TESTIMONY OF

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Thank you, Chairman Mustio, Chairman Readshaw, and members of the committee for the opportunity to provide testimony regarding House Bill 789, which my colleagues, many surgeons, facility administrators, and I oppose. My name is Pamela Wrobleski and I have been a practicing board-certified Certified Registered Nurse Anesthetist (CRNA) since 1983. As a summary of my background, I have safely administered anesthesia in many settings to thousands of patients throughout the past 35 years including major teaching institutions, community hospitals, ambulatory surgery centers, and medical and dental offices. I have also been involved in the start-up and business and administrative aspects of several multi-specialty, free-standing ambulatory surgery centers, and consulted to various hospitals in our state throughout my career. I am an adjunct faculty member, guest lecturer, and clinical coordinator for three doctoral level nurse anesthesia programs as well as for a university-affiliated sedation certification review course for dentists. I received an appointment as the State Reimbursement Specialist for the Pennsylvania Association of Nurse Anesthetists four years ago. Since 1996, I have been the owner of BPW Medical Associates, which is a professional anesthesia corporation that I started with my late husband, who was also a CRNA. I guess the practice of anesthesia runs in our blood, as my son is a recent graduate from the University of Pittsburgh's Nurse Anesthesia Program, employed at a trauma hospital in Pittsburgh, and my daughter recently graduated from the University of North Texas medical school and is completing her first year of internship in Houston at the University of Texas Medical Center, where she will begin her anesthesia residency program in July.

I am here to confirm that the requirement for physician supervision of CRNAs that is proposed in House Bill 789 is obsolete. By law, as nurses, CRNA practice has always been and should continue to be controlled by the Pennsylvania State Board of Nursing, as it is set forth in Pa. Code Section 21.17 of the Nurse Practice Act, which states that "the administration of anesthesia is a proper function of a registered nurse and is regulated by this section … and the CRNA is authorized to administer anesthesia in cooperation with a surgeon or dentist." In this

code, it further states that "cooperation" means a process in which the nurse anesthetist and the surgeon work together with each contributing an area of expertise, at their individual and respective levels of education and training." This cooperative arrangement is significant because the surgeon is not overseeing or controlling the functions of the nurse anesthetist, who is responsible for his/her own actions, the same as when working with an anesthesiologist or other medical specialist. H.B. 789, by requiring physician supervision through physicians' Medical Practice Act (whose jurisdiction is medical doctors and not nurses), would then add an additional liability concern to the physician who is currently required to "supervise" the CRNA, without that physician having expertise in the administration of anesthesia.

In many states, anesthesia staffing models are at the discretion of the health-care facility through their bylaws and their credentialing policies and procedures. The facilities then grant specific practice privileges to professionals who demonstrate appropriate education and training in their specialties, in accordance with the various existing rules, regulations, and standards that the facilities must follow. H.B. 789 would require additional physician supervision for all CRNA practice is bad policy and will add another bureaucratic layer to the current outdated regulation applicable to CRNAs, which does not even reflect current clinical practice.

My anesthesia staffing company currently contracts with five multi-specialty surgery centers, a community hospital, and urology and dental offices to provide all anesthesia services in those facilities for more than 10,000 patients per year, consistently for more than 10 years. These facilities are located within a 100-mile radius around Pittsburgh, mainly in suburban and rural areas. We employ more than 30 CRNAs as well as several part-time physician anesthesiologists to provide anesthesia care to these facilities and their patients. It is up to the facility to work with us to determine the type of anesthesia model that works best for their patients and surgeons. **In 2017, more than 75 percent of the total cases performed by our practice at our facilities were performed by CRNAs working independently, in cooperation with the operating surgeon, with no anesthesiologist present.** Each facility monitors all patient care through their quality improvement program and is required to report any serious events to the Pennsylvania Patient Safety Reporting System (PSERS). Our outcomes have been comparable to what has been reported on a national level, with no difference when a physician anesthesiologist has been involved in the anesthesia care or not. At all health-care facilities, CRNAs, surgeons, anesthesiologists, and other physicians regularly consult with medical experts in other fields (such as in cardiology, internal medicine, etc.) to work together to plan the best course of action for their patients. Throughout the past 22 years, my group has been asked to provide anesthesia using this staffing model for facilities, especially in those in rural areas due to our consistent safety record and cost-effective model. Because our company functions using mainly a CRNA model, working in cooperation with the operating surgeon or dentist, we are then able to provide 2 to 2.5 CRNAs at the same cost of one physician anesthesiologist. This helps to increase the efficiency and availability of anesthesia providers to the facility --- without compromising quality outcomes --- all of which is critical to maintain safety in the case of an unexpected event during or after a procedure, and provide on-call coverage for emergency services.

For example, at one community hospital that had previously employed only an anesthesia care team model, the hospital requested proposals from several anesthesia staffing groups, and they decided to utilize our all-CRNA model. The hospital administrator, operating room manager, and Board of Directors were seeking to increase the available services of the hospital by recruiting additional surgeons while maintaining patient safety, which required 24-hour anesthesia coverage for emergencies. We have been able to achieve these objectives over the past year by having an additional CRNA available during the day, which allows adding additional surgeries to the schedule, as needed, while reducing overall costs to the hospital, which was not possible using the previous anesthesia model in the past. Our CRNAs skillfully added regional nerve block services for post-op pain management, which reduces the use of opioids at this facility. Two other surgery centers also changed their practice model from physician anesthesiologist-only to a CRNA-only model. In these facilities, an anesthesiologist works with our group on an occasional basis when a patient requests this provider or to fill in for the full-time CRNA. Again, the surgeons report high-quality outcome data with both types of providers, without safety concerns, and add that the provider credential is indistinguishable in the clinical area.

CRNAs decrease the total cost of health care. CMS reimburses for anesthesia services at the same rate no matter which provider personally provides the anesthesia service. This reimbursement model recognizes the same high-quality anesthesia care provided by both anesthesiologists and CRNAs working alone or in a care team model. Physician anesthesiologist salaries are approximately 2.5 times that of CRNAs based on national averages. When CRNAs are employed by a hospital, the differential in salaries is used by the facility to offset the other costs incurred by hospitals to provide care, such as 24-hour on-call emergency services, including obstetrics, code response teams, on-call staff to provide emergency procedures and surgeries. This is especially significant in rural areas of Pennsylvania. Our state has 15 Critical Access Hospitals that provide 24-hour emergency care and in most cases, another facility is over 35 miles away. CRNAs provide comprehensive anesthesia care independent of a physician anesthesiologist in seven of these 15 hospitals. The residents of Pennsylvania in rural areas depend on the access to cost-effective, high-quality care that CRNAs provide. This proposed legislation for CRNA supervision is unnecessary and is not in the best interest of all residents in Pennsylvania. Pennsylvania needs CRNAs and physicians to practice to their full scope of education and training to care for all PA patients.

There is a well-documented need in Pennsylvania and across the country for more physicians and CRNAs in the field of anesthesia, both working to the fullest extent of their education and training, particularly as the baby boom generation ages. I would not have advised either of my children to take these career paths if that was not the case. Respect for the knowledge and competencies of each other and a willingness to work together in cooperation will improve access to quality care for all patients without any need for additional laws.

I am happy to answer any questions or clarify any information for members of the committee. Thank you again for your consideration.