do so if the physician who is medically directing the prescriptive activity is physically present in the institution, clinic or other setting where the surgery is being performed. For purposes of this subdivision, “collaboration” means a mutually agreed upon relationship between such advanced practice registered nurse and a physician who is educated, trained or has relevant experience that is related to the work of such advanced practice registered nurse. The collaboration shall address a reasonable and appropriate level of consultation and referral, coverage for the patient in the absence of such advanced practice registered nurse, a method to review patient outcomes and a

method of disclosure of the relationship to the patient. Relative to the exercise of prescriptive authority, the collaboration between such advanced practice registered nurse and a physician shall be in writing and shall address the level of schedule II and III controlled substances that such advanced practice registered nurse may prescribe and provide a method to review patient outcomes, including, but not limited to, the review of medical therapeutics, corrective measures, laboratory tests and other diagnostic procedures that such advanced practice registered nurse may prescribe, dispense and administer.

(3) An advanced practice registered nurse having (A) been issued a license pursuant to section 20-94a, (B) maintained such license for a period of not less than three years, and (C) engaged in the performance of advanced practice level nursing activities in collaboration with a physician for a period of not less than three years and not less than two thousand hours in accordance with the provisions of subdivision (2) of this subsection, may, thereafter, alone or in collaboration with a physician or another health care provider licensed to practice in this state: (i) Perform the acts of diagnosis and treatment of alterations in health status, as described in subsection (a) of this section; and (ii) prescribe, dispense and administer medical therapeutics and corrective measures and dispense drugs in the form of professional samples as described in subdivision (2) of this subsection in all settings. Any advanced practice registered nurse electing to practice not in collaboration with a physician in accordance with the provisions of this subdivision shall maintain documentation of having engaged in the performance of advanced practice level nursing activities in collaboration with a physician for a period of not less than three years and not less than two thousand hours. Such advanced practice registered nurse shall maintain such documentation for a period of not less than three years after completing such requirements and shall submit such documentation to the Department of Public Health for inspection not later than forty-five days after a request made by the department for such documentation. Any such advanced practice registered nurse shall submit written notice to the Commissioner of Public Health of his or her intention to practice without collaboration with a physician after completing the requirements described in this subdivision and prior to beginning such practice. Not later than December first, annually, the Commissioner of Public Health shall publish on the department's Internet web site a list of such advanced practice registered nurses who are authorized to practice not in collaboration with a physician.

(4) An advanced practice registered nurse licensed under the provisions of this chapter may make the determination and pronouncement of death of a patient, provided the advanced practice registered nurse attests to such pronouncement on the certificate

of death and signs the certificate of death not later than twenty-four hours after the pronouncement.

(c) The practice of nursing by a licensed practical nurse is defined as the performing of selected tasks and sharing of responsibility under the direction of a registered nurse or an advanced practice registered nurse and within the framework of supportive and restorative care, health counseling and teaching, case finding and referral, collaborating in the implementation of the total health care regimen and executing the medical regimen under the direction of a licensed physician, physician assistant, podiatrist, optometrist or dentist. A licensed practical nurse may also execute dietary orders written in a patient's chart by a certified dietitian-nutritionist.

(d) In the case of a registered or licensed practical nurse employed by a home health care agency, the practice of nursing includes, but is not limited to, executing the medical regimen under the direction of a physician licensed in a state that borders Connecticut.

APPENDIX C

COMMITTEE MEMBERSHIP

1. Nancy Moriber, PhD, CRNA, APRN, FAANA, CTANA
2. Terri Williams, DNP, CRNA, APRN, CTANA
3. Joseph O'Connell, MD
4. Joe Rodriquez, CRNA, Wilton Anesthesia Associates, LLC
5. Christopher Bartels, CRNA, Wilton Anesthesia Associates, LLC
6. Kimberly Sandor, MSN, RN, FNP, CT Nurses Association
7. Gwen Moraski, MD, CT State Medical Society
8. Ken Stone, MD, CT State Medical Society
9. Leah Ward, MSN, MA, A-GNP-C, CT APRN Society
10. John Satterfield, MD, CSSA
11. John Guzzi, MD, CSSA
12. Karen Buckley, CT Hospital Association
13. Jen Cox, CT Hospital Association
14. Jeanne Ring, AORN CT
15. Linda Perfetto, AORN CT
16. Patrick Felice, MD, CT Society of Plastic Surgeons
17. Boris Goldman, MD, CT Society of Plastic Surgeons
18. Lynn Rapsilber, Northwest NPs
19. Ann Bassett, Northwest NPs
20. Chris Andresen, DPH
21. Laura Morris, DPH
22. Sara Montauti, DPH
23. Melia Allan, DPH

APPENDIX D

INITIAL SCOPE OF PRACTICE REQUEST

Connecticut Association of Nurse Anesthesiology
1224 Mill Street, Building B
East Berlin, CT 06023

August 11, 2023

Sara Montauti, MPH
Healthcare Quality and Safety Branch
Practitioner Licensing and Investigations
Department of Public Health
410 Capital Avenue, MS # 12HSR P.O. Box 340308
Hartford, CT 06134
Phone: (860) 509-7307
Email: sara.montauti@ct.gov

Via e-mail

Dear Ms. Montauti,

On behalf of the 600 active members of the Connecticut Association of Nurse Anesthesiology (CTANA), I respectfully submit the attached Scope of Practice Review request for consideration during the 2024 legislative session.

CTANA is requesting to amend the Certified Registered Nurse Anesthetist (CRNA) scope of practice 20-87a(b)(2) to allow CRNAs to practice in accordance with the provisions set forth for all other Advanced Practice Registered Nurses (APRNs) licensed and practicing in Connecticut. We also seek to amend the language in the Nurse Practice Act, section 20-94a to accurately reflect the certifying and recertifying body for CRNAs: the National Board of Certification and Recertification of Nurse Anesthetists (NBCRNA).

Please feel free to contact me if you have any questions regarding our proposal.

Sincerely,

Nancy A. Moriber PhD, CRNA, APRN, FAANA
President
Connecticut Association of Nurse Anesthesiology
Ctnurseanesthetists@gmail.com

CTANA Scope of Practice Review Request

Submitted to: The State of Connecticut Department of Public Health
August 15, 2023
By: The Connecticut Association of Nurse Anesthesiology Board of Directors

1. A plain language description of the request

The Connecticut Association of Nurse Anesthesiology (CTANA) is requesting the following changes to the Certified Registered Nurse Anesthetist (CRNA) scope of practice 20-87a(b)(2)[1] to allow CRNAs to practice in accordance with provisions set forth for all other Advanced Practice Registered Nurses (APRNs) licensed and practicing in Connecticut. We also seek to amend the language in the Nurse Practice Act, section 20-94a to accurately reflect the certifying and recertifying body for CRNAs: the National Board of Certification and Recertification of Nurse Anesthetists (NBCRNA).

a. In Chapter 378, the Nurse Practice Act, in section 20-87a(b)(2) CTANA requests the removal of the requirement for physician direction as highlighted in this statute.[1]

Section 20-87a(b)(2). Definitions. Scope of practice. An advanced practice registered nurse having been issued a license pursuant to section 20-94a shall, for the first three years after having been issued such license, collaborate with a physician licensed to practice medicine in this state. In all settings, such advanced practice registered nurse may, in collaboration with a physician licensed to practice medicine in this state, prescribe, dispense and administer medical therapeutics and corrective measures and may request, sign for, receive and dispense drugs in the form of professional samples in accordance with sections 20-14c to 20-14e, inclusive, **except such advanced practice registered nurse licensed pursuant to section 20-94a and maintaining current certification from the American Association of Nurse Anesthetists who is prescribing and administrating medical therapeutics during surgery may only do so if the physician who is medically directing the prescriptive activity is physically present in the institution, clinic or other setting where the surgery is being performed.** For purposes of this subdivision, "collaboration" means a mutually agreed upon relationship between such advanced practice registered nurse and a physician who is educated, trained or has relevant experience that is related to the work of such advanced practice registered nurse. The collaboration shall address a reasonable and appropriate level of consultation and referral, coverage for the patient in the absence of such advanced practice registered nurse, a method to review patient outcomes and a method of disclosure of the relationship to the patient. Relative to the exercise of prescriptive authority, the collaboration between such advanced practice registered nurse and a physician shall be in writing and shall address the level of schedule II and III controlled substances that such advanced practice registered nurse may prescribe and provide a method to review patient outcomes, including, but not limited to, the review of medical therapeutics, corrective measures, laboratory tests and other diagnostic procedures that such advanced practice registered nurse may prescribe, dispense and administer.[2][2]

b. In section 20-94a, CTANA requests that all references to the American Association of Nurse Anesthetists be changed to the National Board of Certification and Recertification (NBCRNA) to reflect the current certifying and recertifying body for CRNAs.

Section 20-94a. Licensure as advanced practice registered nurse. (a) The Department of Public Health may issue an advanced practice registered nurse license to a person seeking to perform the activities described in subsection (b) of section 20-87a, upon receipt of a fee of two hundred dollars, to an applicant who: (1) Maintains a license as a registered nurse in this state, as provided by section 20-93 or 20-94; (2) holds and maintains current certification as a nurse practitioner, a clinical nurse specialist or a nurse anesthetist from one of the following national certifying bodies that certify nurses in advanced

[1] Connecticut General Assembly. Chapter 378 Nursing. Section 20-87a. CGA. Accessed August 1, 2023. https://www.cga.ct.gov/current/pub/chap_378.htm#sec_20-87a

[2] Connecticut General Assembly. Chapter 378 Nursing. Section 20-94a. CGA. Accessed August 1, 2023. https://www.cga.ct.gov/current/pub/chap_378.htm#sec_20-94a

practice: The American Nurses' Association, the Nurses' Association of the American College of Obstetricians and Gynecologists Certification Corporation, the National Board of Pediatric Nurse Practitioners and Associates or the **American Association of Nurse Anesthetists, their successors or other appropriate national certifying bodies** approved by the Board of Examiners for Nursing…[2]

Background

The American Association of Nurse Anesthetists changed its name to the American Association of Nurse Anesthesiology (AANA) in 2022 to reflect the nursing profession more accurately. The AANA professional organization represents CRNAs and associate members and is not involved in the certification process.

Prior to 2007, initial certification and recertification were via the Council on Certification of Nurse Anesthetists (CCNA), and the Council on Recertification of Nurse Anesthetists (COR). In 2007, these entities merged and formed the National Board of Certification and Recertification of Nurse Anesthetists (NBCRNA). The mission of the National Board of Certification and Recertification for Nurse Anesthetists (NBCRNA) is to "promote patient safety through credentialing programs that support lifelong learning."[3]

Following successful completion of an accredited nurse anesthesia program, graduates must pass the National Certification Examination (NCE) to be eligible to apply for their Connecticut APRN license and controlled substance license. Connecticut CRNAs cannot work as a CRNA without being certified and licensed (APRN). To obtain recertification, CRNAs must participate in the NBCRNA's Continued Professional Certification (CPC) program which requires extensive continuing education and successful completion of the CPC assessment examination.[4]

As the patient population ages and becomes more diversified in the United States, CRNAs play a vital role in ensuring access to safe and cost-effective anesthesia care for all Americans. CRNAs are highly educated anesthesia experts who provide **every type of anesthesia, for patients of all ages, for any kind of procedure, and in every healthcare setting in the United States.**

Rationale

The current Connecticut statute restricts nurse anesthesia practice which limits CRNAs from providing the full scope of anesthesia services at a time when there is a severe shortage of anesthesia providers (CRNAs and physician anesthesiologists) in Connecticut. These statutory restrictions also prevent CRNAs who are experts in airway management from administering anesthesia or sedation in dental and podiatry offices. Additionally, restrictive practice for CRNAs limits patient access to the full range of anesthesia services. CRNAs provide cost-effective and high-quality anesthesia care. The removal of the requirement for physician direction will improve access to health services for patients in Connecticut.

During the COVID 19 pandemic, restrictions on CRNA practice were removed across the country. At the federal level, the Center for Medicare & Medicaid Services (CMS) suspended the supervision requirement for CRNAs in the CMS regulations for hospitals, critical access hospitals (CAHs), and

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[2] Connecticut General Assembly. Chapter 378 Nursing. Section 20-94a. CGA. Accessed August 1, 2023. https://www.cga.ct.gov/current/pub/chap_378.htm#sec_20-94a

[3] National Board of Certification and Recertification of Nurse Anesthetists. Mission and vision. 2023. Accessed August 1, 2023. https://www.nbcrna.com/about-us/mission-vision

[4] National Board of Certification & Recertification for Nurse Anesthetists. Continued professional certification. NBCRNA.2023. Accessed August 1, 2023. https://www.nbcrna.com/continued-certification/CPC_Program

ambulatory surgical centers from March 1, 2020, through the duration of the pandemic state of emergency.[5] This federal waiver, together with Governor Lamont's executive order[6] suspending "in-person supervision" for Connecticut CRNAs under state law, allowed CRNAs to practice without unnecessary restrictions, and gave facilities the ability to provide optimal care to Connecticut patients by fully utilizing CRNAs. This was all achieved without sacrificing patient outcomes.

CTANA is requesting a change to Connecticut statute to ensure that patients and facilities continue to benefit from CRNAs practicing to the full extent of their academic and clinical education. As healthcare professionals, CRNAs practice according to their expertise, state statutes and regulations, and institutional policy. The AANA supports the full scope of CRNA practice as set forth in the AANA's "Scope of Nurse Anesthesia Practice"[7] and "Standards for Nurse Anesthesia Practice."[8]

CRNAs work with all members of the patient-centered team to ensure patient safety and comfort. They are responsible for the patient's safety before, during, and after anesthesia and stay with the patient for the entire procedure. CRNAs are uniquely prepared to care for patients suffering from acute and/or chronic pain and are educated, trained, and experienced in managing emergency situations. [9]

Practice by CRNAs and other APRNs to the full extent of their academic and clinical education is also supported by the 2010 Institute of Medicine (IOM) report titled, *The Future of Nursing: Leading Change, Advancing Health* (the IOM report).[10] The IOM report includes the "key message" that: "Nurses should practice to the full extent of their education and training." [page 3-1] The IOM report further indicates "…regulations in many states result in APRNs not being able to give care they were trained to provide. The committee believes all health professionals should practice to the full extent of their education and training so that more patients may benefit."[10] [page 3-10]

2. Public health and safety benefits that the requestor believes will occur if the request is implemented and, if applicable, a description of any harm to public health and safety if it is not implemented

CRNAs are highly educated, trained, and qualified anesthesia experts. They provide 50 million anesthetics per year in the United States, working in every setting in which anesthesia is delivered.

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[5] Center for Medicare and Medicaid Services. COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers. CMS. Updated May 4, 2021. Accessed August 13, 2023. https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf

[6] State of Connecticut. Executive Order 7DD: Protection of Public Health and Safety During Covid-19 Pandemic and Response-Expansion of Healthcare Workforce. March 10, 2020. Accessed August 1, 2023.https://portal.ct.gov/-/media/Office-of-the-Governor/Executive-Orders/Lamont-Executive-Orders/Executive-Order-No-7DD.pdf

[7] American Association of Nurse Anesthesiology. Scope of Nurse Anesthesia Practice. AANA. February 2020. Accessed August 1, 2023. https://issuu.com/aanapublishing/docs/scope_of_nurse_anesthesia_practice_2.23?fr=sNDg2MDU2NDAxMjU

[8] American Association of Nurse Anesthesiology. Standards for Nurse Anesthesia Practice. AANA. February 2019. Accessed August 1, 2023. https://issuu.com/aanapublishing/docs/standards_for_nurse_anesthesia_practice_2.23?fr=sOGNhNjU2NDAxMjU

[9] Quintana J. Answering today's need for high-quality anesthesia care at a lower cost. *Becker's Hospital Review*. January 20, 2016. Accessed August 10, 2023. http://www.beckershospitalreview.com/hospital-physician-relationships/answering-today-s-need-for-high-quality-anesthesia-care-at-a-lower-cost.html

[10]National Academies of Science. The Future of Nursing: Leading Change, Advancing Health. National Academies Press. 2011. Accessed August 13, 2023. http://www.nap.edu/catalog.php?record_id=12956

CRNAs practice in accordance with their professional scope and standards of practice; federal, state, and local law; and facility policy to provide dental sedation and anesthesia services. They also deliver quality care to rural and other medically underserved areas, where they ensure access to anesthesia care to populations that would otherwise have to travel significant distances from their homes for treatment. To provide public health and safety benefits, approval of CTANA's scope of practice review request will increase accessibility to safe, high-quality anesthesia services across Connecticut. This is supported by current best evidence and national trends in nurse anesthesiology practice.[11,12]

Restrictions on CRNA practice are not supported by evidence and are contrary to the national trend, which is toward allowing each practitioner to practice to the full extent of their academic and clinical education. Currently, 36 states and the District of Columbia have no language for supervision or direction requirements concerning nurse anesthetists in nurse practice acts, board of nursing rules/regulations, medical practice acts, board of medicine rules/regulations, or their generic equivalents.[13] (See Exhibit A- American Association of Nurse Anesthesiology, State Government Affairs. Prescriptive Authority Map). This national trend is further supported by the Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education, adopted in 2008 and endorsed by over 40 nursing organizations.[11]

There is overwhelming evidence that CRNAs provide safe, high quality, cost-effective anesthesia care. The excellent safety record of CRNAs is reflected in a landmark national study of 500,000 cases that was conducted by RTI International and published in the August 2010 issue of *Health Affairs*. This study demonstrated similar patient outcomes when anesthesia services are provided by CRNAs, physician anesthesiologists, or CRNAs supervised by physicians confirming that CRNAs provide safe, high-quality care.[12] Additional research shows no empirical evidence to support scope of practice laws that restrict CRNA practice[14] and a Cochrane Review found insufficient evidence to support any one anesthesia practice model.[15]

Access to qualified anesthesia providers is essential to assure safety for procedures performed in an office-based setting. Children, individuals with special needs, and medically complex adults may require sedation or general anesthesia for routine dental care. It is paramount that patient safety remains central to the delivery of these services. The removal of the requirement for physician direction for CRNA

[11] APRN Consensus Work Group, National Council of State Boards of Nursing APRN Advisory Committee**.** Consensus Model for APRN Regulation: Licensure, Accreditation, Certification, and Education. July 7, 2008. Accessed August 1, 2023. https://www.aacn.org/~/media/aacn-website/nursing-excellence/standards/aprnregulation.pdf?la=en

[12] Dulisse B, Cromwell J. No harm found when nurse anesthetists work without supervision by physicians. *Health Affairs. Health Aff (Millwood)*. 2010 Aug;29(8):1469-75. doi:10.1377/hlthaff.2008.0966

[13] American Association of Nurse Anesthesiology, State Government Affairs. Prescriptive Authority Map. Updated 2023. Accessed August 1, 2023. https://www.aana.com/wp-content/uploads/2023/04/CRNA-Prescriptive-Authority-1.png

[14] Negrusa B, Hogan PF, Warner JT, Schroeder CH, Pang B. Scope of practice laws and anesthesia complications: no measurable impact of Certified Registered Nurse Anesthetist expanded scope of practice on anesthesia-related complications. *Med Care*. 2016 Oct;54(10):913-20. doi:10.1097/MLR.0000000000000554

[15] Lewis SR, Nicholson A, Smith AF, Alderson P. Physician anaesthetists versus non-physician providers of anaesthesia for surgical patients. *Cochrane Database Syst Rev*. 2014 Jul 11;(7):CD010357. doi:10.1002/14651858

practice will expand the settings in which CRNA services can be provided, expanding the access to care in the dental and podiatric setting.[16]

For example, safe dental care is critically important to the overall health of children and adults in Connecticut. If a dental procedure requires general anesthesia or deep sedation, anesthesia care is safest when provided by a qualified, licensed anesthesia professional. CRNAs are licensed and certified by education and clinical experience to fill this void. CRNAs possess the education, clinical training, and skills to provide safe, high-quality, and cost-effective care as members of the patent-centered dental care team in all settings, including dental offices. CRNAs practice in accordance with their professional scope[17] and standards of practice,[18] federal, state, and local law, and facility policy to provide dental sedation and anesthesia services. In fact, Connecticut is only one of four states in the country, including New Jersey, Delaware, and Indiana, that does not allow CRNAs to provide anesthesia services for in office procedures.[19] (See Exhibit V-State Dental Board Permit Map)

There is also evidence demonstrating the potential harm to patients when care is provided without a qualified, cost-effective anesthesia care provider. Deaths in both adults and children have occurred secondary to inadequate monitoring, oversedation and loss of airway.[20,21,22,23] A collaborative report from the American Academy of Pediatrics (AAP) and the American Academy of Pediatric Dentistry (AADP),[24] recommends that sedation should not be provided without a:

- focused airway examination for large (kissing) tonsils or anatomic airway abnormalities that might increase the potential for airway obstruction;
- a clear understanding of the medication's pharmacokinetic and pharmacodynamic effects and drug interactions;
- appropriate training and skills in airway management, venous access, and medication management to allow rescue of the patient; and

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[16] American Association of Nurse Anesthesiology, State Government Affairs. State Dental Board Permit Status for CRNA Practice in Dental Offices Source. Updated 2023. Accessed August 1, 2023. https://www.aana.com/wp-content/uploads/2023/07/CRNA-Dental-Board-Permit-Map.png

[17] American Association of Nurse Anesthesiology. Scope of Nurse Anesthesia Practice. AANA. February 2020. Accessed August 1, 2023. https://issuu.com/aanapublishing/docs/scope_of_nurse_anesthesia_practice_2.23?fr=sNDg2MDU2NDAxMjU

[18] American Association of Nurse Anesthesiology. Standards for Nurse Anesthesia Practice. AANA. February 2019. Accessed August 1, 2023. https://issuu.com/aanapublishing/docs/standards_for_nurse_anesthesia_practice_2.23?fr=sOGNhNjU2NDAxMjU

[19] American Association of Nurse Anesthesiology, State Government Affairs. State Dental Board Permit Status for CRNA Practice in Dental Offices Source. Updated 2023. Accessed August 1, 2023. https://www.aana.com/wp-content/uploads/2023/07/CRNA-Dental-Board-Permit-Map.png

[20] Dental Sedation Kills 4-Year-Old Who Might Have Been Saved by A Toothbrush | WBUR News

[21] Little Abiel Valenzuela Zapata, 3, dies during routine dental procedure in Kansas (nypost.com)

[22] After dental patient dies following routine procedure, widow calls for changes to anesthesia requirements. February 3, 2022. Accessed July 31, 2023. https://www.wect.com/2022/02/03/after-dental-patient-dies-following-routine-procedure-widow-calls-changes-anesthesia-requirements/

[23] WDRB. Louisville woman's death highlights rare complications with dental procedures. January 25, 2023. Accessed July 31, 2023. https://www.wdrb.com/wdrb-investigates/louisville-woman-s-death-highlights-rare-complications-with-dental-procedures/article_135538ea-91ee-11ed-8610-a791fcc93c44.html

[24] Coté CJ, Wilson S, American Academy of Pediatrics, American Academy of Pediatric Dentistry. Guidelines for Monitoring and Management of Pediatric Patients Before, During, and After Sedation for Diagnostic and Therapeutic Procedures. *Pediatrics.* 2019 Jun;143(6):e20191000. doi:10.1542/peds.2019-1000

- properly equipped and staffed recovery area to ensure return to the pre-sedation level of consciousness.

Poor outcomes can be avoided with the utilization of qualified providers, including CRNAs, whose sole focus is on assuring a patent airway and adequate ventilation, not the conduct of the procedure itself.

3. The impact of the request on public access to healthcare.

Approval of CTANA's Scope of Practice Review request would favorably impact public access to health care. Eliminating restrictive scope-of-practice regulations will allow Connecticut to unlock the full potential of the anesthesia workforce, increasing access to anesthesia services.

Advanced Practice Registered Nurses (APRNs) are crucial to the US healthcare workforce. According to the US Bureau of Labor Statistics, the nationwide demand for employment for APRNs is expected to increase 40% by 2031.[25] According to the Connecticut Department of Labor, the need for APRNs, including CRNAs, in Connecticut is expected to increase 47.5% by 2030.[26] This dramatic rise in demand is related to the aging population with complex medical conditions requiring medical procedures.[27]

CRNAs, like other APRNs, provide many of the same healthcare services as physicians.[28] The demand for healthcare providers requires that all professionals practice to the full extent of their academic and clinical education. Removing barriers to practice for CRNAs increases the access to anesthesia care necessary for surgical and procedural treatment for Connecticut residents.[29]

More specifically, access to care would improve in both the northwest and northeast corners of Connecticut. For example, in July 2022, Johnson Memorial Hospital in Stafford Springs announced that it would be closing its obstetrical unit because of a staffing shortage. Laboring women in the area must travel to Saint Francis Hospital. Attorney General William Tong commented, "I am deeply concerned by this news and the potential impact on families who rely on Johnson Memorial for safe, community-based care. This is a distressing pattern that we seem to be seeing across rural hospitals here."[30] CRNAs are trained to care for all patients throughout their lifespan, including obstetrical anesthesia management.[31]

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[25]Bureau of Labor Statistics. US Department of Labor. Occupational Outlook Handbook: Nurse Anesthetists, Nurse Midwives, and Nurse Practitioners. Updated September 8, 2022. Accessed May 31, 2023. https://www.bls.gov/ooh/healthcare/nurse-anesthetists-nurse-midwives-and-nurse-practitioners.htm

[26]Office of Research. State of Connecticut Department of Labor. Labor market information: healthcare practitioners and technical occupations. Accessed May 31, 2023. https://www1.ctdol.state.ct.us/lmi/projections2020/healthcare.asp

[27]Bureau of Labor Statistics. US Department of Labor. Occupational Outlook Handbook: Nurse Anesthetists, Nurse Midwives, and Nurse Practitioners. Updated September 8, 2022. Accessed May 31, 2023. https://www.bls.gov/ooh/healthcare/nurse-anesthetists-nurse-midwives-and-nurse-practitioners.htm

[28] Bureau of Labor Statistics. US Department of Labor. Occupational Outlook Handbook: Nurse Anesthetists, Nurse Midwives, and Nurse Practitioners. Updated September 8, 2022. Accessed May 31, 2023. https://www.bls.gov/ooh/healthcare/nurse-anesthetists-nurse-midwives-and-nurse-practitioners.htm

[29] National Academies of Science. The Future of Nursing: Leading Change, Advancing Health. National Academies Press. 2011. Accessed August 13, 2023. http://www.nap.edu/catalog.php?record_id=12956

[30] NBC Connecticut. Johnson Memorial Hospital plans to end labor and delivery services. July 13, 2022. Accessed May 31, 2023. https://www.nbcconnecticut.com/news/local/johnson-memorial-hospital-plans-to-end-labor-and-delivery-services/2825043/

[31] Council on Accreditation of Nurse Anesthesia Educational Programs. Standards for accreditation of nurse anesthesia programs: practice doctorate. Revised January 30, 2023. Accessed May 31, 2023. https://www.coacrna.org/wp-content/uploads/2023/02/Standards-for-Accreditation-of-Nurse-Anesthesia-Programs-Practice-Doctorate-revised-January-2023.pdf

Removing restrictive language will allow CRNAs to collaborate with obstetricians and surgeons to provide access to care in these regions.

It is essential that decisions regarding regulations are evidence-based with the community's healthcare needs as the priority. The COVID-19 pandemic allowed legislators to temporarily expand the scope of practice for CRNAs in Connecticut. At the federal level, CMS suspended the supervision requirement for CRNAs in the CMS regulations for hospitals, critical access hospitals (CAHs), and ambulatory surgical centers from March 1, 2020, until May 11, 2023.[32] This federal waiver, together with Governor Lamont's executive order[33] suspending "in-person supervision" for Connecticut CRNAs under state law, allowed CRNAs to practice without unnecessary restrictions, and gave facilities the ability to provide optimal care to Connecticut patients by fully utilizing CRNAs. This change was possible because the needs of Connecticut residents for access to care was greater than the opposition's influence. Patients and facilities can continue to benefit if CRNAs in Connecticut are allowed to practice to the full extent of their academic and clinical education.

4. A brief summary of the state and federal laws governing the profession;

Currently, the practice of nurse anesthesiology is regulated by legislation at both the state and federal level, as well as professional organizations, including the American Association of Nurse Anesthesiology (AANA) and the National Board on Certification and Recertification of Nurse Anesthetists (NBCRNA). The AANA Scope of Practice[34] defines the professional role of CRNAs across the country. CRNAs are "advanced practice registered nurses (APRNs) licensed as independent practitioners who plan and deliver anesthesia, pain management, and related care to patients of all health complexities across the lifespan. As autonomous healthcare professionals, CRNAs collaborate with the patient and a variety of healthcare professionals to provide patient-centered high-quality, holistic, evidence- based and cost-effective care. CRNAs exercise independent, professional judgment within their scope of practice. They are accountable for their services and actions and for maintaining individual clinical competence". CRNA practice involves, but is not limited to:

- Performing a comprehensive history and physical, pre-anesthesia evaluation
- Obtaining informed consent for anesthesia
- Selecting, ordering, prescribing, and administering drugs and controlled substances
- Providing acute, chronic, and interventional pain management services, critical care, and resuscitation
- Ordering and evaluating diagnostic tests; requesting consultations, performing point-of care testing
- Planning/initiating anesthetic techniques, including general, regional, local, and sedation
- Facilitating emergence and recovery from anesthesia; providing post-anesthesia care, i.e., medication management, post-anesthesia evaluation, and discharge from post-anesthesia care area/facility

[32] Center for Medicare and Medicaid Services. COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers. CMS. Updated May 4, 2021. Accessed August 13, 2023. https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf

[33] Executive Order 7DD. March 10, 2020. Accessed May 31, 2023. https://portal.ct.gov/-/media/Office-of-the-Governor/Executive-Orders/Lamont-Executive-Orders/Executive-Order-No-7DD.pdf

[34] American Association of Nurse Anesthesiology. Scope of Nurse Anesthesia Practice. AANA. February 2020. Accessed August 1, 2023. https://issuu.com/aanapublishing/docs/scope_of_nurse_anesthesia_practice_2.23?fr=sNDg2MDU2NDAxMjU

Within the state of Connecticut, CRNA licensure is regulated by the Department of Public Health (DPH) with additional oversight by the Connecticut Board of Examiners for Nursing (BOEN). CRNA practice regulations are outlined in Chapter 378, section 20-87 to 20-102z of the Nurse Practice Act.[35] As outlined in the Connecticut General statutes, Sec. 20-87b1-4: APRN Definition and Scope of Practice:[36]

- (b) (1) Advanced nursing practice is defined as the performance of advanced level nursing practice activities that, by virtue of post-basic specialized education and experience, are appropriate to and may be performed by an advanced practice registered nurse. The advanced practice registered nurse performs acts of diagnosis and treatment of alterations in health status, as described in subsection (a) of this section.
- (2) An advanced practice registered nurse having been issued a license pursuant to section 20-94a shall, for the ***first three years after having been issued such license, collaborate with a physician licensed to practice medicine in this state.*** In all settings, such advanced practice registered nurse may, in collaboration with a physician licensed to practice medicine in this state prescribe, dispense and administer medical therapeutics and corrective measures and may request, sign for, receive and dispense drugs in the form of professional samples, ***except such advanced practice registered nurse licensed pursuant to section 20-94a and maintaining current certification from the American Association of Nurse Anesthetists who is prescribing and administrating medical therapeutics during surgery may only do so if the physician who is medically directing the prescriptive activity is physically present in the institution, clinic, or other setting where the surgery is being performed.***[37]

Following successful completion of a nurse anesthesia educational program and the National Certification Exam (NCE) provided by the National Board of Certification and Recertification of Nurse Anesthetists (NBCRNA), licensure as an APRN is pursuant to Sec. 20-94a: Licensure as APRN:

- (a) The Department of Public Health may issue an advanced practice registered nurse license to a person seeking to perform the activities described in subsection (b) of section 20-87a. The advanced practice registered nurse is required to (1) maintain a registered nurse license in the state and (2) hold and maintain current certification as a nurse practitioner, a clinical nurse specialist or a nurse anesthetist from one of the following national certifying bodies that certify nurses in advanced practice. CRNAs are certified by The National Board of Certified and Recertification of Nurse Anesthetist which is the certifying body of the American Association of Nurse Anesthesiology. (3) has completed thirty hours of education in pharmacology for advance nursing practice; and (4) (A) holds a graduate degree in nursing or in a related field recognized for certification as wither a nurse practitioner, a clinical nurse specialist, or a nurse anesthetist by one of the foregoing certifying bodies.[38]

[35] Connecticut General Assembly. Chapter 378 Nursing. CGA. Accessed August 1, 2023. https://www.cga.ct.gov/current/pub/chap_378.htm

[36] Connecticut General Assembly. Chapter 378 Nursing. Section 20-87a. CGA. Accessed August 1, 2023. https://www.cga.ct.gov/current/pub/chap_378.htm#sec_20-87a

[37] Connecticut General Assembly. Chapter 378 Nursing. Section 20-94a. CGA. Accessed August 1, 2023. https://www.cga.ct.gov/current/pub/chap_378.htm#sec_20-94a

Requirements for prescriptive authority for APRNs (CRNAs) are outlined in Connecticut General Statute, Chapter 378, Sec. 20-94b and as required by the CT Department of Public Health.[38]

- Sec. 20-94b. Nurse anesthetists. Prescriptive authority.
    - An advanced practice registered nurse licensed pursuant to section 20-94a and maintaining current certification from the **American Association of Nurse Anesthetists** may prescribe, dispense, and administer drugs, including controlled substances in schedule II, III, IV, V.
- CT Controlled Substance Practitioner Registration
    - Registration permits practitioners to distribute, dispense, conduct research, administer, or procure controlled substances in the course to their professional practice as permitted by the DPH or other governing agency.

In addition, APRNs must maintain professional liability insurance as outlined in Chapter 378, Sec. 20-94c.[39] There are also provisions for CRNAs in Chapter 370, Sec.20-9.[40]

- (a) Each person licensed as an advanced practice registered nurse under the provisions of section 20-94a who provides direct patient care services shall maintain professional liability insurance or other indemnity against liability for professional malpractice. The provisions of this subsection shall not apply to any advanced practice registered nurse licensed pursuant to section 20-94a and maintaining current certification from the **American Association of Nurse Anesthetists** who provide services under the direction of a licensed physician.

Chapter 370 (Medicine and Surgery), Section 20-9[41] (Who may practice medicine or surgery) of the Connecticut general statutes also refers to the regulation of CRNA practice.

- (a) No person shall, for compensation, gain, or reward, receive or expected, diagnose, treat, operate for, or prescribe for any injury, deformity, ailment, or disease, actual or imaginary, of another person, nor practice surgery, until he has obtained such a license as provided in section 20-10,[42] and then only in the kind or branch of practice stated in such license.
- (b)The provisions of this chapter shall not apply to: (6) Any person rendering service as (A) an advanced practice registered nurse if such service is rendered in accordance with section 20-87a, or (B) an advanced practice registered nurse maintaining classification from the **American Association of Nurse Anesthetist** if such service is under the direction of a licensed physician.

[38] Connecticut General Assembly. Chapter 378 Nursing. Section 20-94b. CGA. Accessed August 1, 2023. https://www.cga.ct.gov/current/pub/chap_378.htm#sec_20-94b
[39] Connecticut General Assembly. Chapter 378 Nursing. Section 20-94c. CGA. Accessed August 1, 2023. https://www.cga.ct.gov/current/pub/chap_378.htm#sec_20-94c
[40] Connecticut General Assembly. Chapter 370 Medicine and Surgery. Section 20-9. CGA. Accessed August 1, 2023. https://www.cga.ct.gov/current/pub/chap_370.htm#sec_20-9
[41] Connecticut General Assembly. Chapter 370 Medicine and Surgery. Section 20-9. CGA. Accessed August 1, 2023. https://www.cga.ct.gov/current/pub/chap_370.htm#sec_20-9
[42] Connecticut General Assembly. Chapter 370 Medicine and Surgery. Section 20-10. CGA. Accessed August 1, 2023. https://www.cga.ct.gov/current/pub/chap_370.htm#sec_20-10

The Center for Medicare/Medicaid (CMS) outlines requirements for CRNA supervision/direction for billing purposes. Pursuant to Appendix A-1001, Subsection 482.52(c) Standard: State Exemption:[43]

- A hospital may be exempted from the requirement for MD/DO supervision of CRNAs as described in paragraph (a4) of this section, if the state in which the hospital is located submits a letter to CMS signed by the Governor, following consultation with the State's Board of Medicine and Nursing, requesting exemption from the MD/DO supervision of CRNA's. The letter from the Governor must attest that he or she has consulted with the State Boards of Medicine and Nursing about issues related to access to and the quality of anesthesia services in the State and has concluded that it is in the best interests of the State's citizens to opt-out of the current MD/DO supervision requirement, and that the opt out is consistent with State law.

In summary, the Connecticut Department of Public Health (DPH) licenses CRNA pursuant to the Connecticut General Statutes. CRNAs remain the only advanced practice nursing provider excluded in the statute for full practice authority despite clinical experience as a critical care registered nurse prior to the extensive academic and clinical requirements of a nurse anesthesia program.

5. **The State's Current Regulatory Oversight of the Profession**:

The Connecticut Department of Public Health licenses all Registered Nurses and Advanced Practice Registered Nurses, including Certified Registered Nurse Anesthetists. CRNAs are also regulated by the State Board of Examiners for Nursing, which consists of 12 Connecticut residents appointed by the Governor, as outlined in section 20-88 of the Connecticut Nurse Practice Act.[44] As APRNs, CRNAs are subject to the regulation of the state's insurance carriers and must meet the Department of Social Services (DSS) Medicaid requirements as enrolled Medicaid providers.

6. All current education, training, and examination requirements and any relevant certification requirements applicable to the profession;

a. Education and Training

CRNAs are advanced practice registered nurses that practice in all 50 states, the District of Columbia, Puerto Rico, and the United States Armed Services. The Council on Accreditation of Nurse Anesthesia Educational Programs (COA) is the sole accrediting body for nurse anesthesia programs in the United States and Puerto Rico.[45] The mission of the COA is to "establish standards that promote quality education in nurse anesthesia programs through accreditation."[48] Beginning on January 1, 2022, all accredited nurse anesthesia programs are full time, at least 36 months in duration, and offer a Doctor of Nursing Practice (DNP) or Doctor of Nurse Anesthesia Practice (DNAP) degree. All accredited nurse anesthesia educational programs are listed on the COA website.[46]

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[43] Center for Medicare and Medicaid Services. Condition of participation: anesthesia services. Accessed August 10, 2023. https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R59SOMA.pdf

[44]Connecticut General Assembly. Chapter 378 Nursing. Section 20-88. CGA. Accessed August 1, 2023. https://www.cga.ct.gov/current/pub/Chap_378.htm#sec_20-88

[45] Council on Accreditation. About us. 2023. Accessed August 1, 2023. https://www.coacrna.org/about-coa/

[46] Council on Accreditation. Position Statement on Doctoral Education for Nurse Anesthetists. COA. Updated 2020. Accessed August 1, 2023. https://www.coacrna.org/about-coa/position-statements/

The COA Curriculum Standards[47] focus on the full scope of nurse anesthesia practice that includes:

- Courses/Content (excerpt of courses/content)
    - Advanced Physiology/Pathophysiology (120 contact hours)
    - Advance Pharmacology (90 contact hours)
    - Principles on Nurse Anesthesia Practice (120 contact hours)
    - Research (75 contact hours)
    - Advanced Health Assessment (45 contact hours)
    - Human anatomy, chemistry, biochemistry, physics, genetics, acute and chronic pain management, 12-lead ECG interpretation, radiology, ultrasound, anesthesia equipment, professional role development, wellness and substance use disorder, informatics, ethical and multicultural healthcare, leadership and management, business of anesthesia/practice management, health policy, healthcare finance, integration/clinical correlation
- Clinical Experiences [48](excerpt of clinical experiences)
    - A minimum of 2000 clinical hours
    - 650 cases (700 preferred)
    - Geriatric 100 required (200 preferred)
    - Pediatric 40 required (100 preferred)
    - Trauma/emergency
    - Obstetrical 30 required (40 preferred)
    - Pain Management 15 required (50 preferred)
    - Intracranial
    - Intraabdominal
    - Intrathoracic heart 15 required (40 preferred)
    - Intrathoracic lung 5 required
    - General Anesthesia
        - Endotracheal intubation
        - LMA insertion
    - Sedation
    - Major regional anesthesia
    - Peripheral nerve blocks
- Completion of scholarly works that demonstrates knowledge and scholarship skills within the area of academic focus

While the COA sets minimum requirements for eligibility to practice, the mean clinical hours for graduates across the country is 2,731.3± 329.6 and the mean number of clinical cases is 855 ± 141 which exceeds the requirements for clinical hour by 30% and the clinical cases by 40%.[49] These statistics reflect

[47] Council on Accreditation. 2004 Standards for Accreditation of Nurse Anesthesia Educational Programs. COA. Updated May 2022. Accessed August 1, 2023. https://www.coacrna.org/wp-content/uploads/2023/03/2004-Standards-for-Accreditation-of-Nurse-Anesthesia-Educational-Programs-revised-May-2022.pdf

[48]Council on Accreditation. Guidelines for Counting Clinical Cases. COA. Updated January 2021. Accessed August 1, 2023. https://www.coacrna.org/wp-content/uploads/2021/03/Guidelines-for-Counting-Clinical-Experiences-Jan-2021.pdf

[49] National Board of Certification and Recertification. NCE and SEE Annual Report. NBCRNA. December 2022. Accessed August 1, 2023. https://www.nbcrna.com/docs/default-source/exams-documents/nce-resources-landing-page/nceandseeannualreportfinal_2022.pdf?sfvrsn=7cea6bef_2

the clinical requirements for the nurse anesthesia programs in CT. (Verbal communication with Nurse Anesthesia Program Directors 2023)

The COA identifies Student Standards[50] for admission including:

- *A baccalaureate or graduate degree in nursing or another appropriate major*
- *An unencumbered license as a registered professional nurse and/or APRN in the United States or its territories*
- *A minimum of one year of full-time work experience (or its part-time equivalent) as a registered nurse in a critical care setting. The applicant must have developed as an independent decision maker capable of using and interpreting advanced monitoring techniques based on the knowledge of physiological and pharmacological principles.*[53]

The COA Graduate Standards[51] focus on the graduates' abilities in the following areas:

- patient safety standards include vigilance and protecting the patient from iatrogenic complications;
- perianesthesia standards include providing individualized, culturally competent anesthesia services across the lifespan, the ability to complete a comprehensive physical assessment, an anesthesia preoperative assessment, and a variety of anesthetic techniques including general, sedation, and regional anesthesia;
- critical thinking standards include demonstrating the ability to use knowledge and evidence-based practice to formulate an anesthesia plan, interpret and respond to data from invasive and noninvasive devices, laboratory, and diagnostic testing, evaluate and respond to physiological alterations;
- communication skills impact the patient, significant others, and members of the healthcare team;
- leadership that fosters intraprofessional and interprofessional collaboration; and
- professionalism standards include integrity, responsibility, and accountability in practice including the decision-making process and advocacy for the patients, outcomes, and the nurse anesthesia profession.

All requirements outlined above must be met before a graduate is eligible to sit for the National Certification Exam (NCE).

b. National Certification Exam (NCE)

In addition to successful completion of the rigorous academic, professional, and clinical requirements, an applicant must be a graduate of an unabridged nurse anesthesia educational program (accredited by the COA) within the past 2 years and hold a valid US RN nursing license to be eligible to take the NCE.
The NCE is a computerized adaptive test with four content domains (basic sciences, equipment instrumentation, and technology, general principles of anesthesia, and anesthesia for surgical procedures and special populations) that is administered at Pearson Vue testing centers. The test is 100-170 questions with a maximum time of three hours. Test questions have been tested, validated, and

[50] Council on Accreditation. 2004 Standards for Accreditation of Nurse Anesthesia Educational Programs. COA. Updated May 2022. Accessed August 1, 2023. https://www.coacrna.org/wp-content/uploads/2023/03/2004-Standards-for-Accreditation-of-Nurse-Anesthesia-Educational-Programs-revised-May-2022.pdf

revised based on a professional practice analysis to reflect the knowledge of an entry to practice anesthesia provider.[51]

Successful completion of the NCE is required to become a CRNA and to obtain a CT APRN license to practice as a CRNA.

c. Recertification (Continued Professional Competency)

The credentials committee of the AANA administered the primary certification for CRNAs beginning in 1945. In 1975, the AANA transitioned certification responsibilities to the Council on Certification of Nurse Anesthetists (CCNA) which included the National Certification Exam (NCE).

In 1969, the AANA adopted bylaws to establish an optional continuing education program and certificate and in 1978, continuing education became mandatory. In September of 1978, the AANA created the Council on Certification of Nurse Anesthetists (COR) to oversee the recertification process. In 1983 the COR was made an autonomous agency to separate the professional organization from the recertification process. In 2007, the CCNA and COR became independent of the AANA and were incorporated as the NBCRNA.[52] The recertification process for CRNAs is known as Continued Professional Competency (CPC).

The current CPC Program[53] is an 8-year cycle, divided into two, 4-year terms. To participate in the CPC program, CRNAs require:

- Licensure as a registered nurse with the authority to practice nurse anesthesia
- Nurse anesthesia practice that may include clinical practice, nurse anesthesia-related administrative, educational or research activities, or a combination of two or more of such areas of practice

During the first four-year CPC cycle requirements include:

- 60 Class A credits[54]
- 4 Class B credits[55]
- Four Core Modules[56] – one in each of the following four domains:
    - Airway Management Techniques
    - Applied Clinical Pharmacology
    - Human Physiology and Pathophysiology
    - Anesthesia Equipment, Technology and Safety

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[51] National Board of Certification and Recertification of Nurse Anesthetists. NCE Handbook. NBCRNA. Updated 2023. Accessed August 1, 2023. https://www.nbcrna.com/docs/default-source/publications-documentation/handbooks/nbcrna-hb-nce-v6.pdf?sfvrsn=2d78115b_2

[52] National Board of Certification and Recertification of Nurse Anesthetists. History. NBCRNA. Updated 2023. Accessed August 1, 2023. https://www.nbcrna.com/about-us/history

[53] National Board of Certification and Recertification of Nurse Anesthetists. The Continued Professional Certification (CPC) Program. NBCRNA. Updated 2023. Accessed August 1, 2023. https://www.nbcrna.com/continued-certification/CPC_Program

[54] National Board of Certification and Recertification of Nurse Anesthetists. Class A Credits. Updated 2023. Accessed August 1, 2023. https://www.nbcrna.com/continued-certification/class-a-credits

[55] National Board of Certification and Recertification of Nurse Anesthetists. Class B Credits. Updated 2023. Accessed August 1, 2023. https://www.nbcrna.com/continued-certification/class-b-credits

[56] National Board of Certification and Recertification of Nurse Anesthetists. Core Modules. Updated 2023. Accessed August 1, 2023. https://www.nbcrna.com/continued-certification/core-modules

During the second four-year CPC cycle requirements include:

- 60 Class A credits
- 40 Class B credits
- Four Core Modules – one in each of the following four domains:
    - Airway Management Techniques
    - Applied Clinical Pharmacology
    - Human Physiology and Pathophysiology
    - Anesthesia Equipment, Technology and Safety
- CPC Assessment (CPCA)-taken only one time during an 8-year CPC period.[57]

7. A summary of known scope of practice changes requested or enacted concerning the profession in the five years preceding the request

Leading up to and during the COVID-19 pandemic, changes in the scope of practice for CRNAs have been enacted across the country. These changes were accelerated in 2020 because of the overwhelming healthcare needs of Americans. However, this is the first scope of practice review request by CTANA.

At the start of the pandemic, the Centers for Medicare & Medicaid Services (CMS) Medicare suspended the supervision requirement for CRNAs in the CMS regulations for hospitals, critical access hospitals (CAHs) and ambulatory surgical centers from March 1, 2020, through the duration of the pandemic state of emergency, which ended on May 11, 2023.[58]CRNAs across the country provided essential critical care and anesthesia services without medical direction.

Simultaneously, in Connecticut, Governor Lamont issued an executive order "Temporary Suspension of In-Person Supervision Requirement for Advanced Practice Registered Nurses. Section 20-87a(b)(2) of the Connecticut General Statutes is modified to suspend the requirement that a physician, medically directing the prescriptive activity of an **advanced practice registered nurse who is prescribing and administering medical therapeutics during surgery [i.e., CRNAs]**, must be physically present in the institution, clinic, or other setting where the surgery is being performed." This executive order was never rescinded but expired at the end of the pandemic.[59]

[57]National Board of Certification and Recertification of Nurse Anesthetists. CPC Assessment. Updated 2023. Accessed August 1, 2023. https://www.nbcrna.com/continued-certification/cpc-assessment

[58] Center for Medicare and Medicaid Services. COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers. CMS. Updated May 4, 2021. Accessed August 13, 2023. https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf

[59] State of Connecticut. Executive Order 7DD: Protection of Public Health and Safety During Covid-19 Pandemic and Response-Expansion of Healthcare Workforce. March 10, 2020. Accessed August 1, 2023.https://portal.ct.gov/-/media/Office-of-the-Governor/Executive-Orders/Lamont-Executive-Orders/Executive-Order-No-7DD.pdf

Similar executive orders were enacted in surrounding states including Massachusetts, New York, New Jersey, Maine, and Pennsylvania. Requirements for physician supervision and collaboration were lifted for all APRNs including CRNAs.[60,61,62,63,64]

Since the beginning of the pandemic, Arizona, Oklahoma, Utah, Michigan, Arkansas, Wyoming, and Delaware enacted legislation to permanently remove restrictions from the state nursing laws to permanently opt-out of the federal supervision. By doing so, facilities in these states can be assured that the requirements for CRNA practice are not subject to sudden changes when waivers expire.

Restrictions on CRNA practice are not supported by evidence and are contrary to the national trend. Currently, 24 states and Guam have no supervision or direction requirement concerning nurse anesthetists in nurse practice acts, board of nursing rules/regulations which allows CRNA to practice to the full extent of their academic and clinical education. This national trend is further supported by the Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education adopted in 2008 and endorsed by over 40 nursing organizations.[65]

8. The extent to which the request directly affects existing relationships within the health care delivery system

The requested changes to the CRNA scope of practice will have a positive impact on the health care delivery system in Connecticut and existing relationships will be enhanced. Physician anesthesiologists are valued and respected members of the health care team and CRNAs will continue to practice alongside physician anesthesiologists in many practice locations. Additionally, hospital-based settings may choose to maintain an anesthesia care team model of delivery where physicians do still supervise or direct CRNAs. This request does not mandate changes to the way in which anesthesia is provided in practice locations, it rather allows CRNAs the ability to practice to the full scope of their academic and clinical education.

New relationships will be created between CRNAs, podiatrists, dentists, and surgeons especially in small office-based settings, improving patient access to high quality, safe anesthesia care. With the removal of the requirement for physician direction, CRNAs will be able to fill the gaps and reduce the anesthesia provider shortages. CRNAs will no longer be required to sign agreements with another physician if they are the only anesthesia provider at a particular facility. They will instead be able to practice to the full scope of their practice.

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[60] https://www.mass.gov/doc/march-26-2020-advanced-practice-registered-nurses-order/download

[61] https://www.governor.ny.gov/news/no-20210-continuing-temporary-suspension-and-modification-laws-relating-disaster-emergency

[62] https://nj.gov/infobank/eo/056murphy/pdf/EO-112.pdf

[63] https://www.maine.gov/governor/mills/sites/maine.gov.governor.mills/files/inline-files/EO%2016%20An%20Order%20Suspending%20Provisions%20of%20Certain%20HC%20Professional%20Licensing.pdf

[64] https://www.governor.pa.gov/wp-content/uploads/2020/05/20200506-GOV-health-care-professionals-protection-order-COVID-19.pdf

[65] APRN Consensus Work Group, National Council of State Boards of Nursing APRN Advisory Committee**.** Consensus Model for APRN Regulation: Licensure, Accreditation, Certification, and Education. July 7, 2008. Accessed August 1, 2023. https://www.aacn.org/~/media/aacn-website/nursing-excellence/standards/aprnregulation.pdf?la=en

Graduates from Connecticut programs are being educated and trained in the full scope of anesthesia practice. Removal of practice restrictions may encourage graduates to remain in Connecticut rather than taking positions in surrounding states where they are able to practice to the full scope of their education. In addition, the removal of requirements for physician "direction" may bring CRNAs into the state, helping to offset the anesthesia provider shortages that currently exist.

9. The anticipated economic impact of the request on the health care delivery system

When patients are given greater access to a broad range of treatment options and healthcare providers, health care is timelier, and costs are reduced.[66] Removal of requirements for physician direction for CRNAs will allow patients to receive care in a wider variety of health care settings, which has the potential to increase convenience and overall satisfaction with the care provided.

The Federal Trade Commission has weighed in numerous times in support of removing restrictions on APRNs, including CRNAs, stating that "[c]consistent with patient safety, however, we have urged regulators and legislators to consider the benefits that more competition from independent APRNs – including CRNAs – might provide – especially benefits to patients. If APRNs are better able to practice to the full extent of their education, training, and abilities, and if institutional health care providers are better able to deploy APRNs as needed, health care consumers – patients – are likely to benefit from improved access to health care, lower costs, and additional innovation."[67]
Restrictive physician involvement in CRNA practice raises several competitive concerns for patients. By restricting CRNAs' access to the marketplace, these barriers can:

- Increase the cost of care.
- Restrict provider innovation in healthcare delivery.
- Create provider shortage and access problems, particularly for rural and underserved populations that lack adequate cost-effective healthcare.

Cost effectiveness directly relates to access for patients. In addition to delivering essential healthcare in thousands of medically underserved communities, CRNAs are the primary providers of anesthesia care for women in labor and for the men and women serving in the U.S. Armed Forces, especially on frontlines around the globe.[68] They also serve as the backbone of anesthesia care in rural and other medically underserved areas of the United States. A recent study[69] published in the September/October 2015 Nursing Economic$ found that CRNAs are providing the majority of anesthesia care in U.S. counties with lower-income populations and populations that are more likely to be uninsured or unemployed.[72] They are also more likely to be found in states with less-restrictive practice regulations in the more rural counties.[70]

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[66] Osman BM, Shapiro FE. Office-based anesthesia: a comprehensive review and 2019 update. *Anesthesiol Clin*. 2019;37(2):271-281.
[67] https://www.ftc.gov/policy/advocacy/advocacy-filings/2019/12/ftc-comment-texas-medical-board-its-proposed-rule-19313-add
[68] https://issuu.com/aanapublishing/docs/scope_of_nurse_anesthesia_practice_2.23?fr=sNDg2MDU2NDAxMjU
[69] Liao CJ, Quraishi JA, Jordan LM (2015). Geographical imbalance of anesthesia providers and its impact on the uninsured and vulnerable populations. *Nursing Economic$*, 33(5):263-270.
[70] Quintana, J. "Answering today's need for high-quality anesthesia care at a lower cost," *Becker's Hospital Review,*, January 20, 2016, available at http://www.beckershospitalreview.com/hospital-physician-relationships/answering-today-s-need-for-high-quality-anesthesia-care-at-a-lower-cost.html

As an example, when Johnson Memorial Hospital in Stafford Springs closed its obstetrical unit because of staffing shortages it became a costly inconvenience for a laboring woman in Putnam.[71] If there was greater access to obstetrical anesthesia services, this may have been avoided. CRNAs deliver essential healthcare to thousands of medically underserved communities. In fact, CRNAs are the main providers of anesthesia care for women in labor and for the men and women serving in the US Armed Forces, especially on frontlines around the globe. They also serve as the backbone of care in rural and other medically underserved areas. Connecticut has identified almost 40% of the towns in the state as rural (67 of the 169). (Appendix A-Connecticut Office of Rural Health Map) Researchers found that CRNAs are providing most of the anesthesia care in US counties with lower-income populations and populations that are more likely to be uninsured or unemployed. Removal of requirements for physician direction of CRNAs in the state of Connecticut would allow for greater access to obstetrical services in these communities.[72]

There is overwhelming evidence that CRNAs provide safe, cost-effective, and patient-centered anesthesia care.[73] The excellent safety record of CRNAs is reflected in a landmark national study conducted by RTI International and published in the August 2010 issue of *Health Affairs*, which determined that there are no differences in patient outcomes when anesthesia services are provided by CRNAs, physician anesthesiologists, or CRNAs supervised by physicians. The study, titled "No Harm Found When Nurse Anesthetists Work Without Supervision by Physicians," examined nearly 500,000 individual cases and confirms what previous studies have shown: CRNAs provide safe, high-quality care. The study also shows the quality of care administered is equal regardless of supervision.[74]

A CRNA acting as the sole anesthesia provider is the most cost-effective model of anesthesia delivery, according to a groundbreaking study conducted by Virginia-based The Lewin Group and published in the May/June 2010 issue of the *Journal of Nursing Economic$*. The study, titled "Cost Effectiveness Analysis of Anesthesia Providers," considered the different anesthesia delivery models in use in the United States today, including CRNAs acting solo, physician anesthesiologists acting solo, and various models in which a single anesthesiologist directs or supervises one to six CRNAs. The results show that CRNAs acting as the sole anesthesia provider cost 25 percent less than the second lowest cost model. On the other end of the cost scale, the model in which one anesthesiologist supervises one CRNA is the least cost-efficient model. The results of the Lewin study are particularly compelling for people living in rural and other areas of the United States where anesthesiologists often choose not to practice for economic reasons.[75]

Current Medicare anesthesia practice models were created to drive reimbursement, not best practice. There is no evidence that one anesthesia delivery model is safer. Researchers analyzed seven years of

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[71] NBC Connecticut. Johnson Memorial Hospital plans to end labor and delivery services. July 13, 2022. Accessed May 31, 2023. https://www.nbcconnecticut.com/news/local/johnson-memorial-hospital-plans-to-end-labor-and-delivery-services/2825043/

[72] Liao CJ, Quraishi JA, Jordan LM. Geographical imbalance of anesthesia providers and its impact on the uninsured and vulnerable populations. *Nurs Econ*. 2015 Sep-Oct;33(5):263-70. PMID:26625579

[73] American Association of Nurse Anesthesiology. Scope of Nurse Anesthesia Practice. AANA. February 2020. Accessed August 1, 2023. https://issuu.com/aanapublishing/docs/scope_of_nurse_anesthesia_practice_2.23?fr=sNDg2MDU2NDAxMjU

[74] Dulisse B, Cromwell J. No harm found when nurse anesthetists work without supervision by physicians. *Health Aff*. 2010;29(8):1469-75. doi:10.1377/hlthaff.2008.0966

[75] Hogan P, Seifert R, Moore C, Simonson B. Cost effectiveness analysis of anesthesia providers. *Nurs Econ*. 2010 May-Jun;28(3):159-69. PMID:20672538

Medicare data and found no increased risk to patients in states that removed physician supervision or direction requirements of CRNAs for reimbursement.[77]

In Connecticut, anesthesia services are provided by physician anesthesiologists and CRNAs in different billing models. Physician anesthesiologists can personally deliver anesthesia care. Alternatively, physician anesthesiologists can simultaneously "supervise," or "direct" multiple CRNAs who are providing direct patient care. Per Medicare billing guidelines, under "medical direction" the physician directs 1 to 4 CRNAs and documents their presence at specific stages of the anesthetic. Under "supervision" the physician anesthesiologist is at the facility and is available to up to 8 CRNAs but is not required to be present in the operating room. While CMS regulations dictate ratios, healthcare facilities can further restrict CRNA practice. It is not uncommon for facilities and/or private anesthesia departments in Connecticut to restrict the medical direction ratio of physician anesthesiologist to CRNA to 1:2 or 1:3, which increases the cost of care and further limits access.

In states and facilities that do not require physician supervision or direction, CRNAs provide the same services without physician anesthesiologist supervision. The practice models used in a facility affect the efficiency and cost of anesthesia services. The model in which all anesthesia providers work collaboratively with surgeons and proceduralists delivering direct patient care is the most cost-effective and productive.[76]

10. Regional and national trends in licensing of the health profession making the request and a summary of relevant scope of practice provisions enacted in other states
Rhode Island

As of submission of this scope review, 24 states, the District of Columbia, and Guam have opted out of the CMS requirements for physician supervision allowing CRNAs to practice to the full extent of their academic and clinical education.[77] (See Exhibit C-CRNA Opt Out Map). The most recent state to opt out of the CMS requirements for physician supervision was Delaware in June 2023.[78] Independent practice has been recognized in the state of New Hampshire for many years. Advanced Practice Registered Nurses in the State of New Hampshire,[79] which includes CRNAs, have been permitted to practice independently of physician supervision since 1991. On June 11, 2002 New Hampshire's former Governor Jeanne Shaheen formally requested an exemption for the State of New Hampshire from the regulation requiring hospitals and ambulatory surgical care facilities to have physicians supervise CRNAs in order to receive federal Medicare reimbursement for anesthesiology services. As fully independent licensed APRNs, New Hampshire CRNAs work to the full extent of their licensure and professional training.

In addition, in January 2021 the state of Massachusetts passed "The Patient First Act", which removed prescriptive supervision for CRNAs.[80] This new law grants CRNAs independent practice authority to issue written prescriptions and medication orders and to order tests and therapeutics without supervision,

[76] Dulisse B, Cromwell J. No harm found when nurse anesthetists work without supervision by physicians. *Health Aff*. 2010;29(8):1469-75. doi:10.1377/hlthaff.2008.0966
[77] American Association of Nurse Anesthesiology, State Government Affairs. CRNA Out Out Map. Updated 2023. Accessed August 1, 2023. https://www.aana.com/wp-content/uploads/2023/06/2023-Opt-Out-Map.png
[78] https://www.aana.com/news/delaware-opts-out-of-physician-supervision-of-crnas/
[79] https://www.nhana.org/new-hampshire-anesthesia-practice-models/
[80] https://www.newswise.com/articles/patients-in-massachusetts-now-have-greater-access-to-high-quality-care-from-crnas

following two years of supervised practice (or satisfactory demonstration of alternative professional experience as determined by Board of Nursing rules).

11. Identification of any health care professions that can reasonably be anticipated to be directly affected by the request, the nature of the impact, and efforts made by the requestor to discuss it with such health care professionals

The standards of care are the same for CRNAs and Physician Anesthesiologists. However, in the state of Connecticut, CRNAs are required to provide anesthesia care under the direction of a physician licensed to practice in the state of Connecticut. Several healthcare professionals may be impacted by the request to remove the requirement for physician direction including physician anesthesiologists, dentists, podiatrists, and surgeons. Allowing CRNAs to practice to the full scope of their academic and clinical education will allow them to provide services in settings previously restricted. This will improve patient access to care and help to meet current demand for anesthesia care providers, helping to offset the current shortage.

The Connecticut Nurse Practice Act has previously been amended to remove requirements for physician supervision for all APRNs in the state **except** CRNAs. The removal of the requirement for physician direction as outlined in the CTANA Scope of Practice review request will bring parity for CRNAs with other APRNs practicing in Connecticut. This will encourage graduates of Connecticut programs and CRNAs from other states with less restrictive practice requirements to join the anesthesia workforce in Connecticut. This would be a benefit to Connecticut residents and have a positive impact on the overall healthcare delivery system.

12**. A description of how the request relates to the health care profession's ability to practice to the full extent of the profession's education and training**.

Certified Registered Nurse Anesthetists (CRNAs) are trained to be full-scope providers able to care for patients across the lifespan, in all practice settings, undergoing any type of surgery or procedure. Nurse Anesthetists practice autonomously around the United States, making up 80-percent of anesthesia providers in rural areas (10 Things you Should Know About CRNAs). Given the current shortage of anesthesia providers, allowing CRNAs to practice to the full extent of their education will enable patients to receive access to high-quality anesthesia care in a timely manner. Currently, 36 states (not including hospital/state regulations) have no supervision or direction requirements (Summary of State Supervision Requirements for Nurse Anesthetists). During COVID, CMS suspended supervision requirements for CRNAs due to a state of emergency. At the same time, Governor Lamont used his executive orders to suspend "supervision for nurse anesthetists" in the State of Connecticut. This allowed patients to receive high-quality health care when the health system was strained tremendously and undoubtedly saved lives. This proved the already known fact that CRNAs could provide safe, high quality anesthesia care and should be able to continue to practice without restrictions as they did during the national crisis. Removing the requirement for physician direction, will allow CRNAs to practice autonomously in the health care system which will decrease the cost of care, improve provider innovation in healthcare delivery, and reduce the provider shortage, increasing access to care.[81] (CT Talking Points MS Word Documents).

[81] https://www.aana.com/about-us/about-crnas/

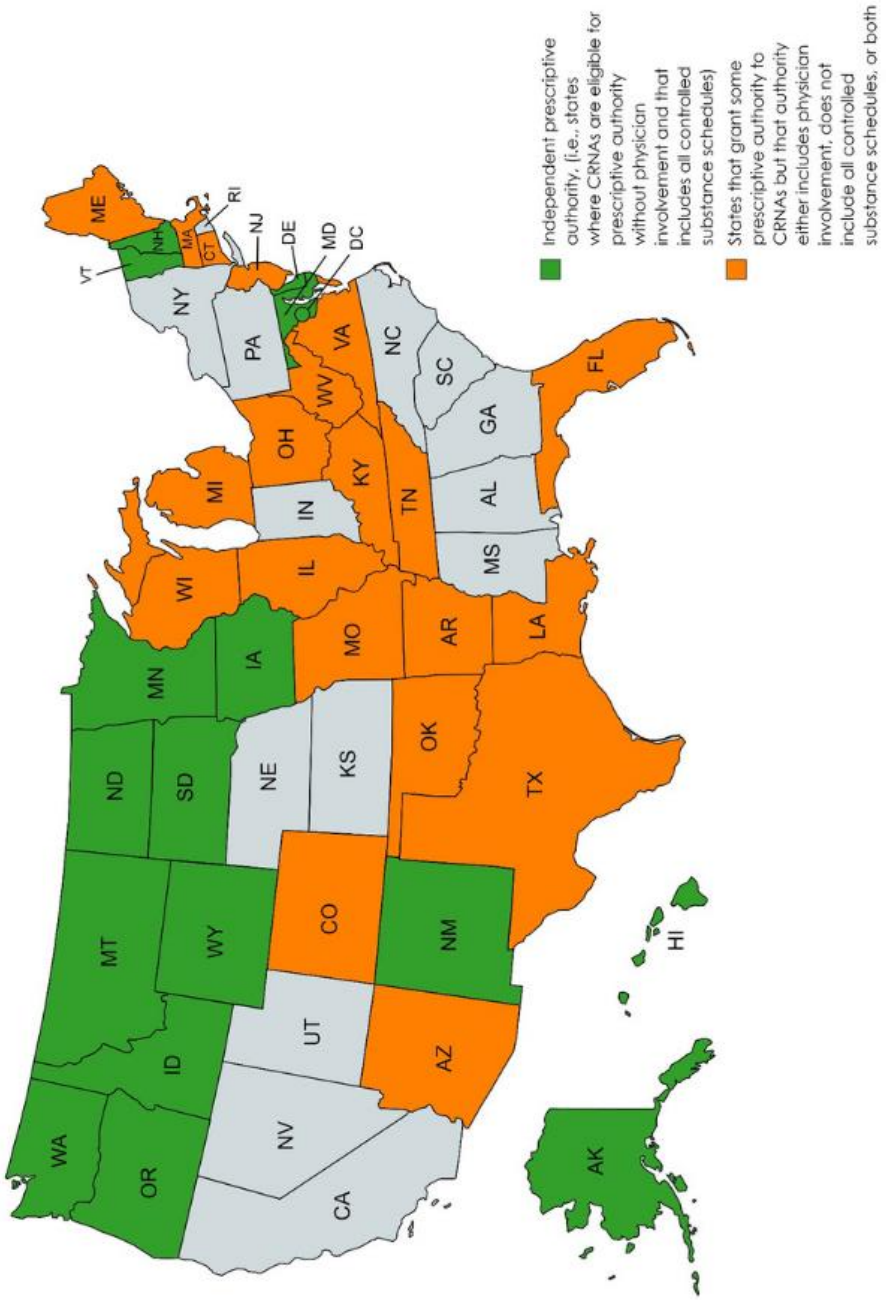
Conclusion

CTANA recognizes that across Connecticut there is a shortage of qualified anesthesia care providers. The current scope of practice for CRNAs in the state restricts both the setting and model for their practice. This limits patient access to the high quality and safe anesthesia services CRNAs can provide in all practice settings including in-patient, ambulatory and office locations.

The standards of care are the same for CRNAs and Physician Anesthesiologists. Removing the requirement for physician direction will allow CRNAs to practice to the full scope of their academic and clinical education and will allow them to provide services in settings previously restricted. This will improve patient access to high-quality anesthesia services and help to meet current demand for anesthesia care providers, helping to offset the current shortage. CRNAs are an integral part of the anesthesia workforce in Connecticut and should be allowed to help meet the growing healthcare needs of its residents. This would be consistent with the current trends in the advancement of nurse anesthesia practice across the country.

The removal of the requirement for physician direction as outlined in this scope review request, will bring parity for CRNAs with other APRNs practicing in Connecticut. It **will** encourage graduates of Connecticut nurse anesthesia programs and CRNAs from other states with less restrictive practice requirements to join the anesthesia workforce here. This will have a positive effect on the healthcare delivery system and improve access to care for Connecticut residents.

Exhibit A- Prescriptive Authority Map



Source: AANA State Government Affairs Division

Exhibit B-Dental Permit Map

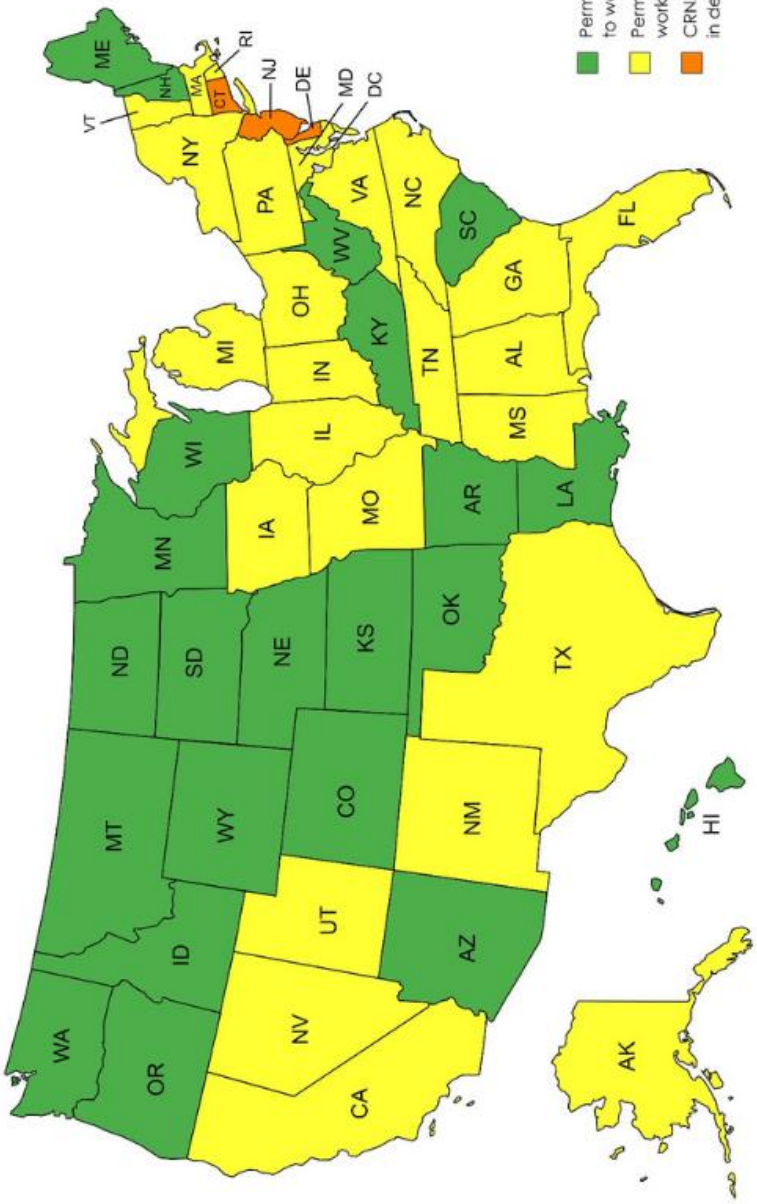
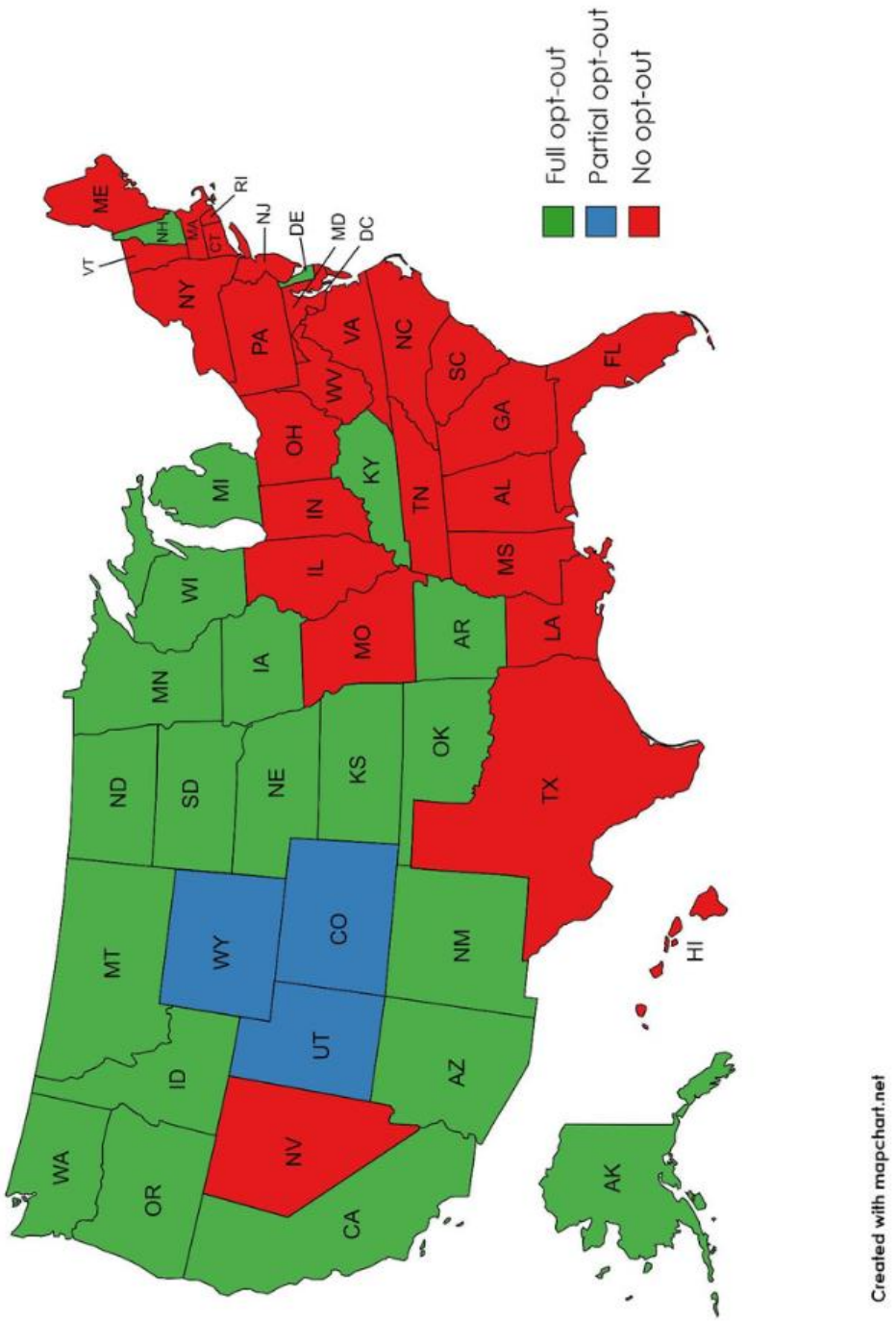


Exhibit C-CRNA Opt Out Map



APPENDIX E

IMPACT STATEMENTS

Sara Montauti, MPH
Healthcare Quality and Safety Branch, Practitioner Licensing and Investigations
Department of Public Health
410 Capitol Avenue, MS#12HSR P.O. Box 340308
Hartford, CT 06134
(860) 509-7307, sara.montauti@ct.gov

September 15, 2023

Dear Ms. Montauti:

The Connecticut Nurses' Association submits this impact statement in response to the Scope of Practice Request from Connecticut Association of Nurse Anesthesiology (CTANA.)

The Connecticut Nurses' Association is a nurse membership organization. For over a hundred years, we have monitored legislation that impacts nursing, the nursing profession, and the public's health. Our Code of Ethics inspires us to share our experiences and expertise on the front lines of health care and across diverse health settings.

All nurses are governed by the CT Nurse Practice Act. The Association collaborates with nurses, advanced practice registered nurses, and other state holders to review and consider the impact of changes to the Nurse Practice Act. The healthcare landscape and research base continue to evolve and support the positive impact and role that CRNAs play in our system. The complexity of the system, with many health care providers, also creates confusion about licensing, supervision, and best practices. We support the changes to bring CRNAs under the Advanced Practice Registered Nurse license in Connecticut, as well as updates to the certifications to ensure accuracy and standards.

If the Department appoints a scope of practice review committee to review the request from the CTANA, the Connecticut Nurses' Association respectfully requests an appointment to the committee.

Respectfully submitted,

Kim Sandor, MSN, RN, FNP
Connecticut Nurses Association
ExecutiveDirector@ctnurses.org

CONNECTICUT HOSPITAL ASSOCIATION

MEMORANDUM

TO: Sara Montauti
Healthcare Quality and Safety Branch
Practitioner Licensing and Investigations
Connecticut Department of Public Health

FROM: Karen Buckley, Vice President, Advocacy

DATE: September 7, 2023

SUBJECT: Impact Statement – Scope of Practice Request – Connecticut Association of Nurse Anesthesiology (CTANA)

The Connecticut Hospital Association (CHA), a trade association representing the 27 acute care hospitals in Connecticut, submits this impact statement, in accordance with Chapter 368a of the Connecticut General Statutes, in response to the scope of practice change requested by the Connecticut Association of Nurse Anesthesiology (CTANA). The change requested seeks to make conforming changes to state statutes to recognize the current certifying and recertifying national entities for Certified Registered Nurse Anesthetists (CRNAs) and to make scope of practice changes that will permit CRNAs to practice in accordance with the statutory provisions set forth for all other Advanced Practice Registered Nurses (APRNs) licensed and practicing in Connecticut.

The proposed changes would impact the healthcare delivery system in Connecticut and require hospital policies, procedures, and credentialing to be changed. Connecticut hospitals employ or utilize a significant number of licensed healthcare professionals including physicians, advanced practice registered nurses, physician assistants, nuclear medicine technologists, and other allied health professionals. The request will impact the delivery of care to hospital patients.

If the Department appoints a Scope of Practice Review Committee, CHA respectfully requests an appointment to the Committee.

KMB:ljs
By E-mail
cc: Nancy A. Moriber PhD, CRNA, APRN, FAANA President Connecticut Association of Nurse Anesthesiology

My name is Christopher Bartels, I am a Certified Registered Nurse Anesthetist and owner of Connecticut Anesthesia Professionals and co-owner of Wilton Anesthesia Associates. Both are CRNA only companies supplying sedation and anesthesia service at 12 sites across the state including both surgical centers and doctors' offices. I am submitting an impact statement to the Certified Registered Nurse Anesthetist Scope of Practice request.

The change in scope of practice would help our practice provide safe, cost-effective anesthesia care to all the patients of Connecticut. It would allow us to work with non-physician providers such as Podiatrists and Dentists. This request would also help remove any perceived physician liability for directing prescriptive activity during surgery. It would help us recruit CRNAs from other states which is currently difficult to impossible with current restrictive state practice language. Lastly and most importantly the removal of the requirement for physician direction will improve access to health services for patients in Connecticut.

September 9th, 2023,

Re: CRNA Scope of Practice Request Impact Statement from Connecticut APRN Society

Dear Ms. Montauti,

My name is Christina Mukon and I am the Chair of Health Policy for the Connecticut APRN Society. I am writing to you regarding the Certified Registered Nurse Anesthetist (CRNA) scope of practice that was submitted to the Department of Public Health.

CRNAs are one of the professions considered APRNs within the consensus model of practice. We are aware of the continued restrictions that limit the ability CRNAs to practice to the full extent of their training in the state of Connecticut. We support efforts to bring Connecticut scope of practice of CRNAs into alignment with their training and the needs of the residents of Connecticut.

Please include us in the review process for scope of practice of CRNAs if chosen. Thank you for your consideration.

Dr. Christina Mukon DNP FNP NP-C
Chair of Health Policy
Connecticut APRN Society
ChristinaMukon@gmail.com
860.753.0293

Joseph B. O'Connell, M.D.

PLASTIC SURGERY OF SOUTHERN CONNECTICUT, L.L.C.

Aesthetic Surgery
Reconstructive Surgery
Internet: www.plasticsurgeryct.com

208 Post Rd. West
Westport, CT 06880
Telephone: (203) 454-0044

September 13, 2023

Sara Montauti, MPH
Healthcare Quality and Safety Branch
Practitioner Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, MS# 12HSR
P.O. Box 34308
Hartford, CT 06134
Phone: 860-509-7303
Email: sara.montauti@ct.gov

Dear Ms. Montauti,

I find the recent request for a removal of physician supervision scope of practice review made by the Connecticut Association of Nurse Anesthetists (CTANA) so troubling that I wish to submit the following as a concerned citizen.

As a Connecticut native and 1981 graduate of Cornell University Medical College I have worked in surgery for the past 42 years. I currently work with nurse anesthetists in the Yale New Haven Health System and have worked with nurse anesthetists for many years. I served as Chief of Plastic Surgery at Bridgeport Hospital for seven years and, I have been trained as a Medicare level outpatient surgical facility inspector.

Anesthesiologists are physicians who have graduated from an accredited four-year medical school and completed three to four years of subsequent residency training. The American Society of Anesthesiologists notes that anesthesiologists have 12,000 to 16,000 hours of clinical training. Because they are educated and trained as physicians, anesthesiologists have a broad understanding of all facets of perioperative and perinatal care including an important nuanced understanding of the surgical procedures themselves which can greatly influence anesthesia care. The education and training of a nurse anesthetist is vastly different and it's important to note that their training is *nursing* training, not physician training.

My experience with nurse anesthetists has unfortunately been extremely unsatisfactory in regard to their clinical skill and professional behavior. I have had several "near misses" with nurse anesthetists that I will gladly share if so desired.

The question arises – where exactly would these unsupervised nurse anesthetists work? Hospitals in our State have either Departments of Anesthesia or exclusive contracts with physician-led anesthesia groups where nurse anesthetists work as physician extenders. This is unlikely to change but what will likely happen is that the nurse anesthetists will work in outpatient facilities (such as the dental and podiatry offices referenced in the review request) with less available equipment and limited personnel where only the most experienced anesthesiologists dare to tread.

Member, The Aesthetic Society
Member, The American Society of Plastic Surgeons

As an aside I believe there is currently a cottage industry in our state where physicians from several specialties ignore our state's outpatient surgical facility and Certificate of Need regulations and contract for the administration of anesthesia in unsuitably equipped offices. The temptation of utilizing an unsupervised nurse anesthetist working at substantially lower cost, could be extremely deleterious to public safety in this scenario.

I am also concerned that there may be an additional agenda here – as you know we currently have an epidemic of undertrained non-physicians and even lay individuals who own and operate so called Medical Spas in our state. Allowing nurse anesthetists to practice without supervision would serve as a "back door" to greatly facilitate their ability to enter this arena. I am personally aware of one nurse anesthetist who was taking a course in the administration of aesthetic services.

I have read the testimony provided by CTANA this past March and conspicuously absent was any discussion on the differences in education, training, skill level, continuing education and insurance coverage requirements between anesthesiologists and nurse anesthetists. When it comes to public safety there can be no short cuts. If nurse anesthetists wish to enjoy the privileges (and salaries) of physicians then go to medical school, perform residency training, pass the rigorous licensure and specialty examinations and maintain the required CME and insurance.

Any reference to a nurse anesthetist as an "anesthesiologist" is deceptive, misleading to the public and deprives us of transparency, safety and choice.

I have much more to say on this topic and should DPH decide to act upon this review I would like to participate further.

Respectfully submitted,

Very truly yours,

Joseph B. O'Connell, M.D.

Joseph O'Connell, M.D.
Plastic Surgery of Southern Connecticut, LLC
jbomd@aol.com

Sara Montauti, MPH
Healthcare Quality and Safety Branch
Practitioner Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, MS# 12HSR
P.O. Box 34308
Hartford, CT 06134
Phone: 860-509-7303
Email: sara.montauti@ct.gov

Dear Ms. Montauti,

Please accept this letter on behalf of the 500-plus members of the Connecticut State Society of Anestheisologists (CSSA) in regards to the recent Scope of Practice Review request submitted by the Connecticut Association of Nurse Anesthetists (CTANA). The CSSA is in full opposition of a change to CRNA scope of practice, and a scope review should not be accepted. This issue was thoroughly studied and vetted in 2014, when Connecticut adopted independent practice for Advanced Practice Registered Nurses. Should the DPH decide to take up the scope review, the CSSA would like to participate in the process and provide further information in opposition.

If you have any questions regarding this letter, please contact me at your convenience.

Best regards,

Gregory Rutkowski, MD

Gregory Rutkowski, MD
President
Connecticut State Society of Anesthesiologists
Grutkowski01@connecticutchildrens.org

AORN | AORN Connecticut Chapter I
SAFE SURGERY TOGETHER | CHAPTER 0701

Sara Montauti, MPH
Healthcare Quality and Safety Branch, Practitioner Licensing and Investigations
Department of Public Health
410 Capitol Avenue, MS#12HSR P.O. Box 340308
Hartford, CT 06134
(860) 509-7307, sara.montauti@ct.gov

September 15, 2023

Dear Ms. Montauti:

I am writing on behalf of the Connecticut chapter of the Association of periOperative Registered Nurses (AORN) to express our full support for the proposed change to bring Certified Registered Nurse Anesthetists (CRNAs) under the Advanced Practice Registered Nurse (APRN) License in Connecticut.

This transition holds significant implications for healthcare in our state, with potential improvements in patient care, safety, and access to anesthesia services. AORN, as a trusted voice in perioperative nursing, is dedicated to advancing the profession and ensuring the highest standards of patient care. We firmly believe that aligning CRNAs with APRN licensure is a step in the right direction to accomplish these goals.

We appreciate the Department of Public Health's commitment to thorough review and examination of these standards. In light of our support for this change and our extensive experience in perioperative care, AORN respectfully requests an appointment to any review committee that may be established to further evaluate and refine these standards. Our expertise and perspective can contribute valuable insights to the process, ultimately benefiting the healthcare landscape in Connecticut.

We look forward to the opportunity to collaborate with the Department and other stakeholders in this important endeavor. Please feel free to contact us to schedule a meeting or discuss further details. Thank you for your dedication to the well-being of our community and the enhancement of healthcare practices.

Sincerely,

Cassandra Eilers

Cassandra Eilers MSHCM, BSN, RN, CNOR
President, Association of periOperative Registered Nurses (AORN)
Aornct0701@gmail.com

Northwest Nurse Practitioner Group

Lynn Rapsilber DNP APRN ANP-BC FAANP

September 15, 2023

Sara Montauti, MPH

Connecticut Department of Public Health
Healthcare Quality Safety Branch
Practitioner Licensing and Investigations Section
410 Capitol Avenue, MS#12HSR P.O. Box 340308
Hartford, CT 06134

Dear Ms. Montauti,

My name is Lynn Rapsilber DNP APRN ANP-BC FAANP and I am a nurse practitioner representing the Northwest Nurse Practitioner (NP) Group. This group is part of the Connecticut Coalition of Advanced Practice Nurses representing all the nursing population focused groups in the state. I am writing this response to the scope of practice request submitted on behalf of the Certified Registered Nurse Anesthetists .

The Connecticut Association of Nurse Anesthesiology (CTANA) is requesting the following changes to the Certified Registered Nurse Anesthetist (CRNA) scope of practice 20-87a(b)(2) 1 to allow CRNAs to practice in accordance with provisions set forth for all other Advanced Practice Registered Nurses (APRNs) licensed and practicing in Connecticut. We also seek to amend the language in the Nurse Practice Act, section 20-94a to accurately reflect the certifying and recertifying body for CRNAs: the National Board of Certification and Recertification of Nurse Anesthetists (NBCRNA).

The Northwest NP Group wishes to be part of the discussion regarding the points articulated in the CRNAs scope of practice request document.

Realizing there is a shortage of health care providers now and in the future, scrutiny of scope of practice requests become paramount. While access to care for the residents of Connecticut is of utmost importance, unwavering regard for patient safety should not be compromised. With the residents of Connecticut at the forefront, a scope request review focuses on the education, training, licensure, current climate of practice in relationship to other states, permitting an examination of the evidence buttressing such a request.

CRNAs are APRNS and are looking for synergy with respect to APRN practice. Currently, they are carved out of the current APRN Practice Authority.

A thorough review performed by a convened scope of practice committee can determine, through evidence presented, whether the CRNA scope of practice change is meritorious and

should proceed. Northwest NP Group respectfully requests an opportunity to discuss this request further.

Sincerely,

Lynn Rapsilber

Lynn Rapsilber DNP APRN ANP-BC FAANP

Northwest NP Group

253 Fairlawn Drive

Torrington, CT 06790

lrapsilber@gmail.com

APPENDIX F

RESPONSES TO IMPACT STATEMENTS

September 29, 2023

Sara Montauti, MPH
Healthcare Quality and Safety Branch
Practitioner Licensing and Investigations
Department of Public Health
410 Capital Avenue, MS # 12HSR P.O. Box 340308
Hartford, CT 06134
Phone: (860) 509-7307
Email: sara.montauti@ct.gov

Via e-mail

Re: Impact Statement- Connecticut State Medical Society (CSMS)

Dear Ms. Montauti,

On behalf of the Connecticut Association of Nurse Anesthesiology (CTANA) I am responding to the impact statement received from the Connecticut State Medical Society (CSMS) and their recognition of the "critical role CRNAs play in the healthcare system." Their conviction that physician supervision is essential to providing safe, high quality anesthesia care is not based on evidence. Restrictions are contrary to the national trend, which is toward allowing each practitioner to practice to the full extent of their academic and clinical education. Currently, 36 states and the District of Columbia have no language for supervision or direction requirements concerning nurse anesthetists in their nurse practice acts, board of nursing rules/regulations, medical practice acts, board of medicine rules/regulations, or their generic equivalents. This is further supported by the Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education, adopted in 2008 and endorsed by over 40 nursing organizations.

Physician anesthesiologist supervision and direction of CRNAs are billing terms that are differentiated by the ability to meet the Center for Medicare and Medicaid Services (CMS) requirements set forth by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). The CTANA Scope of Practice Review request seeks to remove the current requirement for physician direction to align CRNA practice with the other APRN groups in Connecticut. As mentioned in the Scope of Practice Review request, there is overwhelming evidence to support the safe, high quality, independent anesthesia care provided by CRNAs. They provide 50 million anesthetics per year in the United States, working in every setting in which anesthesia is delivered. CRNAs practice in accordance with their professional scope and standards of practice; federal, state, and local law; and facility policy to provide dental sedation and anesthesia services. They also deliver safe, high quality care to rural and other medically underserved areas, where they ensure access to anesthesia care for populations that would otherwise have to travel significant

distances from their homes for treatment. In fact, they serve as the sole anesthesia care providers in these areas. The excellent safety record of CRNAs is reflected in a landmark national study of 500,000 cases that was conducted by RTI International and published in the August 2010 issue of *Health Affairs*. This study demonstrated similar patient outcomes when anesthesia services are provided by CRNAs, physician anesthesiologists, or CRNAs supervised by physicians confirming that CRNAs provide safe, high-quality care.

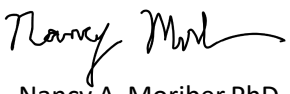
Certified Registered Nurse Anesthetists (CRNAs) are recognized as APRNs in the state of Connecticut and undergo extensive academic and clinical education. As reflected in our scope of practice review request, beginning on January 1, 2022, all accredited nurse anesthesia programs are full time, at least 36 months in duration, and offer a Doctor of Nursing Practice (DNP) or Doctor of Nurse Anesthesia Practice (DNAP) degree. The COA Curriculum Standards focus on the full scope of nurse anesthesia practice that includes both academic content and clinical experiences, as well as completion of scholarly work that demonstrates knowledge and scholarship within anesthesia practice. While the COA sets minimum requirements for eligibility to practice, the mean clinical hours for graduates across the country is 2,731.3± 329.6 and the mean number of clinical cases is 855 ± 141 which exceeds the requirements for clinical hour by 30% and the clinical cases by 40%. These statistics reflect the clinical requirements for the nurse anesthesia programs in CT.

The complex nature of anesthesia practice requires all healthcare providers to work collaboratively. Patients are best served when all providers can practice to the full extent of their academic and clinical education.

We look forward to discussing the merits of this proposal if the scope request moves forward to review.

Please feel free to let me know if you have any additional questions.

Sincerely,



Nancy A. Moriber PhD, CRNA, APRN, FAANA
President
Connecticut Association of Nurse Anesthesiology
Ctnurseanesthetists@gmail.com

September 29, 2023

Sara Montauti, MPH
Healthcare Quality and Safety Branch
Practitioner Licensing and Investigations
Department of Public Health
410 Capital Avenue, MS # 12HSR P.O. Box 340308
Hartford, CT 06134
Phone: (860) 509-7307
Email: sara.montauti@ct.gov

Via e-mail

Re: Impact Statement- Connecticut State Society of Anesthesiologists (CSSA)

Dear Ms. Montauti,

On behalf of the Connecticut Association of Nurse Anesthesiology (CTANA) I am responding to the impact statement received from the Connecticut State Society of Anesthesiologists (CSSA). In 2014, CTANA recused itself from consideration in the proposed statutory changes to APRN practice in the state. This decision was made by CTANA to support and advance the practice of all other APRN groups. The current scope of practice review request seeks to align CRNA practice with existing statutory provisions for other APRNs. This issue has never been evaluated in Connecticut prior to this request.

We look forward to discussing the merits of this proposal if this scope request moves forward for review.

Please feel free to let me know if you have any additional questions.

Sincerely,

Nancy A. Moriber PhD, CRNA, APRN, FAANA President
Connecticut Association of Nurse Anesthesiology
Ctnurseanesthetists@gmail.com

September 29, 2023

Sara Montauti, MPH
Healthcare Quality and Safety Branch
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410 Capital Avenue, MS # 12HSR P.O. Box 340308
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Phone: (860) 509-7307
Email: sara.montauti@ct.gov

Via e-mail

Re: Impact Statement- Joseph B. O'Connell, MD

Dear Ms. Montauti,

On behalf of the Connecticut Association of Nurse Anesthesiology (CTANA) I am responding to the impact statement received from Joseph B. O'Connell, MD. There is overwhelming evidence to demonstrate that CRNAs are highly educated, trained, and qualified anesthesia experts. They provide 50 million anesthetics per year in the United States, working in every setting in which anesthesia is delivered. CRNAs practice in accordance with their professional scope and standards of practice; federal, state, and local law; and facility policy to provide dental sedation and anesthesia services. They also deliver quality care to rural and other medically underserved areas, where they ensure access to anesthesia care to populations that would otherwise have to travel significant distances from their homes for treatment. In fact, they serve as the sole anesthesia care providers in these areas.

Restrictions on CRNA practice are not supported by evidence and are contrary to the national trend, which is toward allowing each practitioner to practice to the full extent of their academic and clinical education. Currently, 36 states and the District of Columbia have no language for supervision or direction requirements concerning nurse anesthetists in nurse practice acts, board of nursing rules/regulations, medical practice acts, board of medicine rules/regulations, or their generic equivalents. This national trend is further supported by the Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education, adopted in 2008 and endorsed by over 40 nursing organizations.

Once again, CRNAs provide safe, high quality, cost-effective anesthesia care. The excellent safety record of CRNAs is reflected in a landmark national study of 500,000 cases that was conducted by RTI International and published in the August 2010 issue of *Health Affairs*. This study demonstrated similar patient outcomes when anesthesia services are provided by CRNAs, physician anesthesiologists, or CRNAs supervised by physicians confirming that CRNAs provide safe, high-quality care. Additional

research shows no empirical evidence to support scope of practice laws that restrict CRNA practice, and a Cochrane Review found insufficient evidence to support any one anesthesia practice model. Links to these landmark studies can be found in the scope of practice review request submitted by CTANA.

We look forward to discussing the merits of this proposal if this scope request moves forward for review.

Please feel free to let me know if you have any additional questions.

Sincerely,

Nancy A. Moriber PhD, CRNA, APRN, FAANA
President
Connecticut Association of Nurse Anesthesiology
Ctnurseanesthetists@gmail.com

September 29, 2023

Sara Montauti, MPH
Healthcare Quality and Safety Branch
Practitioner Licensing and Investigations
Department of Public Health
410 Capital Avenue, MS # 12HSR P.O. Box 340308
Hartford, CT 06134
Phone: (860) 509-7307
Email: sara.montauti@ct.gov

Via e-mail

Re: Impact Statement- Connecticut Anesthesia Professionals

Dear Ms. Montauti,

On behalf of the Connecticut Association of Nurse Anesthesiology (CTANA) I am responding to the impact statement received from Connecticut Anesthesia Professionals (CAP). We would like to thank Mr. Bartels for taking the time to review CTANA's scope of practice review request. His support recognizes the safe, high-quality anesthesia services provided by CRNAs in Connecticut and reaffirms their importance to our health care delivery system. The removal of the requirement for physician direction has the potential to bring needed anesthesia providers to the state, which will further improve access to care for all Connecticut residents.

CTANA welcomes the participation of CAP if this scope request is selected for review.

Please feel free to let me know if you have any additional questions.

Sincerely,

Nancy A. Moriber PhD, CRNA, APRN, FAANA President
Connecticut Association of Nurse Anesthesiology
Ctnurseanesthetists@gmail.com

September 29, 2023

Sara Montauti, MPH
Healthcare Quality and Safety Branch
Practitioner Licensing and Investigations
Department of Public Health
410 Capital Avenue, MS # 12HSR P.O. Box 340308
Hartford, CT 06134
Phone: (860) 509-7307
Email: sara.montauti@ct.gov

Via e-mail

Re: Impact Statement- Connecticut Hospital Association

Dear Ms. Montauti,

On behalf of the Connecticut Association of Nurse Anesthesiology (CTANA) I am responding to the impact statement received from the Connecticut Hospital Association (CHA), which recognizes the necessity for conforming changes to state statutes regarding certifying and recertifying bodies for CRNAs. In addition, the CHA recognizes that CTANA's scope of practice review request would align CRNA practice in Connecticut with current statutes for all other advanced practice registered nurses (APRNs). These changes may require Connecticut hospitals to change policies, procedures, and credentialing. It has the potential increase access to anesthesia services while decreasing health care costs.

CTANA welcomes the participation of CHA if this scope request is selected for review.

Please feel free to let me know if you have any additional questions.

Sincerely,

Nancy A. Moriber PhD, CRNA, APRN, FAANA President
Connecticut Association of Nurse Anesthesiology Ctnurseanesthetists@gmail.com

September 29, 2023

Sara Montauti, MPH
Healthcare Quality and Safety Branch
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Hartford, CT 06134
Phone: (860) 509-7307
Email: sara.montauti@ct.gov

Via e-mail

Re: Impact Statement- Connecticut Nurses Association

Dear Ms. Montauti,

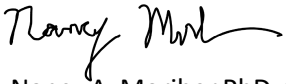
On behalf of the Connecticut Association of Nurse Anesthesiology (CTANA) I am responding to the impact statement received from the Connecticut Nurses Association (CNA). We would like to thank Ms. Sandor for taking the time to review and support CTANA's scope of practice review request. The CNA recognizes that CRNAs are advanced practice registered nurses (APRNs) that are currently restricted from practicing to the full extent of their academic education and clinical training. In addition, it understands the need to accurately reflect certifying organizations in state statutes.

CNA understands that education and training are essential for the provision of safe, high-quality care. Certified Registered Nurse Anesthetists (CRNAs) are recognized as APRNs in the state of Connecticut and undergo extensive academic education and clinical training. As reflected in our scope of practice review request, beginning on January 1, 2022, all accredited nurse anesthesia programs are full time, at least 36 months in duration, and offer a Doctor of Nursing Practice (DNP) or Doctor of Nurse Anesthesia Practice (DNAP) degree. The COA Curriculum Standards focus on the full scope of nurse anesthesia practice that includes both academic content and clinical experiences, as well as completion of scholarly work that demonstrates knowledge and scholarship within anesthesia practice. While the COA sets minimum requirements for eligibility to practice, the mean clinical hours for graduates across the country is 2,731.3± 329.6 and the mean number of clinical cases is 855 ± 141 which exceeds the requirements for clinical hour by 30% and the clinical cases by 40%. These statistics reflect the clinical requirements for the nurse anesthesia programs in Connecticut.

We welcome the participation of CNA if the scope request is selected for review.

Please feel free to let me know if you have any additional questions.

Sincerely,



Nancy A. Moriber PhD, CRNA, APRN, FAANA President
Connecticut Association of Nurse Anesthesiology
Ctnurseanesthetists@gmail.com

September 29, 2023

Sara Montauti, MPH
Healthcare Quality and Safety Branch
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410 Capital Avenue, MS # 12HSR P.O. Box 340308
Hartford, CT 06134
Phone: (860) 509-7307
Email: sara.montauti@ct.gov

Via e-mail

Re: Impact Statement the Connecticut Chapter of AORN

Dear Ms. Montauti,

On behalf of the Connecticut Association of Nurse Anesthesiology (CTANA) I am responding to the impact statement received from the Connecticut chapter of the Association of periOperative Registered Nurses (AORN). We would like to thank Ms. Eilers for taking the time to review and support CTANA's scope of practice review request. Aligning CRNAs with other advanced practice registered nurses is a crucial step for improving patient safety, care, and access to high-quality anesthesia services.

CTANA welcomes the participation of the Connecticut Chapter of AORN if this scope request is selected for review.

Please feel free to let me know if you have any additional questions.

Sincerely,

Nancy A. Moriber PhD, CRNA, APRN, FAANA President
Connecticut Association of Nurse Anesthesiology
Ctnurseanesthetists@gmail.com

September 29, 2023

Sara Montauti, MPH
Healthcare Quality and Safety Branch
Practitioner Licensing and Investigations
Department of Public Health
410 Capital Avenue, MS # 12HSR P.O. Box 340308
Hartford, CT 06134
Phone: (860) 509-7307
Email: sara.montauti@ct.gov

Via e-mail

Re: Impact Statement- Connecticut APRN Society

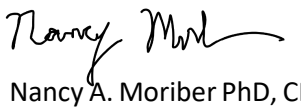
Dear Ms. Montauti,

On behalf of the Connecticut Association of Nurse Anesthesiology (CTANA) I am responding to the impact statement received from the Connecticut APRN Society. We would like to thank Dr. Mukon for taking the time to review CTANA's scope of practice review request. Her support recognizes the need to remove restrictions to nurse anesthesia practice, which will allow CRNAs to provide anesthesia services to the full extent of their academic education and clinical training. This will provide parity and align CRNA practice with current statutory provisions for other advanced practice registered nurses (APRNs) in Connecticut.

CTANA welcomes the participation of Connecticut APRN Society if this scope request is selected for review.

Please feel free to let me know if you have any additional questions.

Sincerely,



Nancy A. Moriber PhD, CRNA, APRN, FAANA President
Connecticut Association of Nurse Anesthesiology Ctnurseanesthetists@gmail.com

September 29, 2023

Sara Montauti, MPH
Healthcare Quality and Safety Branch
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410 Capital Avenue, MS # 12HSR P.O. Box 340308
Hartford, CT 06134
Phone: (860) 509-7307
Email: sara.montauti@ct.gov

Via e-mail

Re: Impact Statement- Northwest NP Group

Dear Ms. Montauti,

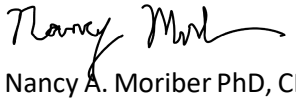
On behalf of the Connecticut Association of Nurse Anesthesiology (CTANA) I am responding to the impact statement received from Northwest NP Group. We would like to thank Dr. Rapsilber for taking the time to review CTANA's scope of practice review request. She recognizes that CRNAs are advanced practice registered nurses (APRNs) that are currently restricted from participation in the APRN Practice Authority.

As Dr. Rapsilber points out, education and training are essential for the provision of safe, high-quality care. Certified Registered Nurse Anesthetists (CRNAs) are recognized as APRNs in the state of Connecticut and undergo extensive academic education and clinical training. As reflected in our scope of practice review request, beginning on January 1, 2022, all accredited nurse anesthesia programs are full time, at least 36 months in duration, and offer a Doctor of Nursing Practice (DNP) or Doctor of Nurse Anesthesia Practice (DNAP) degree. The COA Curriculum Standards focus on the full scope of nurse anesthesia practice that includes both academic content and clinical experiences, as well as completion of scholarly work that demonstrates knowledge and scholarship within anesthesia practice. While the COA sets minimum requirements for eligibility to practice, the mean clinical hours for graduates across the country is 2,731.3$\pm$ 329.6 and the mean number of clinical cases is 855 $\pm$ 141 which exceeds the requirements for clinical hour by 30% and the clinical cases by 40%. These statistics reflect the clinical requirements for the nurse anesthesia programs in CT.

CTANA welcomes the participation of Dr. Rapsilber if this scope request is selected for review.

Please feel free to let me know if you have any additional questions.

Sincerely,



Nancy A. Moriber PhD, CRNA, APRN, FAANA President
Connecticut Association of Nurse Anesthesiology
Ctnurseanesthetists@gmail.com

APPENDIX G

ADDITIONAL INFORMATION

Connecticut State Society of Anesthesiologists
127 Washington Ave., East Bldg., LL, North Haven, CT 06473

Summary Statement Re: Proposed Certified Registered Nurse Anesthetist Scope of Practice Expansion

Below is an abbreviated summary of my previously submitted letter regarding potential expansion of nurse anesthetist scope of practice. Connecticut has a long history of safe and readily available anesthesia care. At this time, there is no good reason to deviate from this established standard of care. Any allowance of nurse anesthesia care:

I. **Will not increase access to care.** Eliminating the requirement for physician supervision of anesthesia does not increase the availability of anesthesia services. Further, our nursing colleagues have not presented any data that suggests there is an issue with access to anesthesia care in Connecticut. Simply put, there is no issue with access to care in our state, and even if there was, removing physicians from the equation would not remedy it.

II. **Needlessly jeopardizes patient safety.** Lowering the standard of care by permitting nurse-only anesthesia creates situations where critically ill patients do not have access to a physician. Many studies, which we have submitted, demonstrate a link between poor outcomes for patients and receive nurse-only anesthesia. The truth is that definitively studying this topic is impossible because it is unethical to expose patients to anesthesia without any physician presence.

III. **Will not decrease costs for patients, taxpayers, or hospitals.** Nurse-only care results in higher resource utilization (labs, imaging, physician consults, and increased length of stay) and more cases of unplanned hospital admissions. These dramatically increase healthcare costs. Further, nurse anesthetists bill CMS at the same rate as physicians. There are no healthcare savings with nurse-only anesthesia.

IV. **Is inconsistent with clinical practice in surrounding states.** Every single one of our neighboring states requires a physician to be present for the administration of anesthesia. If nurse-only anesthesia is permitted, our state will have the lowest standard of care in the region.

V. **Is a contravention of previous decisions by the state legislature regarding this issue.** The Connecticut General Assembly has previously examined this issue in 2007 and 2014 and upheld physician-led anesthesia care both times.

VI. **Is against the preferences of patients.** Patients do not want nurse-only anesthesia. In a survey, 91% of patients expressed that a physician's training is invaluable for the provision of their care.

I have deep respect for our nursing colleagues and appreciate the collaborative relationship we share in the delivery of high-quality anesthesia in the state of Connecticut. As discussed, there is no compelling reason to undermine the existing model for anesthesia care. My detailed response, including citations, is included in my previous letter (dated November 14th). Thank you for your consideration of this important topic. Should you have any questions, please contact me at GuzziMD@gmail.com.

Sincerely,

John Guzzi, MD
Member, Connecticut State Society of Anesthesiologists
December 12, 2023

Connecticut State Society of Anesthesiologists
127 Washington Ave., East Bldg., LL, North Haven, CT 06473

Chris Andresen
Section Chief
Practitioner Licensing & Investigations
Department of Public Health
State of Connecticut

December 13th, 2023

On December 11th, 2023, Nancy Moriber, on behalf of the CTANA, submitted a letter regarding any proposed expansion of nurse anesthetist scope of practice. This letter was distributed at the December 13th, 2023 scope of practice review committee meeting.

After reviewing this letter, I have many concerns regarding its content as well as the sources cited. For brevity, I will focus on three key issues contained in this letter.

I. The CTANA implies that recent obstetric unit closures in the state of Connecticut (Johnson Memorial Hospital and Windham Hospital) are related to anesthesia staffing. This is unfounded speculation with no element of truth. The sources cited by the CTANA note a "healthcare worker" shortage and at no point mention anesthesia care. The closure of these units is irrelevant to the discussion of Connecticut statute as it relates to anesthesia services.

II. Many of the "studies" cited by the CTANA are funded by their national parent organization (AANA). They are biased sources, lack in scientific rigor, and have a clear agenda.

    Further, many of these studies rely on a coding quirk known as "QZ billing" as a surrogate for "independent nursing care." QZ billing does not mean a supervising anesthesiologist is absent, and it certainly does not mean there is not a supervising physician present with the nurse anesthetist. Any study utilizing QZ billing is flawed, because in the vast majority of cases, an anesthesiologist is still present for that patient's care.

III. The CTANA claims that "there are 36 states plus the District of Columbia that have NO requirements for physician supervision or direction." This is a demonstrably false statement. Importantly, their reference for this statement is an AANA document on prescribing drugs. The ability to prescribe a drug is vastly different than the ability to administer anesthesia to a patient in an operating room. Moreover, the prescriptive authority document readily provides that the majority of states require physician involvement or limit the nurse's prescriptions.

They claim specifically that these "36 states plus the District of Columbia" allowing nurse-only anesthesia include Rhode Island, Massachusetts, New York, and New Jersey. If that is true, why was there failed legislation this year in the District of Columbia, New York, and New Jersey that would have reduced or relaxed physician oversight or involvement for nurse anesthetists? Here is the truth regarding the legally-defined relationship between nurse anesthestists and supervising physicians in each of our neighboring states:

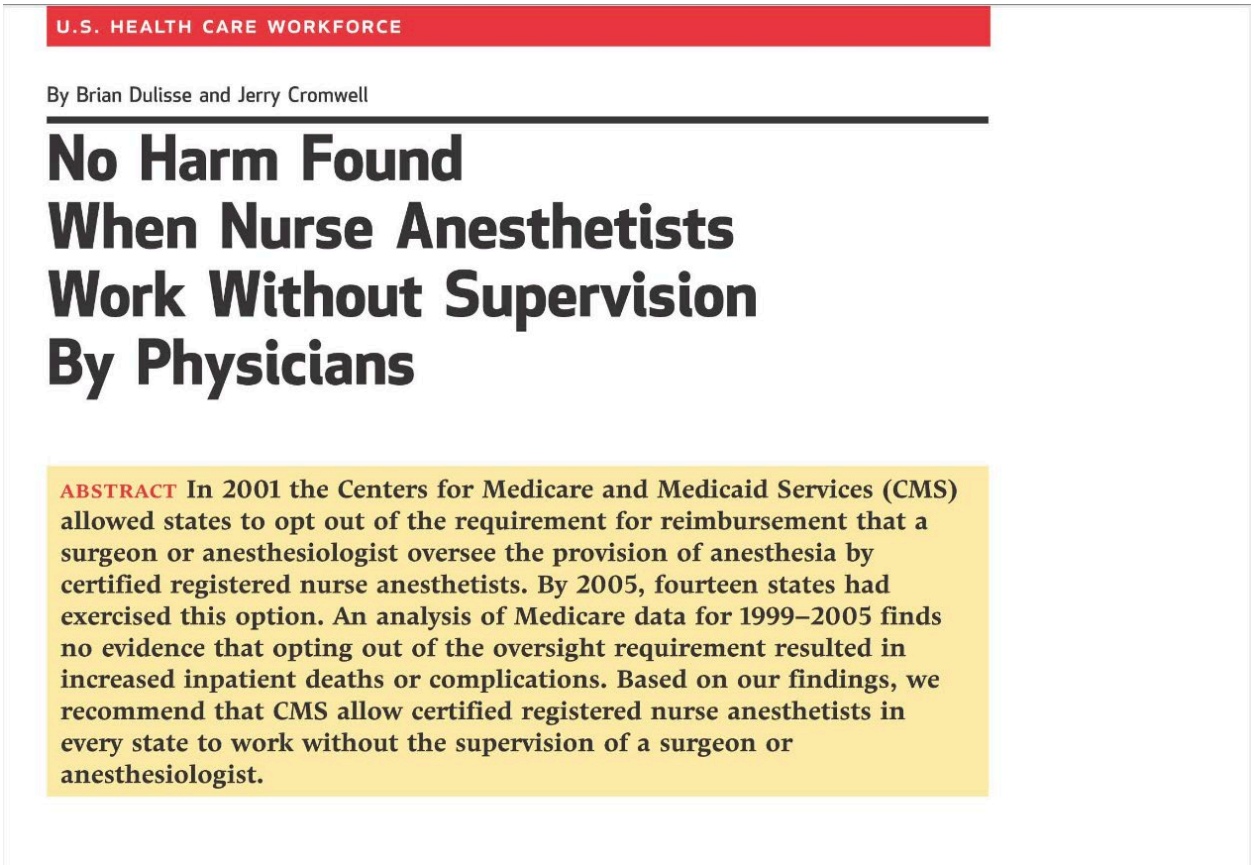
a. Rhode Island: Mandatory "collaboration with a physician"
b. Massachusetts: "Pursuant to guidelines mutually developed by nurse & supervising physician"
c. New York: "Under supervision of an anesthesiologist who is immediately available or under supervision of operating physician"
d. New Jersey: "Under supervision of anesthesiologist or privileged physician"

The CTANA's claim that independent, nurse-only anesthesia is permissible in 36 states plus the District of Columbia is patently false and based on a graphic related to presriptive authority, not the provision of anesthesia. As highlighted in just a few relevant states above, nurse-only anesthesia care would be illegal in the states they claim.

Thank you for your consideration of this important topic. If you have any questions, I am available at GuzziMD@gmail.com.

Sincerely,

John Guzzi, MD
Member, Connecticut State Society of Anesthesiologists



U.S. HEALTH CARE WORKFORCE

By Brian Dulisse and Jerry Cromwell

No Harm Found When Nurse Anesthetists Work Without Supervision By Physicians

ABSTRACT In 2001 the Centers for Medicare and Medicaid Services (CMS) allowed states to opt out of the requirement for reimbursement that a surgeon or anesthesiologist oversee the provision of anesthesia by certified registered nurse anesthetists. By 2005, fourteen states had exercised this option. An analysis of Medicare data for 1999–2005 finds no evidence that opting out of the oversight requirement resulted in increased inpatient deaths or complications. Based on our findings, we recommend that CMS allow certified registered nurse anesthetists in every state to work without the supervision of a surgeon or anesthesiologist.

The above study has been presented by CTANA as evidence that independent CRNA practice will be safe in Connecticut. The Cochrane Anesthesia Review Group analyzed this study in a paper titled ***Physician Anaesthetists versus Non-Physician Providers of Anesthesia for Surgical Patients*** (2014).

The Cochrane Collaboration is an international/independent, not-for-profit organization that aims to help people make well informed decisions about healthcare. The Cochrane Anesthesia Review Group is 1 of 51 review groups within the Cochrane Collaboration.

It is important to critically evaluate the presented information and not assume the title of the article is an appropriate representation of the actual data. Under the rigorous assessment sited above, the Cochrane Anesthesia Review Group found the study was considered to be at “high risk of bias” and “the quality and nature of the evidence to be insufficient to draw any conclusion.”

Finally, there are NO high quality, reliable studies that demonstrate the safety or benefit of independent CRNA practice.