Connecticut Association of Nurse Anesthesiology
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August 11, 2023

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*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,

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President
Connecticut Association of Nurse Anesthesiology
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# 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.[22]

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

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[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

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[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

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[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.

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[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$\pm$ 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%.[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]

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[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,

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[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/

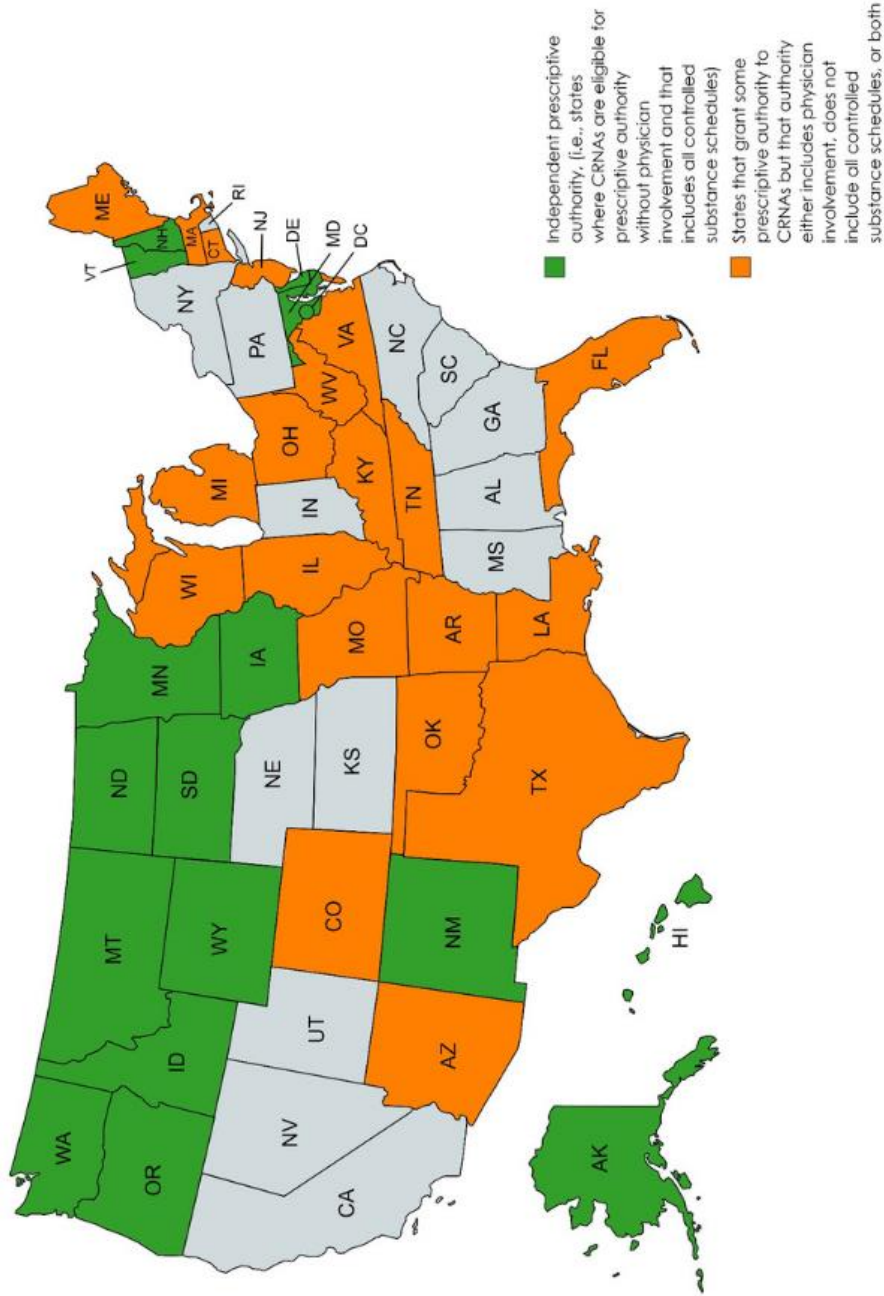
**Conclusion**

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.

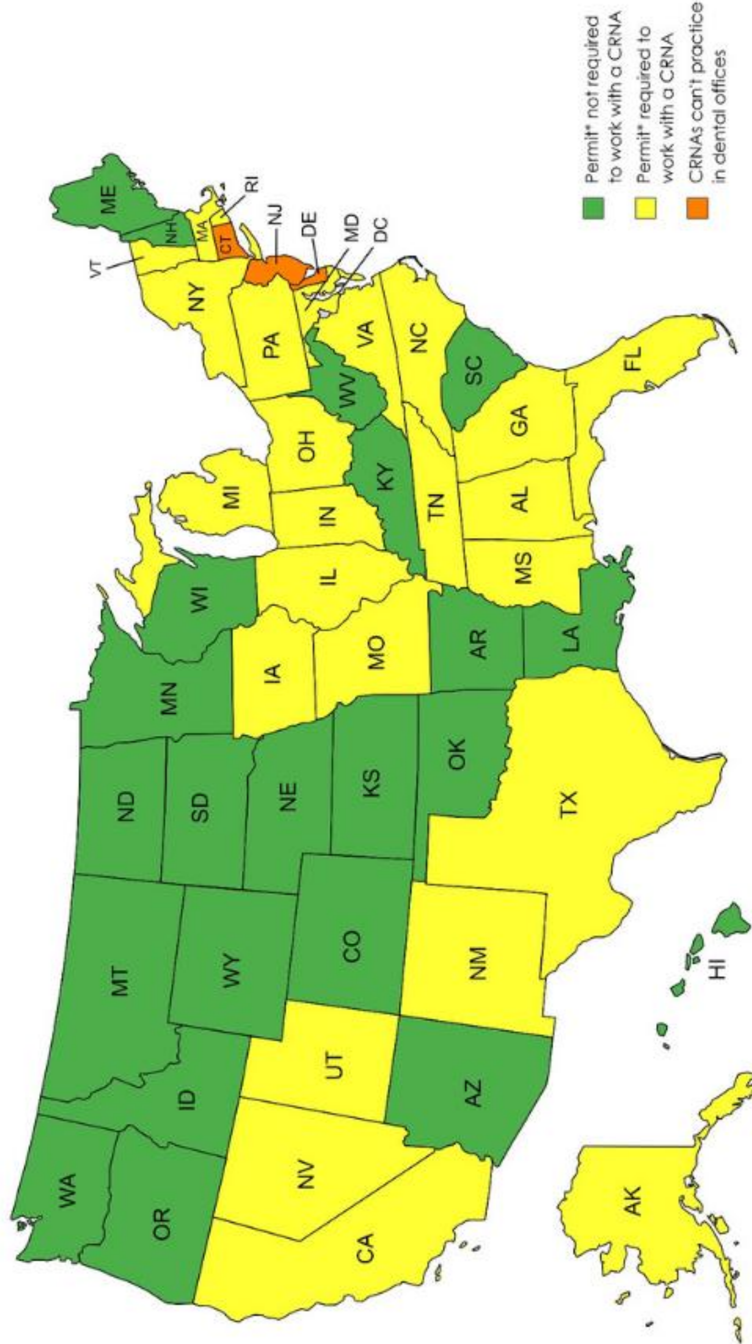
Exhibit A- Prescriptive Authority Map




Created with mapchart.net

Source: AANA State Government Affairs Division

Exhibit B-Dental Permit Map




***Dentist administration permit** status; does not concern facility permits

Virginia: Permit required for deep sedation/general anesthesia only

Created with mapchart.net

Source: AANA State Government Affairs Division

Exhibit C-CRNA Opt Out Map