

IANA Strives to Assure Illinoisans Access to Affordable Anesthesia Care

By Randall Moore, CRNA, MSN-President Elect and Government Relations Committee Chairman

The IANA Government Relations Committee (GRC) underwent an ambitious legislative agenda during the 2008 legislative session. By any objective measure, it was an impressive undertaking. House Bill 1014 was passed by the Illinois legislature and signed by Governor Quinn. This legislation included the expansion of the grandfathering period for CRNAs without a masters degree. This will help to alleviate a pressing CRNA shortage that continues to affect Illinois, particularly in the rural areas. Secondly, APNs were granted Schedule II Prescriptive Authority delegation. This component of the legislation is still pending federal regulatory (DEA) approval. There was a component of our legislative agenda that did fall short however, and that was SB 1600.

SB 1600 was a collaborative effort between the IANA and ISAPN to remove language referring to the Written Collaborative Agreement from the Nurse Practice Act (NPA). This bill was submitted on behalf of the IANA/ISAPN by Senator Heather Steans. The legislation was assigned to the Licensed Activities Committee (LAC) in the Illinois Senate. Lori Anderson eloquently testified, which testimony I will extensively use here, at a LAC hearing in support of the proposed legislation. Ultimately, it became obvious to the IANA and the ISAPN that we were a few votes short of having this bill voted out of the committee. Therefore, the IANA and ISAPN elected to have the legislation tabled to a subcommittee as it did not have the requisite number of votes to progress to the floor of the Senate.

I think it is important to reexamine this legislation and why the IANA decided to pursue the removal of the WCA and restrictive language pertaining to CRNA practice found within the Nurse Practice Act.

A Reality Check

This was not an attack on the practice of our physician colleagues. We fully recognize the contributions physician anesthesiologists have made to the science of anesthesiology and it is clear that they continue to serve a vital role in the delivery of anesthesia services. Unfortunately, some opponents of this legislation have taken the route of disinformation and fear mongering with respect to this legislative effort. The IANA was disappointed to learn that some of these opponents were both publicly and privately making accusations that were at best disingenuous. It has never been the IANA's intention to deleteriously affect anesthesiologist practice in the state of Illinois. The IANA understands that a majority of CRNAs in Illinois practice in the Anesthesia Care Team (ACT) setting, and this legislation would have no substantive affect on that practice arrangement. In other words, if you are employed in a setting that utilizes both CRNAs and anesthesiologists, you will not experience any disruption in that arrangement.

The Facts

You may then ask yourself, why is this legislation needed? There are two major reasons why the IANA has decided to pursue this legislation:

- Patient safety
- Improving access to high quality anesthesia care

It has become increasingly clear to the IANA that there remains a real problem in Illinois concerning patient access to affordable high quality anesthesia services. This obstacle takes the shape of overly restrictive language found within your Nurse Practice Act. Frequently, CRNAs are contacting the IANA office to report difficulties they are having when trying to adhere to NPA language that is unnecessarily onerous and which clearly interferes with their ability to take care of patients. For instance, the following statement can be found in the NPA and daily creates problems with the ability of many CRNAs in Illinois to safely and legally do their job.

“For anesthesia services, an anesthesiologist, physician, dentist, or podiatrist shall participate through discussion of and agreement with the anesthesia plan and shall remain physically present and be available on the premises during the delivery of anesthesia services for diagnosis, consultation, and treatment of emergency medical conditions”

We need to more closely examine why this is problematic for both CRNAs and their patients. The following bullets are excerpts of testimony presented by then President Lori Anderson before the Licensed Activities Committee.

- Illinois has experienced a decreased supply of CRNAs as practitioners seek states with less restrictive practice laws; with more than 50% of Illinois' CRNAs over the age of 50 and more than 18% over the age of 60, it is vitally important to be able to easily recruit CRNAs to our state.
- Facilities who employ CRNAs are experiencing difficulty during their accreditation surveys.
- Documentation requirements imposed to demonstrate compliance with the statutes have left some CRNAs without the ability to independently write orders for medications needed by their patients---such medications include those to reduce anxiety, pain, or nausea.
- While CRNAs were the first nursing specialty to be accorded direct reimbursement from Medicare, Illinois CRNA employers are having difficulty in obtaining insurance reimbursement for CRNA services---leading to lost revenue for those Illinois employers.
- These statutes have led to an inability to provide new services to patients which involve the administration of anesthesia and/or sedation. We have received numerous member communications about facilities seeking to employ CRNAs, who subsequently determine that they can not meet the requirements of the Illinois statutes and rules associated with CRNAs and then either: 1) abandon their plans for additional services due to the cost-prohibition of utilizing an anesthesiologist for the new service, or 2) try to perform the patient services without the benefit of a skilled anesthesia provider---in this case, the physician performing the surgery or procedure would attempt to concurrently sedate or anesthetize the patient. It is this type of situation that has led to recent patient deaths in dental office settings in Chicago.
- Patients are bearing the brunt of the emotional, physical, and financial cost of delays in surgery or provision of other anesthesia patient care and/or an inability to provide anesthesia services at all---When the designated “participating” anesthesiologist or physician is not both PRESENT AND AVAILABLE ON THE PREMISES, under the law, the CRNA cannot provide services. The patient may have to wait in the pre-op holding area, in the operating room (where charges

accrue by the minute), or may potentially have their procedure canceled entirely. Such delays or inability to provide care may include relief of a patient's anxiety, relief of pain (including labor epidurals for obstetrical patients), resuscitation of critically ill or injured patients, and institution of anesthesia for emergency surgery. The CRNA who strives to meet the needs of his/her patients, especially in the context of a life-threatening emergency, is often put in the position of violating their practice act and institutional bylaws or policies. This lack of physician availability is most acute in Illinois' small and rural hospitals.

- We are experiencing inefficient utilization of anesthesia personnel- Physicians designated to provide oversight of CRNAs are prevented from providing concurrent care to their own set of patients, thus increasing overhead costs. At any given facility, it is not unusual to have more than one anesthesiologist being paid who is not providing anesthesia to patients.
- CRNAs who own their own practice must often hire or pay for the services of an anesthesiologist or other physician (including the physician's malpractice insurance), in order to provide the mandated physician oversight—these costs are all ultimately born by the healthcare consumer.
- Surgeons who recognize they are not anesthesia experts have voiced concern about the increased professional liability for their role as mandated by this statute, patients have had their scheduled surgery unexpectedly canceled---this very unfortunate situation results in financial costs to the patient for preoperative testing and lost time from work.

The Science

As advanced practice nurses and clinicians we guide our practice and professional behavior based on scientific principles. We make decisions in the operating room based on an empirical and scientific foundation. This is as it should be. I find following quote by the highly respected anesthesiologist, **R.K. Stoelting, MD**, particularly enlightening. Dr. Stoelting wrote the following in the December 1996 issue of the journal *Anesthesia and Analgesia*:

"The participation of certified registered nurse anesthetists (CRNAs) in delivery of anesthesia care would have ceased many years ago if there was evidence that this participation resulted in a less favorable outcome compared with anesthesia personally administered by an anesthesiologist....."

Any objective analysis of the research would demonstrate that the language in question is unnecessarily onerous and has no real scientific justification. There is absolutely no evidence that CRNAs practicing independently increase either morbidity or mortality. There is an overwhelming amount of evidence however, that CRNA practice is exceedingly safe and efficacious.

In Summary

The purpose of healthcare legislation and regulations are to protect the patient. We as anesthesia professionals have no higher ethical and legal obligation than to ensure our patients are receiving the highest quality of anesthesia care. Unfortunately, what we find here in Illinois is that CRNAs are time and again presented with regulatory obstacles that all too often jeopardize our ability to fulfill this obligatory duty. This is particularly problematic in the rural areas where hospitals and clinics have

considerable difficulty attracting physicians due to undesirable geography and financial disparities. Fortunately, CRNAs have been willing and capable of filling these anesthesia department positions despite the almost daily struggle with onerous regulatory hurdles.