SENATOR DENNIS G. RODRIGUEZ, JR.

December 9 2014

Honorable Judith T. Won Pat, Ed.D.
Speaker
I Mina'Trentai Dos Na Liheslaturan Guåhan
155 Hesler Place
Hagåtña, Guam 96910

VIA: The Honorable Rory J. Respicio
Chairperson, Committee on Rules

RE: Committee Report – Bill No. 381-32 (COR), as Substituted.

Dear Speaker Won Pat:

Transmitted herewith, for your consideration, is the **Bill 381-32 (COR)- An act to establish the Anesthesiologist Assistants Act by adding a new Article 25 to Chapter 12, Part 2, Title 10, Guam Code Annotated. Introduced by Sen. Dennis G. Rodriguez, Jr.**, and referred to the Committee on Health & Human Services, Health Insurance Reform, Economic Development and Senior Citizens. Bill No. 381-32 (COR), as introduced, was publicly heard on September 10, 2014.

Committee votes are as follows:

__4__ **TO PASS**
_____ **NOT TO PASS**
_____ **ABSTAIN**
_____ **TO REPORT OUT ONLY**
_____ **TO PLACE IN INACTIVE FILE**

2014 DEC 11 PM 3:43

Senseramente,

Senator Dennis G. Rodriguez, Jr.
Chairman

Attachments

Chairman, Committee on Health & Human Services, Health Insurance Reform, Economic Development, & Senior Citizens
Ufisinan Todu Guam • I Mina' Trenta Dos Na Liheslaturan Guåhan • 32nd Guam Legislature
176 Serenu Avenue, Suite 107, Tamuning, Guam 96931 / Telephone: 671-649-TODU (8638) / Facsimile: 671-649-0520
E-mail: senatordrodriguez@gmail.com / www.toduguam.com

COMMITTEE REPORT
ON
BILL NO. 381-32 (COR)
As Substituted

Sponsored by Senator Dennis G. Rodriguez, Jr.

An act to establish the Anesthesiologist Assistants Act by adding a new Article 25 to Chapter 12, Part 2, Title 10, Guam Code Annotated.

SENATOR DENNIS G. RODRIGUEZ, JR.

December 9 2014

MEMORANDUM

To: **ALL MEMBERS**
Committee on Health & Human Services, Health Insurance Reform, Economic Development and Senior Citizens.

From: **Senator Dennis G. Rodriguez, Jr.**
Committee Chairperson

Subject: **Committee Report on Bill no. 381-32 (COR), as Substituted.**

Transmitted herewith, for your consideration, is the **Committee Report Bill 381-32 (COR)- An act to establish the Anesthesiologist Assistants Act by adding a new Article 25 to Chapter 12, Part 2, Title 10, Guam Code Annotated. Introduced by Sen. Dennis G. Rodriguez, Jr.** This report includes the following:

- Committee Voting Sheet
- Committee Report Narrative/Digest
- Copy of Bill No. 381-32 (COR)
- Copy of Substitute Bill No. 381-32 (COR)
- Public Hearing Sign-in Sheet
- Copies of Submitted Testimony and Supporting Documents
- Copy of COR Referral of Bill No. 381-32 (COR)
- Notices of Public Hearing (1st and 2nd)
- Copy of the Public Hearing Agenda
- Related News Articles (Public hearing publication of public notice)

Please take the appropriate action on the attached voting sheet. Your attention to this matter is greatly appreciated. Should you have any questions or concerns, please do not hesitate to contact me.

Si Yu'os Ma'åse'!

Attachments

Chairman, Committee on Health & Human Services, Health Insurance Reform, Economic Development, & Senior Citizens
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SENATOR DENNIS G. RODRIGUEZ, JR.

Substitute Bill 381-32 (COR)- An act to establish the Anesthesiologist Assistants Act by adding a new Article 25 to Chapter 12, Part 2, Title 10, Guam Code Annotated.
Introduced by Sen. Dennis G. Rodriguez, Jr.

	SIGNATURE	TO PASS	NOT TO PASS	ABSTAIN	REPORT OUT ONLY	PLACE IN INACTIVE FILE
DENNIS G. RODRIGUEZ, Jr. Chairman						
V. ANTHONY ADA Vice Chairman						
JUDITH T. WON PAT, Ed.D. Speaker (Ex-officio)						
BENJAMIN J. F. CRUZ Vice-Speaker						
TINA ROSE MUNA-BARNES Legislative Secretary						
FRANK B. AGUON, Jr.	12/9/14					
RORY J. RESPICIO						
ALINE A. YAMASHITA, Ph.D.						
THOMAS MORRISON						
MICHAEL LIMTIACO						
BRANT T. MCCREADIE						
CHRISTOPHER M. DUENAS						

Chairman, Committee on Health & Human Services, Health Insurance Reform, Economic Development, & Senior Citizens
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SENATOR DENNIS G. RODRIGUEZ, JR.

COMMITTEE REPORT DIGEST

Bill No. 381-32 (COR)

I. **OVERVIEW: The Committee on Health & Human Services, Health Insurance Reform, Economic Development and Senior Citizens conducted a public hearing on September 10, 2014.** The hearing convened at 2pm in I Liheslatura's Public Hearing Room. Among the items on the agenda was the consideration **Bill 381-32 (COR)- An act to establish the Anesthesiologist Assistants Act by adding a new Article 25 to Chapter 12, Part 2, Title 10, Guam Code Annotated. Introduced by Sen. Dennis G. Rodriguez, Jr.**

II. **Public Notice Requirements**

Notices were disseminated via hand-delivery/fax and/or email to all senators and all main media broadcasting outlets on September 3, 2014 (5-day notice), and again on September 8, 2014 (48-hour notice).

Senators Present

Senator Dennis G. Rodriguez, Jr.	Chairman
Senator V. Anthony Ada	Vice Chairman
Senator Brant McCreadie	Member
Senator Aline A. Yamashita, Ph.D.	Member
Senator Michael FQ San Nicolas	

The public hearing on agenda item Bill No. 381-32 (COR) was called to order at 2:01pm.

II. SUMMARY OF TESTIMONY & DISCUSSION.

Chairman Rodriguez: I would like to call up Dr. Renal Lim, Dr. Harassem, Melissa Waibel and Merium. Thank you very much for being here and as the sponsor of the measure just a brief description about what this legislation is about.

Bill 381 is an act to establish the anesthesiologist assistant act by adding a new article 25 to chapter 12 part 2 title 10 GCA; what this bill the intent of this legislation is to establish the practice of anesthesiologist assistant act and to designate the Guam board of medical examiners as the governing body which shall have full regulatory purview and administrative authority over the licensure and conduct of anesthesiologist assistant and so this is something that I work with Dr. Lim and other anesthesiologist over at the Guam Memorial Hospital and I'm happy that Melissa from the Guam Surgery Center is here who the other anesthesiologists serves at.

This is sometime late last year that we looked into this, got information, tried put it together what this does is provide the authority the board of medical examiners to put together a regulations to allow for anesthesiologist assistants who are not doctors but trained who are educated to be able to

be assistants of these anesthesiologists. We'll have Dr. Lim who is the chief anesthesiologists of the hospital explain a little bit more and from there we'll have the others provide the testimony. Okay Dr. Lim.

Dr. Lim: Good afternoon Senators, My name is Dr. Lim. I am the Chair of the Department of Anesthesia of GMH. The department actually did approached Senator Rodriguez to come up with a bill defining the role of anesthesiologist's assistants. Now, just as he mentioned, these are not physicians but what we call physician extenders or mid level practitioners. The education background of these anesthesiologists assistants I would say a master level education and they undergo physical training for the delivery of anesthesia. It is similar to physicians assistant basically in the same similar end.

I would say just like the CNRAs, they are also mid level anesthesia care. The anesthesiologist assistants are required to be under the direction of the anesthesiologist, so we are responsible for them. For me it also gives an option to Guam should we have problems and we did have some problem with some anesthesia providers way back that we are able not to stop any services critical, surgical services that is critical to the people of Guam. Thank you.

Chairman Rodriguez: Great. Doc just before we go forward I think you touched up on the fact that there is a shortage of anesthesiologist on Guam and I think even to an extent today it is not in the level of the support demand of surgery and so, maybe you can talk a little bit about that and about how these anesthesiologist assistants would work if it is something approved and how the physician, anesthesiologists MD like yourself would put their license on the line to have these assistance under you.

Dr. Lim: So basically we have these anesthesiologist assistant in a room with a patient and so is the MD, the anesthesiologist and depending on state to state the direction, the ratio, they do have on what we are allowed the anesthesiologist are allowed to direct ranges from one is to two, one is to three, one is to four.

I think us a body then we will have these settle, there's two anesthesiologist assistants, two in both rooms and the doctor the anesthesiologist will be the one responsible, will be with them when they provide the medication the critical moment when they provide the anesthetic care and us being responsible, we have direct oversight on what how the anesthesiologist assistants manage the patient and what drugs to give and what the anesthetic plan to give in the best safety for the patient.
Chairman Rodriguez: Thank you very much doctor Melissa?

Melissa Waibel: Can you hear me okay. I am actually coming out in opposition of having anesthesiologist assistance on Guam. It's a lower level of care. It's true that they are a mastered prepared individual but they don't have to have a medical background before they go into that to get their masters, so their bachelor's could be in English and then they can go into the practice of anesthesia so they got a lower level of knowledge then was the CRNAs have to go through in order to become an anesthesia provider so I don't know why we would want to go backwards. We can at the surgery center we also utilize anesthesia to take care of our patients. I have a medical director that is an anesthesiologist who provides the overall safety for the treatment plans for all of patients,

even patients that are being monitored by nurse anesthetists and there are times when we have difficulties on having providers we got available, but I have never had an instance where I cannot get a provider who is already licensed on Guam to work or is at the same level that currently exists in the law in other words an MD or a CRNA.

I never had trouble getting either one of those to fill positions at the surgery center go to another provider. For me and for other nurses, I've talked with my other nurses as well, we believe for this to be a lower standard of care compared to CRNA, CRNAs are a lower standard of care to MD. There's a lot of knowledge and training that needs to go to a patient not just an anesthesia itself but their medical background and what is going on as a whole with that patient as you're giving them medications. As far as the surgery center's concern, we would never hire an anesthesia assistant whether they are legally license on this island or not.

Chairman Rodriguez: Thank you very much Melissa for that. I think you made a statement earlier that all they needed was an English degree. That is the initial concerns that were brought up by the committee, but then we were provided facts on what is really required and I think Dr. Lim afterwards give him the opportunity to just respond to that. Thank you, doc?

Dr. Harassem: I'm Dr. Harassem. I am an anesthesiologist at the Guam Memorial Hospital, so I would like to say that the perception that it is a lower level of care is completely incorrect. In the American Society of Anesthesiologist recognizes that the training of both anesthesiologist assistants and CRNAs and anesthesiologists prepares them all to adequately deliver anesthesia in a safe manner.

The American College of Obstetricians and Gynecologists as well and in a joint statement with the NSA, they feel that anyone who has gone through a qualified anesthesiologist training program and is licensed and privileged to deliver anesthesia meets the qualifications of being an adequate provider whether they are an AA, CRNA, or anesthesiologists and that statement also in fact does point out that they feel that anytime anesthesia is being delivered be of physician should be physically present and available at all times, so whether it is a AA or CRNA involved in the care they still feel a physician should always be present.

The training for AA was looked into various states. The Kentucky legislature looked at numerous studies and it was determined that the training was equivalent to the CRNA and that any prior clinical training as required did not affect the overall outcome it may have provided a slight advantage at the beginning of training but in the end, there is no difference and they also found that the requirements for AA's to enter the programs are the same requirements needed to enter medical school and all the premed requirements and that is indeed an advantage and prepared the AAs and deliver a better endow training outcome and that is probably due to that type of training the classes that are required biochemistry, organic chemistry, physics, training the mind to deal with situations, so there is no studies that have validated this idea that there is a lower level of care or training and AAs and that it is an opposite and that they're equivalent to CRNAs and delivering anesthesia and there has been a shortage of an anesthesia providers in the past.

I would say 5-6 years ago there was only one single solitary provider at GMH and then for a while there were only 2 and the operating room had to be shut down completely for anything except emergency cases. It was very recently in the past that there was an adequacy of providers and even at the hospital now we have 6 full time anesthesiologists and 1 part time anesthesiologist and we're just at the minimum to provide care.

If we're all involved in a case and there is an emergency, there is nothing that can be done and so this model of supervision and you have two people involved in the care, provides the safest anesthesia it's called the anesthesia care team and the reason that it is the safest is because you have two people if one person with a patient at all times intermittently, if a problem ever happens when one patient we have a second person we can call on that supposedly is supposed to be readily available and that person is trained in providing anesthesia care, now you have two people available.

What we have at GMH now is that if we are all busy and we have an emergency we have no one to call for help and also this model increases efficiency because you have someone free to float around the next case can be seen by the anesthesiologist prepared for the evaluation that can be done or additional testing can be completed in a more timely manner so that they're ready to go into the OR immediately instead of large delays. It also provides more safety because someone who is available to address the problems that may occur in the recovering unit again right now dealing with patients in the rooms and something happens in recovery and no one is available and if there was an airway emergency where someone has trouble breathing and we're all busy in the room, we're not available this model is the safest model of all and it doesn't really matter whether it is an AA or CRNA being supervised, it is the anesthesia care team to take care of the patient.

Chairman Rodriguez: Thank you, doc, could you explain doc, the difference between the CRNA and the anesthesiologist assistant.

Dr. Harassem: The CRNA is a nurse who undergoes training to become an RN and that could be through a 4 year bachelors program or 2 years associate program and then the CRNA programs usually require 1-2 years of intensive care work experience and then there anesthesia training is around 24 months sometimes longer.

Anesthesiologist undergoes four years of undergraduate, which is weighted in the sciences pre-med requirements and then attends 4 years of medical school and then undergoes anesthesiologist training program which the first year is internal medicine which is surgical training sometimes basic doctor training and then 3 years specialized anesthesiologist training and then AA undergoes the premed requirements and then similar to a CRNA, 24 months of specific anesthesiologist training and then they are required to take an exam afterwards that demonstrates they have the knowledge to provide anesthesia. There is another difference between AAs and CRNAs, CRNAs when they take their examination making them a certified registered nurse anesthetists they never take any other exam again, as for AAs, they are required to certify their knowledge every six years.

Chairman Rodriguez: In the delivery of care, CRNAs are able to do it on their own right?

Dr. Harassem: It depends on the state actually some states by law don't ask CRNAs to practice independently. Other states started about 10 years ago it was an insurance issue that they couldn't get reimbursed by Medicare if they were working unsupervised and then under Bill Clinton, the law was changed if the governor felt that it is the best interest of the state, the main argument was due to the lack of care in rural areas, they could opt out of this requirement and Medicare could reimburse CRNAs if they work independently then there's 17 states that have opted out. There's independence CRNA practice on Guam is one of them.

This opt out doesn't really have to do with anything whether the law allows them to or not. The opt out prevented most of them from working independently, they would be working for free basically, so it's mostly whether the state allows them or not. In Guam, CRNAs are allowed to work independently as far as AAs nowhere can they work independently that is part of the entire model they are mandated to be supervised by physicians

Chairman Rodriguez: Okay, is that all Doug?

Dr. Harassem: There is one more thing I would like to add. I don't think there is any reason for any other surgical sites to have any fear of this bill and it won't hurt them take away their current model if anything it has to their abilities to utilize another avenue that may or may not be less expensive and that is the intent of the bill is to give the people of Guam more options so that they are not pushed into the situation as they have before where there only a couple of options available for anesthesia delivery.

Chairman Rodriguez: Can you just press that button so you can go off. Thank you. Dr. Lim, did you have anything to say?

Dr. Lim: Thank you. Also, I would like to add we provided also position papers from the American Society of Anesthesiologists overall body society for anesthesiologists. What they recommend basically is what we call ACT care team and it doesn't matter whether it is a CRNA or an AA and we already know the base on what Dr. Harassem said.

They are as equivalent; the main thing about the anesthesia care team is that the Dr., the anesthesiologist Is basically responsible for these meat level providers whether they are CRNAs or AAs and being the overall responsibility falling on us, the anesthesiologist, actually we are not allowed to do any other case what Melisa was saying they have CRNAs doing one room, they also have an anesthesiologist providing care to another patient;the Anesthesia care team prevents us from doing another case. We need to be free because we're supervising these meat level providers; we're not tied up providing anesthesia in another room. I think this is the best way of delivering care.

Chairman Rodriguez: I'll open the, if there is any questions. Senator Ada?

Senator Tom Ada: The only thing I'm really familiar with about assistance with the room is the physician's assistant. Is the AA can you equate the two equivalents?

Dr. Harassem: Yes I would say very similar that it is a physician extender; it is a medical provider who is not allowed to work on their own. Their decisions are based on either pre existing protocol or direct delegation of this is how you're going to do it and there's the constant in the case of anesthesia there is a constant present of anesthesiologist.

PAs depends on what they're doing, if they are a surgical PA, same thing, there is a direct oversight, office PA maybe less, mid low providers Pas-- midwives depending on how they're used. There are always. The person who is responsible is the physician, they make the final decision, and they are the ones in ultimate responsibility, so it is very similar to a PA who specializes in anesthesia delivery. One difference though in the utilization is that the AAs with this bill would be directly under the board of medicine rather than with allied health which we think was a better idea provides much better oversight.

Chairman Rodriguez: Melissa did you have something to add?

Melissa Wybel: I just have a question. Does the hospital now employ CRNAs?

Dr. Harassem: No.

Chairman Rodriguez: No, I don't believe so. Do they Dr. Lim?

Melissa Wybel: So we're looking at moving a bill to add a provider to island when we're not actually using the providers that are available. Is that what I'm hearing?

Dr. Harassem: We're looking to providing a system, an alternative system, an additional system.
Chairman Rodriguez: You know what we'll do? We are going to have a markup meeting on this bill before it is reported out. We'll take the testimonies. Thank you Senators for joining us and if there is a there is nothing else to add we did receive your written testimony we'll make sure the senators receive the packet that you have provided as well, fact sheet, position sheet on the AAs and we will schedule a markup meeting at my office and we will invite Melissa and all others who wish to participate before moving forward and that is my commitment. Okay? If there is nothing else, thank you very much for your time.

There being no other testimony, or comments by Senators, Chairman Rodriguez declared the bill as having been heard, and concluded the public hearing on Bill No. 381-32 (COR).

Fiscal Note: Request dated July 17, 2014, attached.

III. FINDINGS AND RECOMMENDATIONS

Bill was amended reducing the ratio of supervision allowed by an anesthesiologist over anesthesiologist assistants during procedures from 1:3 to 1:2.

The Committee on Health & Human Services, Health Insurance Reform, Economic Development and Senior Citizens, hereby **reports out Bill No. 381-32 (COR), as Substituted,** with the recommendation to Report out Only.

MINA'TRENTAI DOS NA LIHESLATURAN GUAHAN
2014 (SECOND) Regular Session

Bill No. 381-32 (COR), as Substituted
by Committee on Health and Human Services,
Health Insurance Reform, Economic Development,
and Senior Citizens

Introduced by: **D.G. RODRIGUEZ, JR.**

AN ACT TO ESTABLISH THE ANESTHESIOLOGIST ASSISTANT ACT, BY *ADDING* A NEW ARTICLE 25 TO CHAPTER 12, PART 2, TITLE 10, GUAM CODE ANNOTATED.

BE IT ENACTED BY THE PEOPLE OF GUAM:

Section 1. Legislative Findings and Intent: *I Liheslaturan Guåhan* finds that the providing of healthcare services by Guam's medical community, for surgical or other procedures requiring anesthesia, would positively benefit from the recognition and establishment of the allied healthcare practice of Anesthesiologist Assistant. A qualified anesthesiologist assistant is an allied healthcare who has satisfactorily completed an anesthesiologist assistant program granting a Master's degree, has been certified by the National Commission for Certification of Anesthesiologist Assistants (NCCAA) and has been credentialed by the institution.

I Liheslaturan Guåhan duly notes that since anesthesiologist assistants are not trained to make medical judgments, all states require direct supervision by the anesthesiologist and participation in care provided by the anesthesiologist assistant. Further, although the anesthesiologist assistant is an advanced level allied health care worker, he is *not* an independent practitioner. Generally, all state statutes and regulations specify the requirements for medical direction of anesthesiologist assistants by an anesthesiologist legally authorized to deliver anesthesia services.

Generally, state statutes and regulations that license anesthesiologist assistants, or permit them to practice pursuant to specifically delegated anesthesiologist authority, require the direct supervising participation by the anesthesiologist.

State regulations generally require both direct and immediate supervision of anesthesiologist assistants by a qualified anesthesiologist. Further, relative to the level of supervision, all require that they be directed or supervised by an anesthesiologist, who is, (1) is physically present in the room during induction and emergence; (2) is not concurrently performing any other anesthesiology procedure independently upon another patient; and (3) is available to provide immediate physical presence in the room.

In many situations, anesthesia care is rendered through use of an anesthesia care team in which an anesthesiologist concurrently medically directs nurse anesthetists and/or anesthesiologist assistants in the performance of the technical aspects of anesthesia care. Anesthesiologists engaged in medical direction are responsible for the pre-anesthetic medical evaluation of the patient, prescription, and implementation of the anesthesia plan, personal participation in the most demanding procedures of the plan (including induction and emergence), following the course of anesthesia administration at frequent intervals, remaining physically available for the immediate treatment of emergencies and providing indicated post-anesthesia care.

Subject to the limitation that anesthesiologist assistants are not trained to make medical judgments, an anesthesiologist assistant may, under medical direction by an anesthesiologist who has assumed responsibility for the performance of anesthesia care (collectively, the "responsible anesthesiologist "):

- Provide non-medical assessment of the patient's health status as it relates to the relative risks involved with anesthetic management of the patient during performance of the operative procedure;

- Based on the health status of the patient, determine, in consultation with the responsible anesthesiologist , and administer the appropriate anesthesia plan (i.e., selection and administration of anesthetic agents, airway management, monitoring and recording of vital signs, support of life functions, use of mechanical support devices and management of fluid, electrolyte and blood component balance);

- Recognize and, in consultation with the responsible anesthesiologist, take appropriate corrective action to counteract problems that may develop during implementation of the anesthesia plan;

- Provide necessary, normal post-anesthesia nonmedical care in consultation with the responsible anesthesiologist; and

- Provide such other services as may be determined by the responsible anesthesiologist.

It is the *intent* of *I Liheslaturan Guåhan* to establish the practice of Anesthesiologist Assistant, and to designate the Guam Board of Medical Examiners as the governing body; which *shall* have full regulatory purview and administrative authority over the licensure and conduct of the anesthesiologist assistant.

Section 2. A NEW Article 25, is hereby *ADDED* to Chapter 12, Part 2, Title 10, Guam Code Annotated, to read:

"ARTICLE 25

Anesthesiologist Assistant Act

§ 122517. Prescriptive Authority; Limited to delegation by prescribing anesthesiologist.

§ 122500. Short Title. This Article may be cited as the Anesthesiologist Assistant Act.

§ 122501. Definitions. For purposes of this Article, the following words and phrases have been defined to mean:

(a) *"**Board**"* means the Guam Board of Medical Examiners; which *shall* have regulatory purview and administrative authority over the licensure and conduct of the anesthesiologist assistant;

(b) ***"Anesthesiologist"*** means an anesthesiologist who holds an active, unrestricted licensed to practice medicine in Guam; who has successfully completed an anesthesiology training program certified and approved by the Accreditation Council on Graduate Medical Education, or its equivalent; or the American Osteopathic Association, and who is certified by the American Osteopathic Board of Anesthesiology or is a candidate to take that board's examination; or is certified by the American Board of Anesthesiology or is eligible to take that board's examination;

(c) *"**Anesthesiologist assistant**"* means a graduate of an approved program who is licensed to perform medical services delegated and directly supervised by a supervising anesthesiologist. A ***licensed*** anesthesiologist assistant means a skilled person who has passed the nationally recognized examination administered through the National Commission on Certification of Anesthesiologist Assistants, and is licensed by the Board who may be employed by a medical practice to assist

an anesthesiologist in developing and implementing anesthesia care plans for patients, while *solely* under the direct supervision and direction of the anesthesiologist who is responsible for the performance of that anesthesiologist assistant;

(d) "***Anesthesiology***" means the practice of medicine that specializes in the relief of pain during and after surgical procedures and childbirth, during certain chronic disease processes, and during resuscitation and critical care of patients in the operating room and intensive care environments.

(e) "***Applicant***" means a person who is applying to the Board for a license as an anesthesiologist assistant;

(f) "***Approved Program***" as herein used refers to a program, for the education and training of anesthesiologist assistants approved by the Board, and, from an institution accredited by the Committee on Allied Health Education and Accreditation (CAHEA) or the Commission on Accreditation of Allied Health Education Programs (CAAHEP) that is specifically designed to train an individual to administer general or regional anesthesia as an Anesthesiologist Assistant, and as further required by the Board pursuant to this Article and applicable rules and regulations;

(g) "***Continuing medical education***" means courses recognized and approved by the Board, the sources of which include, but are not limited to, programs and courses recognized by the American Academy of Physician Assistants, the American Medical Association, the American Osteopathic Association, the American Academy of Anesthesiologist Assistants, the American Society of Anesthesiologists, or the Accreditation Council on Continuing Medical Education.

(h) *"Direct supervision"* as used herein means the on-site and physically in immediate proximity of the patient and, personal supervision by an anesthesiologist who is present in the office when the procedure is being performed in that office, or is present in the surgical or obstetrical suite when the procedure is being performed in that surgical or obstetrical suite and who is in all instances immediately available to provide assistance and direction to the anesthesiologist assistant while anesthesia services are being performed.

(i) "***Examination***" means the examination administered through the National Commission on Certification of Anesthesiologist Assistants (NCCAA) as the proficiency examination required for licensure as an anesthesiologist assistant.

(j) "***License***" means an authorization by the Board to practice as an anesthesiologist assistant;

(k) *"Supervising anesthesiologist"* means a licensed anesthesiologist who is registered by the Board to supervise an anesthesiologist assistant.

§ 122502. Rules; Promulgation.

(a) The Board may adopt and enforce reasonable rules:

(1) For setting qualifications of education, skill and experience for licensure of a person as an anesthesiologist assistant;

(2) For providing procedures and forms for licensure and annual registration;

(3) For examining and evaluating applicants for licensure as an anesthesiologist assistant regarding the required skill, knowledge and

experience in developing and implementing anesthesia care plans under supervision;

(4) For allowing a supervising anesthesiologist to temporarily delegate his supervisory responsibilities for an anesthesiologist assistant to another anesthesiologist;

(5) For allowing an anesthesiologist assistant to temporarily serve under the supervision of an anesthesiologist other than the supervising anesthesiologist with whom the anesthesiologist assistant is registered; and

(6) To carry out the provisions of the Anesthesiologist Assistants Act.

(b) The Board shall not adopt a rule allowing an anesthesiologist assistant to perform procedures outside the anesthesiologist assistant's scope of practice.

(c) The Board shall adopt rules, to include, but not limited to:

(1) Establishing requirements for anesthesiologist assistant licensing, including:

i. Completion of a graduate level training program accredited by the commission on accreditation of allied health education programs;

ii. Successful completion of a certifying examination for anesthesiologist assistants administered by the national commission for the certification of anesthesiologist assistants; and

iii. Current certification, recognized by the Board, in advanced cardiac life-support techniques;

(2) Establishing minimum requirements for continuing education of not less than forty hours every two years;

(3) Requiring adequate identification of the anesthesiologist assistant to patients and others;

(4) Requiring the presence, except in cases of emergency, and the documentation of the presence, of the supervising anesthesiologist in the operating room during induction of a general or regional anesthetic and during emergence from a general anesthetic, the presence of the supervising anesthesiologist within the operating suite and immediate availability to the operating room at other times when the anesthetic procedure is being performed and requiring that the anesthesiologist assistant comply with the above restrictions;

(5) Requiring the supervising anesthesiologist to ensure that all activities, functions, services, and treatment measures are properly documented in written form by the anesthesiologist assistant. The anesthesia record shall be reviewed, countersigned, and dated by the supervising anesthesiologist;

(6) Requiring the anesthesiologist assistant to inform the supervising anesthesiologist of serious adverse events;

(7) Establishing the number of anesthesiologist assistants a supervising anesthesiologist may supervise at one time, which number, except in emergency cases, shall not exceed two (2). An anesthesiologist *shall not* concurrently supervise, *except in emergency cases*, more than three (3) anesthesia providers during the emergency, and only if they are a

licensed anesthesiologist assistant, or as otherwise determined to be appropriate by the Board during emergency cases only; and

(d) Within three (3) months of the date on which the Anesthesiologist Assistant Act becomes effective, providing for enhanced supervision at the commencement of an anesthesiologist assistant's practice.

(e) Establish appropriate fees.

§ 122503. Qualifications for Licensure.

(a) Program Approval. The Board *shall* approve programs for the education and training of anesthesiologist assistants which meet standards established by board rules. The board *shall* recommend only those anesthesiologist assistant training programs that hold full accreditation or provisional accreditation from the Commission on Accreditation of Allied Health Education Programs.

(b) Licensed anesthesiology assistant's *shall* be graduates of programs approved and recognized by the Board and approved by the Anesthesiologist Assistant Examining Committee from an institution accredited by the Committee on Allied Health Education and Accreditation (CAHEA) or the Commission on Accreditation of Allied Health Education Programs (CAAHEP) that is specifically designed to train an individual to administer general or regional anesthesia.

(c) Licensed anesthesiology assistants *shall* have passed a proficiency examination developed and administered by the National Commission for Certification of Anesthesiologist Assistants (NCCAA), or its successor.

(d) Licensed anesthesiologist assistant's *shall* meet all other requisite educational requirements established by the Board pursuant to § 122502 of this Article.

§ 122504. Application for Licensure; Requirements for Anesthesiologist Assistants.

(a) Application for Licensure.

(1) All persons applying for licensure as an anesthesiologist assistant shall submit an application to the Board on forms approved by Board.

(2) The application may not be used for more than one year from the date of original submission of the application and fee. After one year from the date that the original application and fee have been received in the Board office, a new application and fee shall be required from any applicant who desires licensure as an anesthesiologist assistant.

(3) All application information must be submitted no later than 15 days prior to the meeting at which the applicant desires his or her application to be considered.

(b) Requirements for Licensure.

(1) All applicants for licensure as an anesthesiologist assistant must submit an application as set forth in paragraph (1) above. The applicant must meet all of the requirements of Article, and the applicant must submit two personalized and individualized letters of recommendation from anesthesiologists. Letters of recommendation must be composed and signed by the applicant's supervising physician, or, for recent graduates, the faculty

physician, and give details of the applicant's clinical skills and ability. Each letter must be addressed to the Board and must have been written no more than six months prior to the filing of the application for licensure.

(2) The applicant must have obtained a passing score on the examination administered through the NCCAA. The passing score shall be established by the NCCAA.

(3) The applicant must be certified in advanced cardiac life support.

(4) The applicant must submit notarized statements containing the following information:

(i) Completion of three hours of all Category I, American Medical Association Continuing Medical Education or American Osteopathic Association approved Category I-A continuing education related to the practice of osteopathic medicine or under osteopathic auspices which includes the topics of Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome: the disease and its spectrum of clinical manifestations: epidemiology of the disease; related infections including TB; treatment, counseling, and prevention; transmission from healthcare worker to patient and patient to healthcare worker; universal precautions and isolation techniques; and legal issues related to the disease. If the applicant has not already completed the required continuing medical education, upon submission of an affidavit of good cause, the applicant will be allowed six months to complete this requirement.

(ii) Completion of one hour of continuing medical education on domestic violence which includes information on the number of patients in that professional's practice who are likely to be victims of domestic violence and the number who are likely to be perpetrators of domestic violence, screening procedures for determining whether a patient has any history of being either a victim or a perpetrator of domestic violence, and instruction on how to provide such patients with information on, or how to refer such patients to, resources in the local community such as domestic violence centers and other advocacy groups, that provide legal aid, shelter, victim counseling, batterer counseling, or child protection services, and which is approved by any state or federal government agency, or nationally affiliated professional association, or any provider of Category I or II American Medical Association Continuing Medical Education or American Osteopathic Association approved Category I-A continuing education related to the practice of osteopathic medicine or under osteopathic auspices. Home study courses approved by the above agencies will be acceptable. If the applicant has not already completed the required continuing medical education, upon submission of an affidavit of good cause, the applicant will be allowed six months to complete this requirement.

(iii) Completion of two hours of continuing medical education relating to prevention of medical errors which includes a study of root cause analysis, error reduction and prevention, and patient safety, and which is approved by any state or federal government agency, or nationally affiliated professional association, or any provider of

Category I or II American Medical Association Continuing Medical Education or American Osteopathic Association-approved Category I-A continuing education related to the practice of osteopathic medicine or under osteopathic auspices.

§ 122505. Requirements for Approval of Training Programs.

Anesthesiologist Assistant programs approved and recognized by the Board must hold full accreditation or provisional (initial) accreditation from the Committee on Accreditation of Allied Health Education Programs (CAAHEP), or its successor.

The Board may provide for, by regulation, any and all additional requirements deemed necessary to ensure an appropriate, high standard of training and competence are met and maintained.

§ 122506. Performance of Supervising Anesthesiologist.

(a) An anesthesiologist who directly supervises an anesthesiologist assistant must be qualified in the medical areas in which the anesthesiologist assistant performs and is liable for the performance of the anesthesiologist assistant. An anesthesiologist may only concurrently supervise two (2) anesthesiologist assistants at the same time.

(b) An anesthesiologist or group of anesthesiologists must, upon establishing a supervisory relationship with an anesthesiologist assistant, file with the board a written protocol that includes, at a minimum:

(1) The name, address, and license number of the anesthesiologist assistant.

(2) The name, address, license number, and federal Drug Enforcement Administration number of each physician who will be supervising the anesthesiologist assistant.

(3) The address of the anesthesiologist assistant's primary practice location and the address of any other locations where the anesthesiologist assistant may practice.

(4) The date the protocol was developed and the dates of all revisions.

(5) The signatures of the anesthesiologist assistant and all supervising physicians.

(6) The duties and functions of the anesthesiologist assistant.

(7) The conditions or procedures that require the personal provision of care by an anesthesiologist.

(8) The procedures to be followed in the event of an anesthetic emergency.

The protocol *shall* be on file with the Board *before* the anesthesiologist assistant may practice with the anesthesiologist or group. An anesthesiologist assistant *shall* not practice unless a written protocol has been filed for that anesthesiologist assistant in accordance with this paragraph, and the anesthesiologist assistant may only practice under the direct supervision of an anesthesiologist who has signed the protocol. The protocol must be updated biennially.

§ 122507. Licensure; registration of anesthesiologist assistant.

(a) The Board may license qualified persons as anesthesiologist assistants.

(b) A person shall not perform, attempt to perform or hold himself out as an anesthesiologist assistant until he is licensed by the Board as an anesthesiologist assistant and has registered his supervising licensed anesthesiologist in accordance with Board regulations.

§ 122508. Performance of Anesthesiologist Assistant.

(a)An anesthesiologist assistant may assist an anesthesiologist in developing and implementing an anesthesia care plan for a patient. In providing assistance to an anesthesiologist, an anesthesiologist assistant may perform duties established by rule by the board in any of the following functions that are included in the anesthesiologist assistant's protocol while under the direct supervision of an anesthesiologist:

1. Obtain a comprehensive patient history and present the history to the supervising anesthesiologist.

2. Pretest and calibrate anesthesia delivery systems and monitor, obtain, and interpret information from the systems and monitors.

3. Assist the supervising anesthesiologist with the implementation of medically accepted monitoring techniques.

4. Establish basic and advanced airway interventions, including intubation of the trachea and performing ventilatory support.

5. Administer intermittent vasoactive drugs and start and adjust vasoactive infusions.

6. Administer anesthetic drugs, adjuvant drugs, and accessory drugs.

7. Assist the supervising anesthesiologist with the performance of epidural anesthetic procedures and spinal anesthetic procedures.

8. Administer blood, blood products, and supportive fluids.

9. Support life functions during anesthesia health care, including induction and intubation procedures, the use of appropriate mechanical supportive devices, and the management of fluid, electrolyte, and blood component balances.

10. Recognize and take appropriate corrective action for abnormal patient responses to anesthesia, adjunctive medication, or other forms of therapy.

11. Participate in management of the patient while in the post-anesthesia recovery area, including the administration of any supporting fluids or drugs.

12. Perform other tasks not prohibited by law that are delegated by the supervising licensed anesthesiologist, and for which the anesthesiologist assistant has been trained and is proficient to perform.

(b) Nothing in this section or chapter shall prevent third-party payors from reimbursing employers of anesthesiologist assistants for covered services rendered by such anesthesiologist assistants.

(c) An anesthesiologist assistant must clearly convey to the patient that he or she is an anesthesiologist assistant.

(d) An anesthesiologist assistant may perform anesthesia tasks and services within the framework of a written practice protocol developed between the supervising anesthesiologist and the anesthesiologist assistant.

(e) An anesthesiologist assistant may not prescribe, order, or compound any controlled substance, legend drug, or medical device, nor may an anesthesiologist assistant dispense sample drugs to patients. Nothing in this paragraph prohibits an anesthesiologist assistant from administering legend drugs or controlled substances; intravenous drugs, fluids, or blood products; or inhalation or other anesthetic agents to patients which are ordered by the supervising anesthesiologist and administered while under the direct supervision of the supervising anesthesiologist.

(f) An anesthesiologist assistant *shall* not administer or monitor general or regional anesthesia unless the supervising anesthesiologist:

(1) Is physically present in the room during induction and emergence;

(2) Is not concurrently performing any other anesthesiology procedure independently upon another patient; and

(3) Is available to provide immediate physical presence in the room.

§ 122509. Registration of Anesthesiologist Assistant Supervision.

Prior to practicing on Guam, the anesthesiologist assistant shall present for approval of the Board of Medical Examiners a completed application for supervision by a Guam- licensed anesthesiologist. The practice of the anesthesiologist assistant must fall within the practice of the supervising anesthesiologist with whom the anesthesiologist assistant is registered. In the

event of any changes of supervising anesthesiologist, the names of the supervising anesthesiologist s must be provided to the Board. The Board must be notified at least ten (10) days prior to the effective date of change. Practicing without a supervising anesthesiologist shall be grounds for disciplinary action, including revocation of license.

§ 122510. Renewal of License.

Each licensed Anesthesiologist assistant *shall* present evidence of current certification, and recertification through the National Commission on Certification of Anesthesiologist Assistants, or its successor, every two (2) years for renewal of license.

§ 122511. Annual registration of employment; change.

(a) Upon becoming licensed, the Board *shall* register the anesthesiologist assistant on the anesthesiologist assistants' roster, including his name, address and other board-required information and the anesthesiologist assistant's supervising anesthesiologist's name and address.

(b) Annually, each anesthesiologist assistant *shall* register with the Board, providing the anesthesiologist assistant's current name and address, the name and address of the supervising anesthesiologist for whom he is working and any additional information required by the Board. Failure to register annually will result in the anesthesiologist assistant being required to pay a late fee or having his license placed on inactive status.

(c) Every two years, each licensed anesthesiologist assistant in Guam shall submit proof of completion of board-required continuing education to the Board.

(d) The registration of an anesthesiologist assistant *shall* be void upon changing his supervising anesthesiologist, until the anesthesiologist assistant registers a new supervising anesthesiologist with the Board, accompanied by a change in supervision fee, in an amount to be determined by the Board.

§ 122512. Anesthesiologist Assistant Protocols and Performance.

(a) Every anesthesiologist or group of anesthesiologists, upon entering into supervisory relationship with an anesthesiologist assistant *shall* file with the Board a written, protocol, to include, at a minimum, the following:

(1) Name, address, and license number of the anesthesiologist assistant;

(2) Name, address, license number and federal Drug Enforcement Administration (DEA) number of each Anesthesiologist who will supervise the anesthesiologist assistant;

(3) Address of the anesthesiologist assistant's primary practice location and any other locations where the assistant may practice;

(4) The date the protocol was developed and the dates of all revisions;

(5) The designation and signature of the primary supervising anesthesiologist;

(6) Signatures of the anesthesiologist assistant and all supervising anesthesiologists;

(7) The duties and functions of the anesthesiologist assistant;

(8) Conditions or procedures that require the personal provision of care by an anesthesiologist;

(9) The procedures to be followed in the event of an anesthetic emergency.

(b) The protocol *shall* be on file with the Board prior to the time the anesthesiologist assistant begins practice with the anesthesiologist or the anesthesiology group.

(c) The protocol must be updated biennially.

(d) Anesthesiologist assistants may perform the following duties under the direct supervision of an anesthesiologist and as set forth in the protocol outlined in paragraph (1) above:

(1) Obtaining a comprehensive patient history and presenting the history to the supervising anesthesiologist;

(2) Pretesting and calibration of anesthesia delivery systems and monitoring, obtaining and interpreting information from the systems and monitors;

(3) Assisting the anesthesiologist with implementation of monitoring techniques:

(4) Establishing basic and advanced airway interventions, including intubations of the trachea and performing ventilatory support;

(5) Administering intermittent vasoactive drugs and starting and adjusting vasoactive infusions;

(6) Administering anesthetic drugs, adjuvant drugs, and accessory drugs;

(7) Assisting the anesthesiologist with the performance of epidural anesthetic procedures and spinal anesthetic procedures;

(8) Administering blood, blood products, and supportive fluids;

(9) Supporting life functions during anesthesia health care, including induction and intubation procedures, the use of appropriate mechanical supportive devices, and the management of fluid, electrolyte, and blood component balances.

(10) Recognizing and taking appropriate corrective action for abnormal patient responses to anesthesia, adjunctive mediation or other forms of therapy;

(11) Participating in management of the patient while in the post-anesthesia recovery area, including the administration of supporting fluids;

(12) Perform other tasks not prohibited by law that are delegated by the supervising licensed anesthesiologist, and for which the anesthesiologist assistant has been trained and is proficient to perform.

(e) The supervising anesthesiologist *shall* delegate *only* tasks and procedures to the anesthesiologist assistant which are within the supervising physician's scope of practice. The anesthesiologist assistant may work in any setting that is within the scope of practice of the supervising anesthesiologist's practice.

(f) Continuity of Supervision in practice settings *shall* require the anesthesiologist assistant to document in the anesthesia record any change in supervisor.

(g) All tasks and procedures performed by the anesthesiologist assistant must be documented in the appropriate medical record.

§ 122513. Identification.

(a) While working, the anesthesiologist assistant *shall* wear or display appropriate identification, clearly indicating that he or she is an anesthesiologist assistant.

(b) The anesthesiologist assistant's license *shall* be displayed in the office, and any satellite operation in which the anesthesiologist assistant may function.

(c) A anesthesiologist assistant *shall* not advertise him or herself in any manner that would mislead the patients of the supervising anesthesiologist or the public.

§ 122514. Direct Supervision Required.

(a) Tasks performed by the anesthesiologist assistant must be under the direct supervision of a registered supervising anesthesiologist.

(b) All medical records *shall* be reviewed and co-signed by the approved supervising anesthesiologist within seven (7) days.

(c) Upon being duly licensed by the Board, the licensee *shall* have his or her name, address and other pertinent information enrolled by the Board on a roster of licensed anesthesiologist assistants.

(d) Not more than two (2) currently licensed anesthesiologist assistants may be supervised by a licensed anesthesiologist at any one time, except as *may* be otherwise provided pursuant to § 122506(a).

(e) If no registered supervising anesthesiologist is available to supervise the anesthesiologist assistant, the anesthesiologist assistant *shall* not perform patient care activities.

(f) Nothing in these rules *shall* be construed to prohibit the employment of anesthesiologist assistants by a medical care facility where such anesthesiologist assistants function under the supervision of a Guam-licensed anesthesiologist.

§ 122515. Supervision ratio; one-to-two (1:2); Limited.

The registered supervising Anesthesiologist *shall* be limited to a supervision maximum ratio of one-to-two (1:2), and *shall not* supervise the anesthesiologist assistants while concurrently performing any anesthesiology procedure upon more than one (1) patient.

§ 122516. Exceptions to Licensure Requirement.

No person may practice as a anesthesiologist assistant on Guam who is not licensed by the Board. This Article, however, shall not be construed to prohibit a student in an anesthesiologist assistant program from performing duties or functions assigned by his instructors, who is working under the direct supervision of a licensed anesthesiologist in an approved externship.

§ 122517. Prescriptive Authority - None; Limited to delegation by prescribing anesthesiologist.

An anesthesiologist assistant, *shall* only be able to select and administer any form of anesthetic by delegation while under the direct supervision of an anesthesiologist licensed by the Board, and, may select and administer any licensed drug *solely* by delegation and pursuant to the direct supervision instructions of the prescribing anesthesiologist, the established written practice protocol, and in accordance to any applicable rules and regulation established by the Board pursuant to this Article."

Section 3. Severability. If any provision of this Act or its application to any person or circumstance is found to be invalid or contrary to law, such invalidity shall not affect other provisions or applications of this Act which can be given effect without the invalid provisions or application, and to this end the provisions of this Act are severable.

Section 4. Effective Date. This Act shall become immediately effective upon enactment.

MINA'TRENTAI DOS NA LIHESLATURAN GUAHAN
2014 (SECOND) Regular Session

Bill No. 381 **-32 (COR)**

Introduced by: **D.G. RODRIGUEZ, JR.**

AN ACT TO ESTABLISH THE ANESTHESIOLOGIST ASSISTANT ACT, BY *ADDING* A NEW ARTICLE 25 TO CHAPTER 12, PART 2, TITLE 10, GUAM CODE ANNOTATED.

BE IT ENACTED BY THE PEOPLE OF GUAM:

Section 1. Legislative Findings and Intent: *I Liheslaturan Guåhan* finds that the providing of healthcare services by Guam's medical community, for surgical or other procedures requiring anesthesia, would positively benefit from the recognition and establishment of the allied healthcare practice of Anesthesiologist Assistant. A qualified anesthesiologist assistant is an allied healthcare who has satisfactorily completed an anesthesiologist assistant program granting a Master's degree, has been certified by the National Commission for Certification of Anesthesiologist Assistants (NCCAA) and has been credentialed by the institution.

I Liheslaturan Guåhan duly notes that since anesthesiologist assistants are not trained to make medical judgments, all states require direct supervision by the anesthesiologist and participation in care provided by the anesthesiologist assistant. Further, although the anesthesiologist assistant is an advanced level allied health care worker, he is *not* an independent practitioner. Generally, all state statutes and regulations specify the requirements for medical direction of anesthesiologist assistants by an anesthesiologist legally authorized to deliver anesthesia services. Generally, state statutes and regulations that license anesthesiologist assistants, or

permit them to practice pursuant to specifically delegated anesthesiologist authority, require the direct supervising participation by the anesthesiologist.

State regulations generally require both direct and immediate supervision of anesthesiologist assistants by a qualified anesthesiologist. Further, relative to the level of supervision, all require that they be directed or supervised by an anesthesiologist, who is, (1) is physically present in the room during induction and emergence; (2) is not concurrently performing any other anesthesiology procedure independently upon another patient; and (3) is available to provide immediate physical presence in the room.

In many situations, anesthesia care is rendered through use of an anesthesia care team in which an anesthesiologist concurrently medically directs nurse anesthetists and/or anesthesiologist assistants in the performance of the technical aspects of anesthesia care. Anesthesiologists engaged in medical direction are responsible for the pre-anesthetic medical evaluation of the patient, prescription, and implementation of the anesthesia plan, personal participation in the most demanding procedures of the plan (including induction and emergence), following the course of anesthesia administration at frequent intervals, remaining physically available for the immediate treatment of emergencies and providing indicated post-anesthesia care.

Subject to the limitation that anesthesiologist assistants are not trained to make medical judgments, an anesthesiologist assistant may, under medical direction by an anesthesiologist who has assumed responsibility for the performance of anesthesia care (collectively, the "responsible anesthesiologist "):

- Provide non-medical assessment of the patient's health status as it relates to the relative risks involved with anesthetic management of the patient during performance of the operative procedure;

- Based on the health status of the patient, determine, in consultation with the responsible anesthesiologist , and administer the appropriate anesthesia plan (i.e., selection and administration of anesthetic agents, airway management, monitoring and recording of vital signs, support of life functions, use of mechanical support devices and management of fluid, electrolyte and blood component balance);

- Recognize and, in consultation with the responsible anesthesiologist, take appropriate corrective action to counteract problems that may develop during implementation of the anesthesia plan;

- Provide necessary, normal post-anesthesia nonmedical care in consultation with the responsible anesthesiologist; and

- Provide such other services as may be determined by the responsible anesthesiologist.

It is the *intent* of *I Liheslaturan Guåhan* to establish the practice of Anesthesiologist Assistant, and to designate the Guam Board of Medical Examiners as the governing body; which *shall* have full regulatory purview and administrative authority over the licensure and conduct of the anesthesiologist assistant.

Section 2. A NEW Article 25, is hereby *ADDED* to Chapter 12, Part 2, Title 10, Guam Code Annotated, to read:

"ARTICLE 25

Anesthesiologist Assistant Act

§ 122517. Prescriptive Authority; Limited to delegation by prescribing anesthesiologist.

§ 122500. Short Title. This Article may be cited as the Anesthesiologist Assistant Act.

§ 122501. Definitions. For purposes of this Article, the following words and phrases have been defined to mean:

(a) *"**Board**"* means the Guam Board of Medical Examiners; which *shall* have regulatory purview and administrative authority over the licensure and conduct of the anesthesiologist assistant;

(b) ***"Anesthesiologist"*** means an anesthesiologist who holds an active, unrestricted licensed to practice medicine in Guam; who has successfully completed an anesthesiology training program certified and approved by the Accreditation Council on Graduate Medical Education, or its equivalent; or the American Osteopathic Association, and who is certified by the American Osteopathic Board of Anesthesiology or is a candidate to take that board's examination; or is certified by the American Board of Anesthesiology or is eligible to take that board's examination;

(c) *"**Anesthesiologist assistant**"* means a graduate of an approved program who is licensed to perform medical services delegated and directly supervised by a supervising anesthesiologist. A ***licensed*** anesthesiologist assistant means a skilled person who has passed the nationally recognized examination administered through the National Commission on Certification of Anesthesiologist Assistants, and is licensed by the Board who may be employed by a medical practice to assist

an anesthesiologist in developing and implementing anesthesia care plans for patients, while *solely* under the direct supervision and direction of the anesthesiologist who is responsible for the performance of that anesthesiologist assistant;

(d) "***Anesthesiology***" means the practice of medicine that specializes in the relief of pain during and after surgical procedures and childbirth, during certain chronic disease processes, and during resuscitation and critical care of patients in the operating room and intensive care environments.

(e) "***Applicant***" means a person who is applying to the Board for a license as an anesthesiologist assistant;

(f) "***Approved Program***" as herein used refers to a program, for the education and training of anesthesiologist assistants approved by the Board, and, from an institution accredited by the Committee on Allied Health Education and Accreditation (CAHEA) or the Commission on Accreditation of Allied Health Education Programs (CAAHEP) that is specifically designed to train an individual to administer general or regional anesthesia as an Anesthesiologist Assistant, and as further required by the Board pursuant to this Article and applicable rules and regulations;

(g) "***Continuing medical education***" means courses recognized and approved by the Board, the sources of which include, but are not limited to, programs and courses recognized by the American Academy of Physician Assistants, the American Medical Association, the American Osteopathic Association, the American Academy of Anesthesiologist Assistants, the American Society of Anesthesiologists, or the Accreditation Council on Continuing Medical Education.

(h) *"Direct supervision"* as used herein means the on-site and physically in immediate proximity of the patient and, personal supervision by an anesthesiologist who is present in the office when the procedure is being performed in that office, or is present in the surgical or obstetrical suite when the procedure is being performed in that surgical or obstetrical suite and who is in all instances immediately available to provide assistance and direction to the anesthesiologist assistant while anesthesia services are being performed.

(i) *"Examination"* means the examination administered through the National Commission on Certification of Anesthesiologist Assistants (NCCAA) as the proficiency examination required for licensure as an anesthesiologist assistant.

(j) *"License"* means an authorization by the Board to practice as an anesthesiologist assistant;

(k) *"Supervising anesthesiologist"* means a licensed anesthesiologist who is registered by the Board to supervise an anesthesiologist assistant.

§ 122502. Rules; Promulgation.

(a) The Board may adopt and enforce reasonable rules:

(1) For setting qualifications of education, skill and experience for licensure of a person as an anesthesiologist assistant;

(2) For providing procedures and forms for licensure and annual registration;

(3) For examining and evaluating applicants for licensure as an anesthesiologist assistant regarding the required skill, knowledge and

experience in developing and implementing anesthesia care plans under supervision;

(4) For allowing a supervising anesthesiologist to temporarily delegate his supervisory responsibilities for an anesthesiologist assistant to another anesthesiologist;

(5) For allowing an anesthesiologist assistant to temporarily serve under the supervision of an anesthesiologist other than the supervising anesthesiologist with whom the anesthesiologist assistant is registered; and

(6) To carry out the provisions of the Anesthesiologist Assistants Act.

(b) The Board shall not adopt a rule allowing an anesthesiologist assistant to perform procedures outside the anesthesiologist assistant's scope of practice.

(c) The Board shall adopt rules, to include, but not limited to:

(1) Establishing requirements for anesthesiologist assistant licensing, including:

i. Completion of a graduate level training program accredited by the commission on accreditation of allied health education programs;

ii. Successful completion of a certifying examination for anesthesiologist assistants administered by the national commission for the certification of anesthesiologist assistants; and

iii. Current certification, recognized by the Board, in advanced cardiac life-support techniques;

(2) Establishing minimum requirements for continuing education of not less than forty hours every two years;

(3) Requiring adequate identification of the anesthesiologist assistant to patients and others;

(4) Requiring the presence, except in cases of emergency, and the documentation of the presence, of the supervising anesthesiologist in the operating room during induction of a general or regional anesthetic and during emergence from a general anesthetic, the presence of the supervising anesthesiologist within the operating suite and immediate availability to the operating room at other times when the anesthetic procedure is being performed and requiring that the anesthesiologist assistant comply with the above restrictions;

(5) Requiring the supervising anesthesiologist to ensure that all activities, functions, services, and treatment measures are properly documented in written form by the anesthesiologist assistant. The anesthesia record shall be reviewed, countersigned, and dated by the supervising anesthesiologist;

(6) Requiring the anesthesiologist assistant to inform the supervising anesthesiologist of serious adverse events;

(7) Establishing the number of anesthesiologist assistants a supervising anesthesiologist may supervise at one time, which number, except in emergency cases, shall not exceed three (3). An anesthesiologist *shall not* concurrently supervise or direct, *except in emergency cases*, more

than four (4) anesthesia providers and only if they are a licensed anesthesiologist assistant; and

(d) Within three (3) months of the date on which the Anesthesiologist Assistant Act becomes effective, providing for enhanced supervision at the commencement of an anesthesiologist assistant's practice.

(e) Establish appropriate fees.

§ 122503. Qualifications for Licensure.

(a) Program Approval. The Board *shall* approve programs for the education and training of anesthesiologist assistants which meet standards established by board rules. The board *shall* recommend only those anesthesiologist assistant training programs that hold full accreditation or provisional accreditation from the Commission on Accreditation of Allied Health Education Programs.

(b) Licensed anesthesiology assistant's *shall* be graduates of programs approved and recognized by the Board and approved by the Anesthesiologist Assistant Examining Committee from an institution accredited by the Committee on Allied Health Education and Accreditation (CAHEA) or the Commission on Accreditation of Allied Health Education Programs (CAAHEP) that is specifically designed to train an individual to administer general or regional anesthesia.

(c) Licensed anesthesiology assistants *shall* have passed a proficiency examination developed and administered by the National Commission for Certification of Anesthesiologist Assistants (NCCAA), or its successor.

(d) Licensed anesthesiologist assistant's *shall* meet all other requisite educational requirements established by the Board pursuant to § 122502 of this Article.

§ 122504. Application for Licensure; Requirements for Anesthesiologist Assistants.

(a) Application for Licensure.

(1) All persons applying for licensure as an anesthesiologist assistant shall submit an application to the Board on forms approved by Board.

(2) The application may not be used for more than one year from the date of original submission of the application and fee. After one year from the date that the original application and fee have been received in the Board office, a new application and fee shall be required from any applicant who desires licensure as an anesthesiologist assistant.

(3) All application information must be submitted no later than 15 days prior to the meeting at which the applicant desires his or her application to be considered.

(b) Requirements for Licensure.

(1) All applicants for licensure as an anesthesiologist assistant must submit an application as set forth in paragraph (1) above. The applicant must meet all of the requirements of Article, and the applicant must submit two personalized and individualized letters of recommendation from anesthesiologists. Letters of recommendation must be composed and signed by the applicant's supervising physician, or, for recent graduates, the faculty

physician, and give details of the applicant's clinical skills and ability. Each letter must be addressed to the Board and must have been written no more than six months prior to the filing of the application for licensure.

(2) The applicant must have obtained a passing score on the examination administered through the NCCAA. The passing score shall be established by the NCCAA.

(3) The applicant must be certified in advanced cardiac life support.

(4) The applicant must submit notarized statements containing the following information:

(i) Completion of three hours of all Category I, American Medical Association Continuing Medical Education or American Osteopathic Association approved Category I-A continuing education related to the practice of osteopathic medicine or under osteopathic auspices which includes the topics of Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome: the disease and its spectrum of clinical manifestations: epidemiology of the disease; related infections including TB; treatment, counseling, and prevention; transmission from healthcare worker to patient and patient to healthcare worker; universal precautions and isolation techniques; and legal issues related to the disease. If the applicant has not already completed the required continuing medical education, upon submission of an affidavit of good cause, the applicant will be allowed six months to complete this requirement.

(ii) Completion of one hour of continuing medical education on domestic violence which includes information on the number of patients in that professional's practice who are likely to be victims of domestic violence and the number who are likely to be perpetrators of domestic violence, screening procedures for determining whether a patient has any history of being either a victim or a perpetrator of domestic violence, and instruction on how to provide such patients with information on, or how to refer such patients to, resources in the local community such as domestic violence centers and other advocacy groups, that provide legal aid, shelter, victim counseling, batterer counseling, or child protection services, and which is approved by any state or federal government agency, or nationally affiliated professional association, or any provider of Category I or II American Medical Association Continuing Medical Education or American Osteopathic Association approved Category I-A continuing education related to the practice of osteopathic medicine or under osteopathic auspices. Home study courses approved by the above agencies will be acceptable. If the applicant has not already completed the required continuing medical education, upon submission of an affidavit of good cause, the applicant will be allowed six months to complete this requirement.

(iii) Completion of two hours of continuing medical education relating to prevention of medical errors which includes a study of root cause analysis, error reduction and prevention, and patient safety, and which is approved by any state or federal government agency, or nationally affiliated professional association, or any provider of

Category I or II American Medical Association Continuing Medical Education or American Osteopathic Association-approved Category I-A continuing education related to the practice of osteopathic medicine or under osteopathic auspices.

§ 122505. Requirements for Approval of Training Programs.

Anesthesiologist Assistant programs approved and recognized by the Board must hold full accreditation or provisional (initial) accreditation from the Committee on Accreditation of Allied Health Education Programs (CAAHEP), or its successor.

The Board may provide for, by regulation, any and all additional requirements deemed necessary to ensure an appropriate, high standard of training and competence are met and maintained.

§ 122506. Performance of Supervising Anesthesiologist.

(a) An anesthesiologist who directly supervises an anesthesiologist assistant must be qualified in the medical areas in which the anesthesiologist assistant performs and is liable for the performance of the anesthesiologist assistant. An anesthesiologist may only concurrently supervise three (3) anesthesiologist assistants at the same time. The Board may, by rule, allow an anesthesiologist to supervise up to four (4) anesthesiologist assistants under certain limited circumstances deemed to be safely appropriate, and which *shall* be specifically delineated.

(b) An anesthesiologist or group of anesthesiologists must, upon establishing a supervisory relationship with an anesthesiologist assistant, file with the board a written protocol that includes, at a minimum:

(1) The name, address, and license number of the anesthesiologist assistant.

(2) The name, address, license number, and federal Drug Enforcement Administration number of each physician who will be supervising the anesthesiologist assistant.

(3) The address of the anesthesiologist assistant's primary practice location and the address of any other locations where the anesthesiologist assistant may practice.

(4) The date the protocol was developed and the dates of all revisions.

(5) The signatures of the anesthesiologist assistant and all supervising physicians.

(6) The duties and functions of the anesthesiologist assistant.

(7) The conditions or procedures that require the personal provision of care by an anesthesiologist.

(8) The procedures to be followed in the event of an anesthetic emergency.

The protocol *shall* be on file with the Board *before* the anesthesiologist assistant may practice with the anesthesiologist or group. An anesthesiologist assistant *shall* not practice unless a written protocol has been filed for that anesthesiologist assistant in accordance with this paragraph, and the anesthesiologist assistant may only practice under the direct supervision of an anesthesiologist who has signed the protocol. The protocol must be updated biennially.

§ 122507. Licensure; registration of anesthesiologist assistant.

(a) The Board may license qualified persons as anesthesiologist assistants.

(b) A person shall not perform, attempt to perform or hold himself out as an anesthesiologist assistant until he is licensed by the Board as an anesthesiologist assistant and has registered his supervising licensed anesthesiologist in accordance with Board regulations.

§ 122508. Performance of Anesthesiologist Assistant.

(a)An anesthesiologist assistant may assist an anesthesiologist in developing and implementing an anesthesia care plan for a patient. In providing assistance to an anesthesiologist, an anesthesiologist assistant may perform duties established by rule by the board in any of the following functions that are included in the anesthesiologist assistant's protocol while under the direct supervision of an anesthesiologist:

1. Obtain a comprehensive patient history and present the history to the supervising anesthesiologist.

2. Pretest and calibrate anesthesia delivery systems and monitor, obtain, and interpret information from the systems and monitors.

3. Assist the supervising anesthesiologist with the implementation of medically accepted monitoring techniques.

4. Establish basic and advanced airway interventions, including intubation of the trachea and performing ventilatory support.

5. Administer intermittent vasoactive drugs and start and adjust vasoactive infusions.

6. Administer anesthetic drugs, adjuvant drugs, and accessory drugs.

7. Assist the supervising anesthesiologist with the performance of epidural anesthetic procedures and spinal anesthetic procedures.

8. Administer blood, blood products, and supportive fluids.

9. Support life functions during anesthesia health care, including induction and intubation procedures, the use of appropriate mechanical supportive devices, and the management of fluid, electrolyte, and blood component balances.

10. Recognize and take appropriate corrective action for abnormal patient responses to anesthesia, adjunctive medication, or other forms of therapy.

11. Participate in management of the patient while in the post-anesthesia recovery area, including the administration of any supporting fluids or drugs.

12. Perform other tasks not prohibited by law that are delegated by the supervising licensed anesthesiologist, and for which the anesthesiologist assistant has been trained and is proficient to perform.

(b) Nothing in this section or chapter shall prevent third-party payors from reimbursing employers of anesthesiologist assistants for covered services rendered by such anesthesiologist assistants.

(c) An anesthesiologist assistant must clearly convey to the patient that he or she is an anesthesiologist assistant.

(d) An anesthesiologist assistant may perform anesthesia tasks and services within the framework of a written practice protocol developed between the supervising anesthesiologist and the anesthesiologist assistant.

(e) An anesthesiologist assistant may not prescribe, order, or compound any controlled substance, legend drug, or medical device, nor may an anesthesiologist assistant dispense sample drugs to patients. Nothing in this paragraph prohibits an anesthesiologist assistant from administering legend drugs or controlled substances; intravenous drugs, fluids, or blood products; or inhalation or other anesthetic agents to patients which are ordered by the supervising anesthesiologist and administered while under the direct supervision of the supervising anesthesiologist.

(f) An anesthesiologist assistant *shall* not administer or monitor general or regional anesthesia unless the supervising anesthesiologist:

(1) Is physically present in the room during induction and emergence;

(2) Is not concurrently performing any other anesthesiology procedure independently upon another patient; and

(3) Is available to provide immediate physical presence in the room.

§ 122509. Registration of Anesthesiologist Assistant Supervision.

Prior to practicing on Guam, the anesthesiologist assistant shall present for approval of the Board of Medical Examiners a completed application for supervision by a Guam- licensed anesthesiologist. The practice of the

anesthesiologist assistant must fall within the practice of the supervising anesthesiologist with whom the anesthesiologist assistant is registered. In the event of any changes of supervising anesthesiologist, the names of the supervising anesthesiologist s must be provided to the Board. The Board must be notified at least ten (10) days prior to the effective date of change. Practicing without a supervising anesthesiologist shall be grounds for disciplinary action, including revocation of license.

§ 122510. Renewal of License.

Each licensed Anesthesiologist assistant *shall* present evidence of current certification, and recertification through the National Commission on Certification of Anesthesiologist Assistants, or its successor, every two (2) years for renewal of license.

§ 122511. Annual registration of employment; change.

(a) Upon becoming licensed, the Board *shall* register the anesthesiologist assistant on the anesthesiologist assistants' roster, including his name, address and other board-required information and the anesthesiologist assistant's supervising anesthesiologist's name and address.

(b) Annually, each anesthesiologist assistant *shall* register with the Board, providing the anesthesiologist assistant's current name and address, the name and address of the supervising anesthesiologist for whom he is working and any additional information required by the Board. Failure to register annually will result in the anesthesiologist assistant being required to pay a late fee or having his license placed on inactive status.

(c) Every two years, each licensed anesthesiologist assistant in Guam shall submit proof of completion of board-required continuing education to the Board.

(d) The registration of an anesthesiologist assistant *shall* be void upon changing his supervising anesthesiologist, until the anesthesiologist assistant registers a new supervising anesthesiologist with the Board, accompanied by a change in supervision fee, in an amount to be determined by the Board.

§ 122512. Anesthesiologist Assistant Protocols and Performance.

(a) Every anesthesiologist or group of anesthesiologists, upon entering into supervisory relationship with an anesthesiologist assistant *shall* file with the Board a written, protocol, to include, at a minimum, the following:

(1) Name, address, and license number of the anesthesiologist assistant;

(2) Name, address, license number and federal Drug Enforcement Administration (DEA) number of each Anesthesiologist who will supervise the anesthesiologist assistant;

(3) Address of the anesthesiologist assistant's primary practice location and any other locations where the assistant may practice;

(4) The date the protocol was developed and the dates of all revisions;

(5) The designation and signature of the primary supervising anesthesiologist;

(6) Signatures of the anesthesiologist assistant and all supervising anesthesiologists;

(7) The duties and functions of the anesthesiologist assistant;

(8) Conditions or procedures that require the personal provision of care by an anesthesiologist;

(9) The procedures to be followed in the event of an anesthetic emergency.

(b) The protocol *shall* be on file with the Board prior to the time the anesthesiologist assistant begins practice with the anesthesiologist or the anesthesiology group.

(c) The protocol must be updated biennially.

(d) Anesthesiologist assistants may perform the following duties under the direct supervision of an anesthesiologist and as set forth in the protocol outlined in paragraph (1) above:

(1) Obtaining a comprehensive patient history and presenting the history to the supervising anesthesiologist;

(2) Pretesting and calibration of anesthesia delivery systems and monitoring, obtaining and interpreting information from the systems and monitors;

(3) Assisting the anesthesiologist with implementation of monitoring techniques:

(4) Establishing basic and advanced airway interventions, including intubations of the trachea and performing ventilatory support;

(5) Administering intermittent vasoactive drugs and starting and adjusting vasoactive infusions;

(6) Administering anesthetic drugs, adjuvant drugs, and accessory drugs;

(7) Assisting the anesthesiologist with the performance of epidural anesthetic procedures and spinal anesthetic procedures;

(8) Administering blood, blood products, and supportive fluids;

(9) Supporting life functions during anesthesia health care, including induction and intubation procedures, the use of appropriate mechanical supportive devices, and the management of fluid, electrolyte, and blood component balances.

(10) Recognizing and taking appropriate corrective action for abnormal patient responses to anesthesia, adjunctive mediation or other forms of therapy;

(11) Participating in management of the patient while in the post-anesthesia recovery area, including the administration of supporting fluids;

(12) Perform other tasks not prohibited by law that are delegated by the supervising licensed anesthesiologist, and for which the anesthesiologist assistant has been trained and is proficient to perform.

(e) The supervising anesthesiologist *shall* delegate *only* tasks and procedures to the anesthesiologist assistant which are within the supervising physician's scope of practice. The anesthesiologist assistant may work in any setting that is within the scope of practice of the supervising anesthesiologist's practice.

(f) Continuity of Supervision in practice settings *shall* require the anesthesiologist assistant to document in the anesthesia record any change in supervisor.

(g) All tasks and procedures performed by the anesthesiologist assistant must be documented in the appropriate medical record.

§ 122513. Identification.

(a) While working, the anesthesiologist assistant *shall* wear or display appropriate identification, clearly indicating that he or she is an anesthesiologist assistant.

(b) The anesthesiologist assistant's license *shall* be displayed in the office, and any satellite operation in which the anesthesiologist assistant may function.

(c) A anesthesiologist assistant *shall* not advertise him or herself in any manner that would mislead the patients of the supervising anesthesiologist or the public.

§ 122514. Direct Supervision Required.

(a) Tasks performed by the anesthesiologist assistant must be under the direct supervision of a registered supervising anesthesiologist.

(b) All medical records *shall* be reviewed and co-signed by the approved supervising anesthesiologist within seven (7) days.

(c) Upon being duly licensed by the Board, the licensee *shall* have his or her name, address and other pertinent information enrolled by the Board on a roster of licensed anesthesiologist assistants.

(d) Not more than three (3) currently licensed anesthesiologist assistants may be supervised by a licensed anesthesiologist at any one time, except as *may* be otherwise provided pursuant to § 122506(a).

(e) If no registered supervising anesthesiologist is available to supervise the anesthesiologist assistant, the anesthesiologist assistant *shall* not perform patient care activities.

(f) Nothing in these rules *shall* be construed to prohibit the employment of anesthesiologist assistants by a medical care facility where such anesthesiologist assistants function under the supervision of a Guam-licensed anesthesiologist.

§ 122515. Supervision ratio; one-to-three (1:3); Limited.

The registered supervising Anesthesiologist *shall* be limited to a supervision maximum ratio of one-to-three (1:3), except as provided in §122506(a), and *shall not* supervise the anesthesiologist assistants while concurrently performing or directing any anesthesiology procedure upon more than one (1) patient.

§ 122516. Exceptions to Licensure Requirement.

No person may practice as an anesthesiologist assistant on Guam who is not licensed by the Board. This Article, however, shall not be construed to prohibit a student in an anesthesiologist assistant program from performing duties or

functions assigned by his instructors, who is working under the direct supervision of a licensed anesthesiologist in an approved externship.

§ 122517. Prescriptive Authority - None; Limited to delegation by prescribing anesthesiologist.

An anesthesiologist assistant, *shall* only be able to select and administer any form of anesthetic by delegation while under the direct supervision of an anesthesiologist licensed by the Board, and, may select and administer any licensed drug *solely* by delegation and pursuant to the direct supervision instructions of the prescribing anesthesiologist, the established written practice protocol, and in accordance to any applicable rules and regulation established by the Board pursuant to this Article."

Section 3. Severability. If any provision of this Act or its application to any person or circumstance is found to be invalid or contrary to law, such invalidity shall not affect other provisions or applications of this Act which can be given effect without the invalid provisions or application, and to this end the provisions of this Act are severable.

Section 4. Effective Date. This Act shall become immediately effective upon enactment.

SENATOR DENNIS G. RODRIGUEZ, Jr., Chairman

COMMITTEE ON HEALTH & HUMAN SERVICES, HEALTH INSURANCE REFORM, ECONOMIC DEVELOPMENT AND SENIOR CITIZENS

Mina'trentai Dos Na Liheslaturan Guåhan • 32nd Guam Legislature

PUBLIC HEARING DATE / Wednesday, September 10 , 2014 2pm

Bill 381-32 (COR)- An act to establish the Anesthesiologist Assistant Act, by adding a new Article 25 to Chapter 12, Part 2, Title 10, Guam Code Annotated. Introduced by Sen. Dennis G. Rodriguez, Jr.

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— None further								

September 8, 2014

TO: Senator Dennis Rodriguez

32nd Guam Legislature

FR: Department of Anesthesia Staff Members

Guam Memorial Hospital

RE: Support for Anesthesiologist Assistant Act

Dear Senator Rodriguez,

We, the anesthesia staff members of Guam Memorial Hospital, are in full support for Anesthesiologist Assistant Act. Anesthesiologist Assistants (AA) carry out their responsibilities as members of the Anesthesia Care Team (ACT). The American Society of Anesthesiologist firmly supports the anesthesia care team concept and the addition of AAs as team members.

In the ACT model, anesthesia is delivered by qualified anesthesia personnel under the direction of an anesthesiologist. Qualified anesthesia personnel include anesthesiology residents and fellows and non-physician anesthetists such as nurse anesthetists and anesthesiologist assistants (AAs). The fellows and residents are physicians undergoing education and training to become physician anesthesiologists. Nurse anesthetists can most applicably be compared to advanced practice nurses with specific training in the delivery of anesthesia, and AAs can most applicably be compared with physician assistants with specific training in the delivery of anesthesia. The physician anesthesiologist, as with any other physician, may delegate appropriate tasks to non-physician providers as long as the physician remains ultimately responsible for the care of the patient.

We also firmly believe that a physician anesthesiologist must be involved with your care … because when seconds count, physician anesthesiologists save lives.

Signed:

Dr. Russel Aubin

Dr. Fernan DeGuzman

Dr. Myroslav Harasym

Dr. Reynald Lim

Dr. Gilbert Lopez

Dr. Virgilio Lopez

American Academy of Anesthesiologist Assistants

Frequently Asked Questions

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For other questions,contact the American Academy of Anesthesiologist Assistants.

Answers

Basic Definitions & Information

1. Who are Anesthesiologist Assistants (AAs)?

Anesthesiologist Assistants (AAs) are highly skilled health professionals who work under the direction of licensed anesthesiologists to implement anesthesia care plans. AAs work exclusively within the anesthesia care team environment as described by the American Society of Anesthesiologists (ASA). All AAs possess a premedical background, a baccalaureate degree, and also complete a comprehensive didactic and clinical program at the graduate school level. AAs are trained extensively in the delivery and maintenance of quality anesthesia care as well as advanced patient monitoring techniques. The goal of AA education is to guide the transformation of qualified student applicants into competent health care practitioners who aspire to practice in the anesthesia care team.

Anesthesiologist Assistants and certified registered nurse anesthetists are both defined as "non-physician anesthetists" within the Centers for Medicare & Medicaid Services section of the Code of Federal Regulations.

2. What is the origin of the Anesthesiologist Assistant profession?

In the 1960s, three anesthesiologists, Joachim S. Gravenstein, John E. Steinhaus, and Perry P. Volpitto, were concerned with the shortage of anesthesiologists in the country. These academic department chairs analyzed the spectrum of tasks required during anesthesia care. The tasks were individually evaluated based on the level of professional responsibility, required education and necessary technical skill. The result of this anesthesia workforce analysis was to introduce the concept of team care and to define a new mid-level anesthesia practitioner linked to a supervising anesthesiologist. This new professional - the Anesthesiologist Assistant or AA - had the potential to at least partially alleviate the shortage of anesthesiologists.

The new type of anesthetist would function in the same role as the nurse anesthetist under anesthesiologist direction. An innovative educational paradigm for anesthetists was created that built on a pre-med background during college and led to a Master's degree. This pathway placed AAs on an anesthesia "career ladder". Some AAs have leveraged their premed background, Master's degree and clinical experience to successfully apply to medical school. A few have returned to anesthesia to become the physician leader of the care team that launched their professional career.

The chairmen's vision became reality in 1969 when the first AA training programs began accepting students at Emory University in Atlanta, Georgia, and at Case Western Reserve University in Cleveland, Ohio.

3. What are the differences between AAs and Physician Assistants?

Although AAs and physician assistants (PAs) both function as physician extenders, they do not perform the same functions. Each has its own separate educational curriculum, standards for accreditation, and its own agency for certification. PAs receive a generalist education and may practice in many different fields under the supervision of a physician who is qualified and credentialed in that field.

An AA may not practice outside of the field of anesthesia or apart from the supervision of an anesthesiologist. An AA may not practice as a physician.s assistant unless the AA has also completed a PA training program and passed the National Commission for the Certification of Physician Assistants (NCCPA) exam.

Likewise a PA may not identify him- or herself as an AA unless he or she has completed an accredited AA program and passed the National Commission for the Certification of Anesthesiologist Assistants (NCCAA) exam. If also certified as an AA, such a dual-credentialed PA would be required to practice as an anesthetist only as an extender for an anesthesiologist and could not provide anesthesia care at the direction of a physician of any other specialty.

4. What are the differences between Nurse Anesthetists (NAs) and AAs?

Although both are considered to be equivalent clinical non-physician anesthesia providers and may serve as physician extenders in the delivery of anesthesia, AAs and NAs are very different with regard to their educational background, training pathway and certification process.

Admission Requirements

According to the Council on Accreditation (COA) of Nurse Anesthesia Educational Programs, a typical applicant to an NA program must have attained a bachelor.s degree in either nursing or another appropriate area. Before 1998, applicants with only an associate's degree in nursing were accepted. Additionally, the applicant must be licensed to practice as a registered nurse and take either the Graduate Record Exam (GRE) or the Miller Analogies Test (MAT) prior to matriculation. Finally, one year of nursing experience is required in an "acute care setting".

In order to be admitted to an AA program, the applicant must have achieved a bachelor's degree with prescribed prerequisites typical of premedical course work. Specific requirements include general and organic chemistry, advanced college math, general and advanced biology, and physics. Applicants must then take either the (MCAT) or the (GRE). Although many applicants who are from allied health backgrounds such as respiratory therapy and emergency medical technology may have years of clinical experience, a clinical background is not an absolute requirement. Nurses who meet the premed coursework prerequisites have been admitted to AA programs.

Educational Programs

NA training programs must include a minimum of 24 months in a Master.s level program accredited by the COA. The training programs may be based at any college or university offering a Master.s level degree. Many nurse anesthetists do not possess a Master.s degree as this was not required until 1998 and some do not possess a bachelor degree. Nurse anesthetist programs do not require involvement of a medical school or academic physician faculty. Community hospitals may serve as main clinical sites. A minimum of 450 hours of classroom/laboratory education, 800 hours of clinical anesthesia education, and administration of 450 anesthetics, including all types of surgery, must be achieved for the student to successfully complete the training program.

AA training programs must include a minimum of 24-28 months in a Master.s level program accredited by the Commission for the Accreditation of Allied Health Educational Programs (CAAHEP). The programs must be based at, or in collaboration with, a university that has a medical school and academic anesthesiologist physician faculty. Each AA program must have at least one director that is a licensed, board-certified anesthesiologist. Main clinical sites must be academic medical centers. An average of 600 hours of classroom/laboratory education, 2600 hours of clinical anesthesia education, and more than 600 anesthetics administered, including all types of surgery, are typically required to successfully complete AA training.

Certification Process

Upon completion of an accredited nurse anesthetist program, a student may become certified by passing the Council for Certification of Nurse Anesthetists certification exam. This examination is an adaptive computer examination consisting of 90-160 questions. Forty hours of approved Continuing Education Units (CEU) are required every two years in order to recertify. To be recertified, nurse anesthetists are not required to pass any further testing. The NCCRNA has proposed a new recertification process requiring CRNAs to pass a recertification exam every 8 years beginning in 2015. If this measure is adopted all CRNAs will have passed a recertification exam by 2023.

Upon completion of an accredited AA program, a student may become certified by passing the NCCAA examination. The examination is administered and scored by the National Board of Medical Examiners as part of services contracted to NCCAA. Performance information for test items and the overall exam are provided by NBME. NCCAA uses this data to set the passing score and provides notification of certification. NCCAA awards a time-limited certificate to each candidate who successfully completes the Certifying Examination.

To re-certify, an AA must complete 40 hours of CME every two years and register the activities with NCCAA. Additionally, AAs must take the Continuing Demonstration of Qualification Exam every six years.

5. What is the professional organization for AAs?

The professional organization for AAs is the American Academy of Anesthesiologist Assistants (AAAA). AAAA was founded in 1975 and serves the various educational, advocacy and national organizational needs of the AA profession. Their website may be found at: www.anesthetist.org.

6. Can AAs become members of ASA?

AAs and AA students, as well as NAs and NA students, are eligible for ASA membership. They join under the category of "Educational Members" and are entitled to all of the educational benefits of ASA memberships, including free registration at the ASA Annual Meeting and a subscription to Anesthesiology.

Educational members are nonvoting members and cannot run for office. However at the invitation of the President, AAs can and do serve on committees and attend Reference Committee and House of Delegates meetings. Dues for Educational Members are currently the same as for Affiliate Members. Applications for membership may be obtained from the ASA website.

Education & Certification

1. Where are AA education programs located?

There are 10 accredited AA educational programs.

- Emory University - Atlanta, Georgia
- Case Western Reserve University - Cleveland, Ohio
- Case Western Reserve University - Houston, Texas
- Case Western Reserve University - Washington, D.C.
- South University - Savannah, Georgia
- Nova Southeastern University - Fort Lauderdale, Florida
- Nova Southeastern University - Tampa, Florida
- University of Missouri - Kansas City, Missouri
- Quinnipiac University - Hamden, Connecticut
- University of Colorado - Aurora, Colorado

2. What are the requirements for sponsoring an AA program?

According to the latest standards established by the Commission on Accreditation of Allied Health Education Programs (CAAHEP), accredited Anesthesiologist Assistant educational program must be supported by an anesthesiology department of a medical school that is accredited by the Liaison Committee on Medical Education or its equivalent. The anesthesiology department must have the educational resources internally or through educational affiliates that would qualify it to meet the criteria of the Accreditation Council for Graduate Medical Education (ACGME), or its equivalent for sponsorship of an anesthesiology residency program. CAAHEP rules also allow for consortium sponsorship utilizing the combined resources of an academic anesthesiology department and an accredited college with appropriate allied health faculty and degrees.

Although the standards recognize the importance of a basic science education within a clinically oriented academic setting, it is also recognized that some of the supervised clinical practice components of the curriculum may be carried out in affiliated community hospitals that have the appropriate affiliation agreements specifying the requisite teaching faculty and staffing ratios for the clinical experience.

3. What is the accrediting body for AA education programs?

The Commission on Accreditation of Allied Health Education Programs (CAAHEP) accredits AA training programs. ASA is a CAAHEP member and participates in the accreditation processes for three health professions - anesthesiologist assistant, respiratory therapy and emergency medical technician-paramedic. CAAHEP is the largest accreditor in the health sciences field. In collaboration with its Committees on Accreditation, CAAHEP reviews and accredits over 2000 educational programs in nineteen (19) health science occupations. CAAHEP is recognized by the Council for Higher Education Accreditation (CHEA).

CAAHEP re-approved the "Standards and Guidelines for Anesthesiologist Assistant Education" most recently in 2009. These standards are composed and submitted by the Accreditation Review Committee on Education for the Anesthesiologist Assistant (ARC-AA). ARC-AA in turn is composed of representatives from the American Academy of Anesthesiologist Assistants (AAAA), and the American Society of Anesthesiologists (ASA). Anesthesiologists from ASA work along with AA representatives from AAAA to define the educational process that produces a competent AA graduate. This partnership of professional organizations has ensured an integral role for anesthesiologists in AA education. This in turn echoes the anesthesiologist / AA relationship in the anesthesia care team.

Additional information on accreditation may be found at the CAAHEP website.

4. What is the length of the AA education program?

According to CAAHEP standards for AA programs, the depth and duration of the total program, and particularly the clinical experience, shall be sufficient to assure the potential employer that the newly graduated AA will be able to perform entry-level functions. The number, content and length of courses shall be appropriate to the training of an assistant to the anesthesiologist. The AA curriculum is based on an advanced graduate degree model, and at least two full academic years are required. The current programs are 24 to 28 months long. Graduates from all AA educational programs earn a masters-level degree.

5. What types of students enter AA education programs?

Qualified student applicants must possess a baccalaureate degree and complete all of the premedical course work required by the typical American medical school.

Though minor differences between programs may exist, generalized admission requirements for students seeking entrance into an AA program include:

- Bachelor's degree from an accredited institution with a premedical sciences track
- Two semesters of biology with laboratory
- Two semesters of vertebrate anatomy and physiology (or other advanced biology) with laboratory
- Two semesters of general chemistry; 1 semester of organic chemistry; a second semester of organic chemistry or biochemistry with laboratory
- Two semesters of general physics with laboratory
- Two semesters of advanced college mathematics including calculus
- Either the Medical College Admissions Test (MCAT) or the Graduate Records Admission Test (GRE)

6. Who are the faculty of AA programs?

According to CAAHEP standards, the program must include faculty who are qualified through academic preparation and experience to teach assigned subjects. Faculty members for the basic sciences are university-based professors and instructors. Faculty for the supervised clinical practice portion of the educational program must include physicians and AAs based within the department of anesthesiology, but also may include other health professionals who are experienced in their disciplines. Faculty members may possess clinical appointments within the affiliated medical school. Although anesthesiology residents and fellows may be involved in AA training, they should not play a predominant role.

7. What is the certification process for AAs?

The National Commission for Certification of Anesthesiologist Assistants (NCCAA) was founded in July 1989 to develop and administer the certification process for AAs in the United States. The NCCAA consists of Commissioners representing ASA, AAAA, and at-large physician and AA members.
Graduates or senior students in their last semester in an AA educational program that has been accredited by CAAHEP may apply for initial certification. Initial certification is awarded to an AA who has successfully completed the Certifying Examination for Anesthesiologist Assistants administered by NCCAA in collaboration with the National Board of Medical Examiners (NBME). Certified AAs are permitted to use the designation AA-C to indicate that they are currently certified.

The content for the Certifying Examination for Anesthesiologist Assistants is based on knowledge and skills required for anesthetist practice. NCCAA has contracted with NBME to serve as a consultant for the development and ongoing administration of the Certifying Examination. A Test Committee of anesthesiologists and AAs is responsible for writing and evaluating test questions for the examinations. The first Certifying Examination was administered in 1992.

NCCAA maintains a database of Anesthesiologist Assistants-Certified from which certification of individual practitioners can be verified. Hospitals, practice groups, state boards, and others can verify an AA.s certification, including a printed verification statement, by going to the Verify Certification page of NCCAA's web site, www.aa-nccaa.org.

The web site also contains additional information about the National Commission and about the certification process.

8. Do AAs have to recertify?

AAs are granted a time-limited certificate after passing the initial examination. The ongoing process or recertification requires that AAs submit documentation to NCCAA every two years that they have completed 40 hours of continuing medical education (CME). In addition, every six years they must pass the Examination for Continued Demonstration of Qualifications (CDQ). This ongoing certification cycle is depicted below.

NCCAA Certification Process
Year 0 Certifying Examination
Year 1
Year 2 CME Registration
Year 3
Year 4 CME Registration

Year 5
Year 6 CME Registration & CDQ Examination

The CDQ Examination was first administered in 1998, making AAs the first anesthesia profession to require passage of a written examination as part of the recertification process. Failure to meet any of the above CME or examination requirements results in withdrawal of certification for the AA.

AA practice

1. What does the ASA Care Team Statement say about AAs?

According to the ASA statement on the Anesthesia Care Team, anesthesia care personally performed or medically directed by an anesthesiologist constitutes the practice of medicine. Certain aspects of anesthesia care may be delegated to other properly trained and credentialed professionals. These professionals, medically directed by the anesthesiologist, comprise the Anesthesia Care Team.

The Care Team statement (last amended on October 21,2009) says,
"Such delegation should be specifically defined by the anesthesiologist and should also be consistent with state law or regulations and medical staff policy. Although selected tasks of overall anesthesia care may be delegated to qualified members of the Anesthesia Care Team, overall responsibility for the Anesthesia Care Team and the patients. safety rests with the anesthesiologist. Anesthesiologists should determine which perioperative tasks, if any, may be delegated. The anesthesiologist may delegate specific tasks to qualified non-anesthesiologist members of the ACT providing that quality of care and patient safety are not compromised, but should participate in critical parts of the anesthetic and remain immediately physically available for management of emergencies regardless of the type of anesthetic."

Members of the medically directed anesthesia care team may include anesthesiology residents as well as non-physicians such as anesthesiologist assistants and nurse anesthetists. The ASA Anesthesia Care Team statement may be read in its entirety here.

2. What is the scope of AA clinical practice?

The scope of AA clinical practice is generally the same as that of nurse anesthetists on the Anesthesia Care Team. The ASA statement on the Recommended Scope of Practice of Nurse Anesthetists and Anesthesiologist Assistants may be found at: www.asahq.org/clinical/crnaaascope.pdf

Specifically, the local scope of practice of AAs is usually defined by

- The medically directing anesthesiologist,
- The hospital credentialing body,
- The state's board of medicine
- Any applicable state statute or regulation.

States may also require a practice agreement between the sponsoring anesthesiologist and the AAs who are medically directed.

3. What is the typical job description for AAs?

The specific job descriptions and duties of AAs may differ according to local practice. State law or board of medicine regulations or guidelines may further define the job descriptions of AAs. The constant ingredient no matter what the local variation is that AAs always practice under the medical direction of a qualified anesthesiologist.

As part of defining the educational goal of AA training programs, the CAAHEP accreditation Standards include a template AA job description. The excerpt is included below. Wherever the term 'assisting' occurs, it is understood that such assistance may be actual performance of the stated task by the AA as part of duties directed by the supervising anesthesiologist.

"Under the medical direction and supervision of an anesthesiologist, the AA.s functions include, but are not limited to, the following:

- Making the initial approach to a patient of any age in any setting to obtain a preliminary preanesthetic health history, perform an appropriate preanesthetic physical examination and record pertinent data in an organized and legible manner for review by an anesthesiologist. These activities help to define the patient's current physical status as it relates to the planned anesthetic.
- Performing or assisting in the conduct of diagnostic laboratory and related studies as appropriate, such as drawing arterial and venous blood samples.
- Establishing noninvasive and invasive routine monitoring modalities as delegated by the responsible anesthesiologist.
- Assisting in the application and interpretation of advanced monitoring techniques such as pulmonary artery catheterization, electroencephalographic spectral analysis, echocardiography and evoked potentials.
- Assisting in inducing, maintaining and altering anesthesia levels, administering adjunctive treatment and providing continuity of anesthetic care into and during the postoperative recovery period.
- Assisting in the use of advanced life support techniques such as high frequency ventilation and intra-arterial cardiovascular assist devices.
- Assisting in making postanesthesia patient rounds by recording patient progress notes, compiling and recording case summaries and by transcribing standing and specific orders.
- Performing evaluation and treatment procedures essential to responding to life-threatening situations, such as cardiopulmonary resuscitation, on the basis of established protocols (basic life support, advance cardiac life support, and pediatric advanced life support).
- Assisting in the performance of duties in intensive care units, pain clinics and other settings, as appropriate.
- Training and supervising personnel in the calibration, trouble shooting and use of patient monitors.
- Performing delegated administrative duties in an anesthesiology practice or anesthesiology department in such areas as the management of personnel, supplies and devices.
- Assisting in the clinical instruction of others."

The complete Standards for Accreditation of Anesthesiologist Assistant Education is available from CAAHEP at AA Standards.

4. Can AAs perform regional anesthesia and place invasive monitors?

AAs are permitted to perform regional anesthesia techniques and place invasive monitors. These aspects of AA practice depend on the discretion of the supervising anesthesiologist, policies and procedures of the Department of Anesthesiology, standards set by the facility credentialing committee, and applicable state law. As always, performance of any such patient care task is under the medical direction of an anesthesiologist.
ASA policy on the performance of regional anesthesia by non-physicians is found in the ASA Statement on Regional Anesthesia and can be read in its entirety here.

5. What is the legal authority for AAs to practice?

Anesthesiologist assistants may be either licensed as AAs or practice under the license of an anesthesiologist under the principle of delegation. Anesthesiologists may delegate those tasks or duties involved in the practice of anesthesiology to qualified individuals such as AAs as long as the anesthesiologist is immediately available and the anesthesiologist retains ultimate responsibility for the care of the patient. The exact details regarding delegation and licensing of AAs are different from state to state, and an anesthesiologist seeking to employ AAs should consult the board of medicine of the state in which he or she practices.

6. Where do AAs practice?

Anesthesiology practices in many states presently employ AAs. Inclusion of AAs in anesthesia care team practices across the country is a dynamic and evolving situation. To get the latest and most accurate information, please contact your state board of medicine or the ASA Washington Office for any questions on the licensure and practice locations of AAs.

Another excellent resource is maintained by the American Academy of Anesthesiologist Assistants (AAAA). Click here for a map highlighting the states where AAs currently practice.

7. What is the difference between delegatory authority and licensure?

Licensure for AAs is created by legislation that is enacted and codified into state law or through regulation adopted by the board of medicine.

Delegatory authority may take the form of either recognition and action by the board of medicine or expressed in a delegation enabling statute such as the state's medical practice act. It is well accepted in various medical specialties, including anesthesiology, that the board of medicine may grant a physician the authority to delegate tasks or duties related to the practice of medicine to qualified individuals so long as the physician: 1) remains ultimately responsible to the patient and 2) assures that the individual performing the tasks is qualified to do so. An anesthesiologist seeking to employ AAs under the principle of delegatory authority should seek input from the board of medicine of their specific state.

Licensure for AA practice, although sometimes more difficult to achieve, better defines and anchors the practice of AAs in a state than does the simpler delegatory authority.

In all states AA practice falls under the auspices of the board of medicine. In contrast, nurse anesthetists' practice is regulated by state boards of nursing.

practice Management of AAs

1. Can I hire an AA to work in my practice?

If your state does not presently provide the legislative or delegatory option of AA practice, consultation should take place with the board of medicine or other governing body to explore the specific legal implications of AA practice in your state. General information on the steps to establish AA practice is available from the ASA's Office of Governmental and Legal Affairs. You may also inquire of other state societies as to their local advocacy and procedural steps that have led to gaining the option to hire AAs.

Also, the American Academy of Anesthesiologist Assistants is a valuable resource on suggested methods of licensing and establishing practice of AAs drawn from various states. Click here to contact AAAA.

Finally, you can also contact the educational programs directly.

2. What is the anesthesiologist supervision ratio for AAs?

In addition to the practical issues that limit how many anesthetists may be supervised by an anesthesiologist at any one time, ratios are also often specified as contract requirements from payors. For instance in order to meet CMS requirements for medical direction, no more than 4 anesthetists (AAs or NAs) may be concurrently directed by an anesthesiologist.

The supervision ratio may also be defined in state law or Board of Medicine guidelines and is usually between 2:1 and 4:1. Check the regulations in your state for the applicable standard. It is important to note that in states where statutes specify a supervision ratio of AAs to anesthesiologists at less than 4:1, the anesthesiologist may also concurrently supervise NAs up to a total combined ratio of 4:1 for both non-physician anesthetists.

3. How is AA practice reimbursed by CMS and third-party payers?

CMS recognizes both CRNAs and AAs as non-physician anesthesia providers. Similarly, commercial insurance payors make no distinction between the two anesthetist types with regard to payments for services provided under medical direction by an anesthesiologist.

According to the United States Code of Federal Regulations (42 C.F.R. § 482.52 Condition of participation: Anesthesia services)

"If the hospital furnishes anesthesia services, they must be provided in a well-organized manner under the direction of a qualified doctor of medicine or osteopathy. The service is responsible for all anesthesia administered in the hospital.

Standard: Organization and staffing. The organization of anesthesia services must be appropriate to the scope of the services offered. Anesthesia must be administered by only

- A qualified anesthesiologist;
- A doctor of medicine or osteopathy (other than an anesthesiologist);
- A dentist, oral surgeon, or podiatrist who is qualified to administer anesthesia under State law;
- A certified registered nurse anesthetist (CRNA), as defined in 410.69(b) of the Federal Register, who is under the supervision of the operating practitioner or of an anesthesiologist who is immediately available if needed; or
- An anesthesiologist's assistant, as defined in 410.69(b) of the Federal Register, who is under the supervision of an anesthesiologist who is immediately available if needed."

4. How do AA and NA salaries compare?

When employed within the same department and when possessing the same job description and experience level within the anesthesia care team, AAs and NAs are compensated with identical salary and benefit packages.

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Adopted March 31St, 2006

STATEMENT ON THE ANESTHESIA CARE TEAM (ACT) MODEL
American Academy of Anesthesiologist Assistants (AAAA)

The American Academy of Anesthesiologist Assistants (AAAA) subscribes in practice, philosophy and training to the Anesthesia Care Team (ACT).

The foundation of the ACT model is grounded in a team approach to anesthesia management in which an anesthesiologist concurrently supervises anesthetists during the performance of the technical aspects of an anesthetic.

Within the Anesthesia Care Team, an anesthesiologist and AA work together to provide anesthesia care in the belief that the interests of patient safety are best served with an anesthesiologist's involvement in the delivery of every anesthetic. The responsibility for medical direction lies with the anesthesiologist, who may then delegate aspects related to the implementation of an anesthetic plan to the AA. Delegation of any aspect of patient care to an AA is at the discretion of the anesthesiologist, in accordance with established state regulation and local credentialing guidelines.

AMERICAN SOCIETY OF ANESTHESIOLOGIST POSITION PAPER

Recommended Scope of Practice of Nurse Anesthetists and Anesthesiologist Assistants

Because nurse anesthetists and anesthesiologist assistants are not trained to make medical judgments, virtually all states require direct physician participation in care provided by these anesthesia providers. State statutes and regulations specify the requirements for medical direction or supervision of nurse anesthetists by a physician or dentist legally authorized to deliver anesthesia services. State statutes and regulations that license anesthesiologist assistants, or permit them to practice pursuant to delegated anesthesiologist authority, require direct anesthesiologist participation in the care provided by them.

State regulations generally require either direct and immediate supervision of nurse anesthetists and other allied healthcare providers by a qualified physician or the existence of a protocol/collaboration arrangement with such a physician. State regulations dealing with anesthesiologist assistants all require that they be directed or supervised by an anesthesiologist.

The following principles related to nurse anesthetist/anesthesiologist assistant scope of practice are supported by ASA:

In many situations, anesthesia care is rendered through use of an anesthesia care team in which an anesthesiologist concurrently medically directs two, three or four nurse anesthetists and/or anesthesiologist assistants in the performance of the technical aspects of anesthesia care. Anesthesiologists engaged in medical direction are responsible for the preanesthetic medical evaluation of the patient, prescription and implementation of the anesthesia plan, personal participation in the most demanding procedures of the plan (including induction and emergence), following the course of anesthesia administration at frequent intervals, remaining physically available for the immediate treatment of emergencies and providing indicated postanesthesia care.

In some institutions, nurse anesthetist performance is supervised by the operating practitioner, who assumes responsibility for satisfying the requirement found in most state health codes and federal Medicare regulations that nurse anesthetists be supervised by a physician. The operating practitioner rarely, if ever, is able to assume all of the supervision involved in medical direction. The operating practitioner's supervision of nurse anesthetist activities, therefore, involves a lesser application of physician judgment or skills for anesthesia care and thus involves greater reliance on the training and capabilities of the individual nurse anesthetist.

A qualified nurse anesthetist is a licensed registered nurse who has satisfactorily completed an accredited nurse anesthesia training program and who has been credentialed by the institution on recommendation of the anesthesiology staff or, in the absence of an anesthesiologist, by the active medical staff. Credentialing of nurse anesthetists should take into account whether the nurse anesthetist will provide care under medical direction by an anesthesiologist or under supervision by the operating practitioner.

A qualified anesthesiologist assistant is an allied healthcare provider who has satisfactorily completed an anesthesiologist assistant program granting a Master's degree, has been certified by the National Commission for Certification of Anesthesiologist Assistants (NCCAA) and has been credentialed by the institution.

Subject to the foregoing limitations, a nurse anesthetist or an anesthesiologist assistant may, under medical direction by an anesthesiologist, or in the case of a nurse anesthetist, under supervision of an operating practitioner who has assumed responsibility for the performance of anesthesia care (collectively, the "responsible physician"):

> Provide non-medical assessment of the patient's health status as it relates to the relative risks involved with anesthetic management of the patient during performance of the operative procedure;
> Based on the health status of the patient, determine, in consultation with the responsible physician, and administer the appropriate anesthesia plan (i.e., selection and administration of anesthetic agents, airway management, monitoring and recording of vital signs, support of life functions, use of mechanical support devices and management of fluid, electrolyte and blood component balance);
> Recognize and, in consultation with the responsible physician, take appropriate corrective action to counteract problems that may develop during implementation of the anesthesia plan;
> Provide necessary, normal postanesthesia nonmedical care in consultation with the responsible physician; and
> Provide such other services as may be determined by the responsible physician.

Nurse anesthetists and anesthesiologist assistants should not be credentialed to perform procedures that involve medical diagnostic assessment, indications, contraindications and treatment in response to complications that require the application of medical skill and judgment. ASA's position on participation by non-physicians in regional anesthesia and invasive monitoring procedures is respectively set forth in its "Statement on Regional Anesthesia" and its "Practice Guidelines for Pulmonary Artery Catheterization," which can be found on the ASA website under "Clinical Information."

For further information, please contact Ronald Szabat, ASA Executive Vice President & General Counsel, or Lisa Percy, ASA State Legislative and Regulatory Issues Manager, at (202) 289-2222.

March 2009

AMERICAN SOCIETY OF ANESTHESIOLOGIST POSITION PAPER

Anesthesiologist Assistants: Qualified Members of the Anesthesia Care Team

Who are Anesthesiologist Assistants?

Anesthesiologist assistants are highly qualified non-physician anesthesia providers who assist anesthesiologists in implementing an anesthesia care plan developed for the patient. Anesthesiologist assistants administer anesthesia under the supervision of an anesthesiologist who is immediately available. They are trained extensively in the delivery and maintenance of quality anesthesia care, as well as advanced patient monitoring techniques. Anesthesiologist assistants work exclusively within the anesthesia care team environment as described by the American Society of Anesthesiologists.

There are approximately 1,800 anesthesiologist assistants who are practicing in 18 states and the Veterans Affairs system. Anesthesiologist assistants are recognized as qualified anesthesia providers by the Centers of Medicare and Medicaid Services, Department of Veterans Affairs, and TriCare. It is a testament to their education, skill, and training that these agencies authorize anesthesiologist assistants to provide anesthesia to the population's sickest patients.

Equivalency of Supervised Anesthesiologist Assistants & Nurse Anesthetists

Anesthesiologist assistants are as safe and effective as nurse anesthetists. The federal government and 18 states recognize anesthesiologist assistants and nurse anesthetists as being qualified anesthesia providers who have identical clinical capabilities and responsibilities. There is no evidence of any sort that the care provided by an anesthesiologist assistant is less safe than that of a nurse anesthetist. For nearly four decades, the anesthesia care team has safely and effectively delivered anesthesia care with either an anesthesiologist assistant or nurse anesthetist as the nonphysician anesthetist member of the team.

An analysis of over 50,000 anesthesia cases by the University Hospital Health System in Ohio did not find a difference in patient outcomes between nurse anesthetists and anesthesiologist assistants. Additionally, professional liability insurance carriers treat anesthesiologist assistants and nurse anesthetists equally; there is no difference in risk when insuring the two providers. No state has amended its state law to limit the scope of practice of an anesthesiologist assistant due to safety concerns. In fact, states have increased the anesthesiologist/anesthesiologist assistant supervision ratio as they have proven to be highly qualified anesthesia providers. Because anesthesiologist assistants work under the supervision of an anesthesiologist, patients will always have an anesthesiologist involved in their care. An anesthesiologist will be immediately available to respond to any complication that may arise.

While differences exist between anesthesiologist assistants and nurse anesthetists in regard to the prerequisites, curriculum, instruction in regional anesthesia and invasive monitoring, and requirements for supervision in practice, these differences are not based on superiority of education or ability, but rather a product of differences in historical development and the philosophies and motivations of those that practice within each profession.

History of Anesthesiologist Assistants

The first anesthesiologist assistant programs began at Emory University and Case Western Reserve University in 1969. The education program and profession is a result of the physician shortage faced by the field of anesthesiology in the mid-1960s, a shortage of nurses in anesthesia, and the increasing technological demands of the field. In response, three anesthesiologists proposed the concept of an "anesthesia technologist" who would be a member of the anesthesia team and be considered an "applied physiologist."

Education and Training

There are five accredited anesthesiologist assistant programs in the United States. All of the programs require the Graduate Record Examination or Medical College Admission Test entrance exam and a bachelor's degree that is based upon a premedical curriculum. The programs consist of 56-132 classroom hours of course work and from 2,000 to 2,700 clinical hours. As part of the program, anesthesiologist assistant students must complete a clinical rotation in all subspecialties of anesthesia with additional training in regional anesthesia and invasive line placement. The anesthesiologist assistant programs are accredited by the Commission for the Accreditation of Allied Health Education Programs. The programs are located in academic facilities that meet anesthesia residency requirements for physicians. Graduates of the anesthesiologist assistant programs are awarded a master's degree.

Upon completion of the program, certification is awarded upon successful completion of the certifying examination administered by the National Commission for Certification of Anesthesiologist Assistants. To become recertified, an anesthesiologist assistant must complete 40 hours of continuing medical education credits biannually and successfully complete every six years the Continued Demonstration of Qualifications (CDQ) exam, which is administered by the National Board of Medical Examiners.

AMERICAN SOCIETY OF ANESTHESIOLOGISTS

ARTICLE

June 1, 2014 Volume 78 Number 6
State Beat Jason Hansen, M.S., J.D.

On March 25, Indiana Governor Mike Pence (R) signed into law Senate Bill 233, which authorizes licensure for anesthesiologist assistants (AAs). This legislative success was the result of a multi-year effort by the Indiana Society of Anesthesiologists (ISA) and the American Academy of Anesthesiologist Assistants. Indiana will be the 17th jurisdiction to authorize AA practice. AAs are also recognized federally by the Centers for Medicare & Medicaid Services and the Veterans Affairs system.

William McNiece, M.D., ISA President, stated that the new law will help Indiana keep pace with the growing demand for anesthesia services. He commented, "I am pleased Indiana has joined the list of states where anesthesiologist assistants can be licensed and work with anesthesiologists to deliver safe anesthetic care to patients. I believe this is a positive step for Indiana patients who need anesthesia for surgery or a procedure. We now look forward to implementing the new legislation and to beginning the process of introducing anesthesiologist assistants into anesthesiology practices in Indiana."

AAs have served patients as members of physician anesthesiologist-led anesthesia care teams for more than 40 years. AAs are highly skilled health professionals who work under the direction of physician anesthesiologists to implement anesthesia care plans. They work exclusively within the anesthesia care team environment as described by ASA. All AAs possess an undergraduate degree with a premedical background and also complete a comprehensive didactic and clinical program at the graduate school level. Upon completion from an accredited program, AAs take an examination that is administered and scored by the National Board of Medical Examiners. AAs are trained extensively in the delivery and maintenance of quality anesthesia care as well as advanced patient monitoring techniques.

It is the position of ASA that both AAs and nurse anesthetists have identical patient care responsibilities and technical capabilities. No state has amended its state law to limit the scope of practice of an AA due to safety concerns. In fact, states have increased the physician anesthesiologist/AA supervision ratio as they have proven to be highly qualified anesthesia providers. Because AAs work under the direction of a physician anesthesiologist, patients always have a physician anesthesiologist involved in their care and, as such, a physician anesthesiologist will be immediately available to respond to any complication that may arise.

According to Howard Odom, M.D., chair of ASA's Committee on Anesthesiologist Assistant Education and Practice, "Throughout the decades physician anesthesiologists and anesthesiologist assistants have worked together, patients have enjoyed increased access to care with a demonstrated and impeccable safety record. This new law offers Indiana patients the benefits of these needed and highly trained professionals – benefits which patients in 15 states, the District of Columbia, and the Veterans Affairs system receive from anesthesiologist assistants today."

The 2015 legislative session is around the corner. If your state is interested in pursuing legislation to authorize AAs, please contact Jason Hansen at j.hansen@asahq.org.

If you are a physician anesthesiologist in Indiana interested in expanding your practice to include AAs or an AA interested in working in Indiana, please contact the ISA at www.inanesthesiologist.net/contact.php for more information about the new law and AA licensure in Indiana.

AA Practice States:

- Alabama
- Colorado
- District of Columbia
- Florida
- Georgia
- Indiana (July 1, 2014)
- Kentucky
- Michigan (Delegation)
- Missouri
- New Mexico (University Hospitals)
- North Carolina
- Ohio
- Oklahoma
- South Carolina
- Texas (Delegation)
- Vermont
- Wisconsin

Jason Hansen, M.S., J.D. is ASA Director of State Affairs.

STATEMENT COMPARING ANESTHESIOLOGIST ASSISTANT AND NURSE ANESTHETIST EDUCATION AND PRACTICE

Committee of Origin: Anesthesia Care Team

(Approved by the ASA House of Delegates on October 17, 2007, and last amended on October 17, 2012)

Anesthesiologist Assistants (AA) and nurse anesthetists are both non-physician members of the Anesthesia Care Team. Their role in patient care is described in the American Society of Anesthesiologists' (ASA) Statement on the Anesthesia Care Team. The ASA document entitled Recommended Scope of Practice of Nurse Anesthetists and Anesthesiologist Assistants further details the safe limits of clinical practice. These documents state ASA's view that both AAs and anesthesia nurses have identical patient care responsibilities and technical capabilities--a view in harmony with their equivalent treatment under the Medicare Program. The proven safety of the anesthesia care team approach to anesthesia with either anesthesia nurses or AAs as the non-physician anesthetists confirms the wisdom of this view. Nevertheless, certain differences do exist between AAs and anesthesia nurses in regard to educational program prerequisites, instruction, and requirements for supervised clinical practice. Some of these differences are mischaracterized and misrepresented for the benefit of one category of provider over the other. The question that must be addressed is whether these differences in education and practice indicate superiority of one category of provider over the other in either innate ability or clinical capability.

Historical Background of Nurse Anesthetists and Anesthesiologist Assistants-

The Nurse Anesthesia discipline developed in the late 1800s and early 1900s out of surgeons' requests for more anesthesia providers since few physicians focused on anesthesia at that time. Surgeons directed the care provided by anesthesia nurses. As early as 1916 and 1917, nurse anesthetists fought their first legal battles to create and maintain the right to provide anesthesia under the direction of surgeons. Current issues related to registered nurse anesthetists' legal right to practice without the supervision of an anesthesiologist are due to their history, tradition, philosophy of education and political efforts, rather than the quality and scope of their education.

The AA profession was established in the late 1960s by anesthesiologists addressing another shortage of anesthesiologists in the country. After studying the educational pathway for anesthesiologists and nurse anesthetists, anesthesiologists created a new educational paradigm for a mid-level anesthesia practitioner emphasizing a science/pre-medical rather than nursing background in college. This person would perform the same job as the anesthesia nurses but could readily attend medical school if appropriate. This new professional, the anesthesiologist assistant, or AA, thus had the potential to alleviate the shortage of anesthesiologists. Trained specifically to share a common practice philosophy with anesthesiologists and to work only with anesthesiologists, AA education was designed to incorporate the basic principles supportive of the Anesthesia Care Team (ACT). The founders recognized early on the advantage of a strong pre-medical background in comparison to the nursing education backgrounds of the anesthesia nurse profession. The wisdom of this view has been confirmed by the increased focus on pre-medical course work as a prerequisite for admission to anesthesia nurse programs that occurred in response to the success of the AA profession. Thus by history, tradition, philosophy of education and desire, the AA is trained to work within the ACT under the supervision of an anesthesiologist alone. The quality and scope of their education has nothing to do with this decision.

STATEMENT COMPARING ANESTHESIOLOGIST ASSISTANT AND NURSE ANESTHETIST EDUCATION AND PRACTICE

The Committee on the Anesthesia Care Team studied and compared the prerequisites for program admission and curriculum of both AA and anesthesia nurse educational programs and the clinical practice in regards to scope of practice and overall quality. Reference was made to published program prerequisites, curricula, and graduation requirements for both AA and anesthesia nurse education programs; the laws and regulations governing clinical practice; requirements for maintenance of certification and available studies on the safety of anesthesia nurses and AA practice. In addition, the Committee reviewed an impartial study comparing AA and anesthesia nurse education and practice commissioned by the Kentucky legislature and published in February 2007, as well as a white paper from the American Association of Anesthesiologists' Assistants (AAAA) entitled "Comparison of AA and NA Education and Practice." The Committee came to the following conclusions:

Differences do exist between Anesthesiologist Assistants and Registered Nurse Anesthetists in regard to the educational program prerequisites, instruction, and requirements for supervision in practice as well as maintenance of certification. These differences are a product of the different manner in which the two professions developed and the desire of Anesthesiologist Assistants to work only with anesthesiologists.

Table 1 provides itemized comparisons. This table is used with permission from AAAA and can be found at the end of this statement.

The major differences between AAs and anesthesia nurses are summarized here:

1. Prerequisites to Anesthesia Training-

   Anesthesia nurse schools require a nursing degree and one year of critical care experience, while AA programs require a bachelor's degree emphasizing pre-medical, science-based coursework. The Committee agrees with the impartial findings of the study commissioned by the Kentucky legislature that the requirement for clinical experience, while it may constitute a temporary aid to those beginning their anesthesia nurse or AA education, makes no difference to the final outcome of that training. This conclusion is born out by the clinical experiences of anesthesiologists who work simultaneously with AA and anesthesia nurses and find no significant difference in clinical practice ability between the two professions.

2. Performance of Regional Anesthesia and Insertion of Invasive Catheters-

   Data compiled by AAAA in its "Comparison of AA and NA education and Practice" show that more anesthesia nurse education programs provide instruction in the technical aspects of regional anesthesia, but that a higher percentage of AA programs provide instruction in the placement of invasive monitoring lines. There is no evidence to suggest that the innate abilities or clinical capabilities of the students have any bearing on their suitability for this aspect of practice. Rather, the decision by some AA programs to limit the teaching of these techniques is based on the reservations expressed by some anesthesiologists about the safety of this practice by either AAs or anesthesia nurses. That limitation is voluntary, consistent with ASA policy and done with a view to enhancing patient safety. The ASA Statement on Regional Anesthesia recognizes that the supervising anesthesiologist may, when appropriate, delegate certain technical aspects of these procedures to a non-physician anesthetist. Nevertheless, as neither anesthesia nurses nor AAs receive the medical education necessary to safely evaluate patients for the appropriateness of these procedures or manage complications when they occur, regional anesthesia is "best performed by an anesthesiologist who

STATEMENT COMPARING ANESTHESIOLOGIST ASSISTANT AND NURSE ANESTHETIST EDUCATION AND PRACTICE

possesses the competence and skills necessary for safe and effective performance." Training in and experience using technical skills are not equivalent to a medical degree.

3. Supervision and Independent Practice-

   AAs must be supervised by an anesthesiologist. The fact that anesthesiologists must supervise AAs does not constitute a mark of inferiority. On the contrary, and as noted in the Kentucky study, AAs work under the direction of anesthesiologists only because that is the history of their profession and their professional expectation.

   Anesthesia nurses practice under different regulations. While most anesthesia nurses function in an anesthesia care team model (with anesthesiologist participation and supervision), some anesthesia nurses practice under the direction of the operating surgeon or other non-anesthesiologist to satisfy requirements for physician supervision of anesthesia nurses care. Finally, in some circumstances anesthesia nurses are allowed to practice independently of physician supervision as a result of decisions made by state governors to remove Medicare requirements for physician supervision of anesthesia nurses (i.e. the "Opt Out" clause). These decisions are often political and are not based upon medical evidence, educational advances in anesthesia nurses training, improvements in patient safety or evidence of anesthesia provider shortages.

4. Maintenance of Certification-

   The AA certifying body, the National Commission for Certification of Anesthesiologist Assistants (NCCAA) was founded in 1989 and provides the certification process for AAs in the United States. Once certified, the AA recertification process involves 40 hours of Continuing Medical Education (CME) submitted biannually to the NCCAA and sitting for the Continued Demonstration of Qualifications (CDQ) examination addressing 16 core competencies every six years. The CDQ examination is administered by the National Board of Medical Examiners. Currently, all (i.e., 100%) AAs recertify with a written examination every 6 years and submit no less than 40 hours of CME to the NCCAA every two years.

   Although anesthesia nurse practice has existed long before AA practice, at the time of this review, there is no recertification program/process nor equivalent of the Continued Demonstration of Qualifications examination in place for anesthesia nurses. The most current documents available for review related to anesthesia nurse recertification suggests that the anesthesia nurses Continued Professional Certification Program will not be in effect until January 1, 2015. At that time, anesthesia nurses' credentials will no longer be valid for the anesthesia nurse's lifetime but for four-year cycles. In that four-year cycle, the anesthesia nurses must complete similar amounts of continuing education as the AAs but also pass the intended recertification examination in less than four tries in a four-year period. If this modification of anesthesia nurse certification progresses, all anesthesia nurses would be required to recertify by 2023.

In summary, review of the prerequisites, curriculum and clinical abilities of both AAs and anesthesia nurses supports ASA policy recognizing equivalence of these anesthesia providers.

American Society of Anesthesiologists

STATEMENT COMPARING ANESTHESIOLOGIST ASSISTANT AND NURSE ANESTHETIST EDUCATION AND PRACTICE

Table 1:

COMPARISON OF AAs AND CRNAs EDUCATION AND PRACTICE
(Used with Permission from the American Academy of Anesthesiologist Assistants)
Updated February 2011

	Anesthesiologist Assistants	CRNA
Description of Practice	Supervision by an anesthesiologist	Supervision by physician of unspecified specialty (excluding Opt-Out states
Model of Practice	Anesthesia Care Team	Anesthesia Care Team- supervision by an anesthesiologist, or without supervision (Medicare Opt Out states)
Distribution of Providers	1800 AAs in 17 states (plus District of Columbia) and Veteran's Administration system	32,000 CRNAs in all 50 states and Veteran's Administration system
Number of Programs	7 (in 5 states)	110 (in 37 states plus D.C. and Puerto Rico)
Length of Program	24-28 months	24-36 months
Type of Program	Master's degree required (specific degree title unique to each program)	Master's degree required (specific degree title unique to each program)
Certifying Body	National Commission for Certification of Anesthesiologist Assistants National Board of Medical Examiners	Council on Certification of Nurse Anesthetists
National Organization	American Academy of Anesthesiologists Assistants (AAAA)	American Association of Nurse Anesthetists (AANA)

STATEMENT COMPARING ANESTHESIOLOGIST ASSISTANT AND NURSE ANESTHETIST EDUCATION AND PRACTICE

Admission Requirements	BS Degree Premedical curriculum required (two semesters of biology with laboratory; two semesters of vertebrate anatomy and physiology (or other advanced biology) with laboratory, two semesters of general chemistry or biochemistry with laboratory, two semesters of general physics with laboratory, two semesters of advanced college mathematics including calculus) GPA > 3.0 Completion of Medical College Admissions Test (MCAT) or Graduate Record Exam (GRE), dependent on each program's individual requirements Previous health care experience preferable Personal interview	BN Degree Science curriculum for general practice nursing (courses vary greatly depending on the program) GPA 3.0 Licensure as a registered nurse Minimum 1 year of nursing experience in acute care setting Personal interview
Program Requirements	Academic faculty with medical school appointments Medical Director is a board-certified anesthesiologist Programs located in academic facilities that meet anesthesia residency requirements for physicians	Faculty include MDs, CRNAs, and graduate nurses Program Director must possess a Master's degree
Program Accreditation	Commission for Accreditation of Allied Health Education Programs (CAAHEP) Accreditation Review Committee for Anesthesiologist Assistants (ARC-AA)	Council on Accreditation of Nurse Anesthesia Programs
Didactic Education (Classroom)	56-132 classroom hours (depending on program)	34-80 classroom hours (depending on program)

American Society of Anesthesiologists

STATEMENT COMPARING ANESTHESIOLOGIST ASSISTANT AND NURSE ANESTHETIST EDUCATION AND PRACTICE

Clinical Education	Minimum of 600 cases and 2000 clinical hours (average ~2500+ hours)	Minimum of 550 cases (average ~1000+ hours)
Clinical Rotations	All sub-specialties of anesthesia	All sub-specialties of anesthesia
Advanced Skills	Regional anesthesia and invasive line placement	Regional anesthesia and invasive line placement
Clinical Instructors	AAs, CRNAs, Anesthesiologists, Anesthesiology Residents in training.	CRNAs and Anesthesiologists
Recertification	40 hours CMEs submitted biannually + sit for Continued Demonstration of Qualifications Exam (CDQ) every six years administered by the National Board of Medical Examiners	40 hours CEUs submitted biannually (no recertification by exam)
Graduation Requirements	3.0 GPA or better and in good class standing All course semester and clinical requirements completed	All course semester and clinical requirements completed

American Society of Anesthesiologists®

STATEMENT ON THE ANESTHESIA CARE TEAM

Committee of Origin: Anesthesia Care Team

(Approved by the ASA House of Delegates on October 26, 1982, and last amended on October 16, 2013)

Anesthesiology is the practice of medicine including, but not limited to, preoperative patient evaluation, anesthetic planning, intraoperative and postoperative care and the management of systems and personnel that support these activities. In addition, anesthesiology includes perioperative consultation, the management of coexisting disease, the prevention and management of untoward perioperative patient conditions, the treatment of acute and chronic pain, and the practice of critical care medicine. This care is personally provided by or directed by the anesthesiologist.

In the interests of patient safety and quality of care, the American Society of Anesthesiologists believes that the involvement of an anesthesiologist in the perioperative care of every patient is necessary. Almost all anesthesia care is either provided personally by an anesthesiologist or is provided by a non-physician anesthesia practitioner directed by an anesthesiologist. The latter mode of anesthesia delivery is called the Anesthesia Care Team and involves the delegation of monitoring and appropriate tasks by the physician to non-physicians. Such delegation should be specifically defined by the anesthesiologist and should also be consistent with state law or regulations and medical staff policy. Although selected tasks of overall anesthesia care may be delegated to qualified members of the Anesthesia Care Team, overall responsibility for the Anesthesia Care Team and patients' safety ultimately rests with the anesthesiologist.

Definitions

1. Core Members of the Anesthesia Care Team

The Anesthesia Care Team includes both physicians and non-physicians. All members of the team have an obligation to accurately identify themselves and other team members to patients and families. Anesthesiologists should not permit the misrepresentation of non-physician personnel as resident physicians or practicing physicians. The nomenclature below is appropriate terminology for this purpose.

a. Physicians

ANESTHESIOLOGIST: **Director of the Anesthesia Care Team; a physician** licensed to practice medicine who has successfully completed a training program in anesthesiology accredited by the ACGME, the American Osteopathic Association or equivalent organizations.

ANESTHESIOLOGY FELLOW: An **anesthesiologist** enrolled in a training program to obtain additional education in one of the subdisciplines of anesthesiology.

ANESTHESIOLOGY RESIDENT: A **physician** enrolled in an accredited anesthesiology residency program.

b. Non-physicians

ANESTHETIST: A **nurse anesthetist** or **anesthesiologist assistant**, as each is defined below. (Note: In some countries where non-physicians do not participate in the administration of anesthesia, a physician who practices anesthesiology is known as an "anaesthetist" or "anesthetist")

NURSE ANESTHETIST: A **registered nurse** who has satisfactorily completed an accredited nurse anesthesia training program and certifying examination (also, "CRNA").

ANESTHESIOLOGIST ASSISTANT: A **health professional** who has satisfactorily completed an accredited anesthesiologist assistant training program and certifying examination (also, "AA").

STUDENT NURSE ANESTHETIST: A **registered nurse** who is enrolled in an accredited nurse anesthesia training program.

ANESTHESIOLOGIST ASSISTANT STUDENT: A **health profession graduate student** who has satisfied all prerequisite coursework typical of an accredited school of medicine and is enrolled in an accredited anesthesiologist assistant training program.

NON-PHYSICIAN ANESTHESIA STUDENT: Student nurse anesthetists, anesthesiologist assistant students, dental anesthesia students and others who are enrolled in accredited anesthesia training programs.

OTHERS: Although not considered core members of the Anesthesia Care Team, other health care professionals make important contributions to the perianesthetic care of the patient (see Addendum A).

2. Additional Terms

ANESTHESIA CARE TEAM: Anesthesiologists supervising resident physicians and/or directing qualified non-physician anesthesia practitioners in the provision of anesthesia care, wherein the physician may delegate monitoring and appropriate tasks while retaining overall responsibility for the patient.

QUALIFIED ANESTHESIA PERSONNEL OR PRACTITIONERS: Anesthesiologists, anesthesiology fellows, anesthesiology residents, oral surgery residents, anesthesiologist assistants, and nurse anesthetists.

MEDICAL SUPERVISION AND MEDICAL DIRECTION: Terms used to describe the physician work required to oversee, manage and guide both residents and non-physician members of the Anesthesia Care Team. For the purposes of this statement, supervision

and direction are interchangeable and have no relation to the billing, payment or regulatory definitions that provide distinctions between these two terms (see Addendum B).

SEDATION NURSE AND SEDATION PHYSICIAN ASSISTANT: A licensed registered nurse, advanced practice nurse or physician assistant who is trained in compliance with all relevant local, institutional, state and/or national standards, policies or guidelines to administer prescribed sedating and analgesic medications and monitor patients during minimal sedation ("anxiolysis") or moderate sedation ("conscious sedation"), but not deeper levels of sedation or general anesthesia. Sedation nurses and sedation physician assistants may only work under the direct supervision of a properly trained and privileged physician (MD or DO).

PROCEDURE ROOM: An operating room or other location where an operation or procedure is performed under anesthesia care.

IMMEDIATELY AVAILABLE: Wherever it appears in this document, the phrase "immediately available" is used as defined in the ASA policy statement "Definition of 'Immediately Available' When Medically Directing" (see Addendum C).

Safe Conduct of the Anesthesia Care Team
In order to achieve optimum patient safety, the anesthesiologist who directs the Anesthesia Care Team is responsible for the following:

1. **Management of personnel**: Anesthesiologists should assure the assignment of appropriately skilled physician and/or non-physician personnel for each patient and procedure.

2. **Preanesthetic evaluation of the patient**: A preanesthetic evaluation allows for the development of an anesthetic plan that considers all conditions and diseases of the patient that may influence the safe outcome of the anesthetic. Although non-physicians may contribute to the preoperative collection and documentation of patient data, the anesthesiologist is responsible for the overall evaluation of each patient.

3. **Prescribing the anesthetic plan**: The anesthesiologist is responsible for prescribing an anesthesia plan aimed at the greatest safety and highest quality for each patient. The anesthesiologist discusses with the patient or guardian, as appropriate, the anesthetic risks, benefits and alternatives, and obtains informed consent. When part of the anesthetic care will be performed by another qualified anesthesia practitioner, the anesthesiologist should inform the patient that delegation of anesthetic duties is included in care provided by the Anesthesia Care Team.

4. **Management of the anesthetic**: The management of an anesthetic is dependent on many factors including the unique medical conditions of individual patients and the procedures being performed. Anesthesiologists will determine which perioperative tasks, if any, may be delegated. The anesthesiologist may delegate specific tasks to qualified

non-anesthesiologist members of the Anesthesia Care Team providing that quality of care and patient safety are not compromised, will participate in critical parts of the anesthetic, and will remain immediately available for management of emergencies regardless of the type of anesthetic (see Addendum C).

5. **Postanesthesia care**: Routine postanesthesia care is delegated to postanesthesia nurses. The evaluation and treatment of postanesthetic complications are the responsibility of the anesthesiologist.

6. **Anesthesia consultation**: Like other forms of medical consultation, this is the practice of medicine and should not be delegated to non-physicians.

Safe Conduct of Minimal and Moderate Sedation Utilizing Sedation Nurses and Physician Assistants

The supervising physician is responsible for all aspects of the continuum of care: pre-, intra-, and post-procedure. While a patient is sedated, the responsible physician must be physically present and immediately available in the procedure suite. Although the supervising physician is primarily responsible for pre-procedure patient evaluation, sedation practitioners must be trained adequately in pre-procedure patient evaluation to recognize when risk may be increased, and related policies and procedures must allow sedation practitioners to refuse to participate in specific cases if they perceive a threat to quality of care or patient safety.

The supervising physician is responsible for leading any acute resuscitation needs, including emergency airway management. Therefore, ACLS (PALS or NALS where appropriate) certification must be a standard requirement for sedation practitioners and for credentialing and privileging the non-anesthesiologist physicians who supervise them. However, because non-anesthesia professionals seldom perform controlled mask ventilation or tracheal intubation often enough to remain proficient, their training should emphasize avoidance of excessive sedation over rescue techniques.

Medical Supervision of Nurse Anesthetists by Non-Anesthesiologist Physicians

Note: In this section, the term "surgeon" may refer to any appropriately trained, licensed and credentialed non-anesthesiologist physician who may supervise nurse anesthetists when consistent with applicable law.

General anesthesia, regional anesthesia, and monitored anesthesia care expose patients to risks. Non-anesthesiologist physicians may not possess the expertise that uniquely qualifies and enables anesthesiologists to manage the most clinically challenging medical situations that arise during the perioperative period. While a few surgical training programs (such as oral surgery and maxillofacial surgery) provide some anesthesia-specific education, no non-anesthesiology programs prepare their graduates to provide an anesthesiologist's level of medical supervision and perioperative clinical expertise. However, surgeons and other physicians significantly add to patient safety and quality of care by assuming medical responsibility for perioperative care when an anesthesiologist is not present.

Anesthetic and surgical complications often arise unexpectedly and require immediate medical diagnosis and treatment, even if state law or regulation says a physician is not required to supervise non-physician anesthesia practitioners. The surgeon may be the only physician on site. Whether the need is preoperative medical assessment or intraoperative resuscitation from an unexpected complication, the surgeon may be called upon, as the most highly trained professional present, to provide medical direction of perioperative health care, including nurse anesthesia care. To optimize patient safety, careful consideration is required when a surgeon will be the only physician available, as in some small hospitals, freestanding surgery centers, and surgeons' offices. In the event of an emergency, lack of immediate support from other physicians trained in critical medical management may reduce the likelihood of successful resuscitation. This should be taken into account when deciding which procedures should be performed in settings without an anesthesiologist, and which patients are appropriate candidates.

Medical Supervision of Non-Physician Anesthesia Students

Anesthesiologists who teach non-physician anesthesia students are dedicated to their education and to providing optimal safety and quality of care to every patient. The ASA Standards for Basic Anesthetic Monitoring define the minimum conditions necessary for the safe conduct of anesthesia. The first standard states, "Qualified anesthesia personnel shall be present in the room throughout the conduct of all general anesthetics, regional anesthetics and monitored anesthesia care." This statement does not completely address the issue of safe patient care during the training of non-physician student anesthetists. Further clarification of the issues involved is in the best interests of patients, students, and anesthesia practitioners.

During 1:1 supervision of non-physician anesthesia students, it may become necessary for the supervising anesthesiologist or nurse anesthetist to leave briefly to attend to other urgent needs or duties. This should only occur in circumstances judged to cause no significant increased risk to the patient.

This practice is to be distinguished from that of scheduling a non-physician student as the primary anesthetist, meaning that no fully-trained anesthesia practitioner is also continuously present to monitor the anesthetized patient. Though the brief interruption of 1:1 student supervision may be unavoidable for the efficient and safe functioning of a department of anesthesiology, the use of non-physician students as primary anesthetists in place of fully trained and credentialed anesthesia personnel is not endorsed as a best practice by the ASA. While the education of non-physician anesthesia students is an important goal, patient safety remains paramount. Therefore, the supervision of students at a ratio other than 1:1 must meet criteria designed to protect the safety and rights of patients and students, as well as the best interests of all other parties directly or indirectly involved: anesthesia practitioners, families, and health care institutions.

1. **Delegation**: All delegating anesthesiologists and the department chairperson must deem non-physician student anesthetists fully capable of performing all duties delegated to them, and all students must express agreement with accepting responsibility delegated to them.

2. **Privileging**: An official privileging process must individually deem each student as qualified to be supervised 1:2 by an anesthesiologist who remains immediately available (see Addendum C). Students must not be so privileged until they have completed a significant portion of their didactic and clinical training and have achieved expected levels of safety and quality (if at all, no earlier than the last 3-4 months of training). Privileging must be done under the authority of the chair of anesthesiology and in compliance with all federal, state, and professional organization and institutional requirements.

3. **Case Assignment and Supervision**: Students must be supervised at a 1:1 or 1:2 anesthesiologist to student ratio. Assignment of cases to students must be done in a manner that assures the best possible outcome for patients and the best education of students, and must be commensurate with the skills, training, experience, knowledge and willingness of each individual non-physician student. Care should be taken to avoid placing students in situations beyond their level of skill. It is expected that most students will gain experience caring for high-risk patients under the continuous supervision of qualified anesthesia practitioners. This is in the best interest of education and patient safety. The degree of continuous supervision must be at a higher level than that required for fully credentialed anesthesiologist assistants and nurse anesthetists. If an anesthesiologist is engaged in the supervision of non-physician students, he/she must remain immediately available. This means not leaving the procedure suite to provide other concurrent services or clinical duties that would be considered appropriate if directing fully credentialed anesthesiologist assistants or nurse anesthetists.

4. **Back-up Support**: If an anesthesiologist is concurrently supervising two non-physician students assigned as primary anesthetists (meaning the only anesthesia personnel continuously present with a patient), the anesthesiologist could be needed simultaneously in both rooms. To mitigate this potential risk, one other qualified anesthesia practitioner must also be designated to provide back-up support and must remain immediately available.

5. **Informed Consent**: The chair of anesthesiology is responsible for assuring that every patient (or the patient's guardian) understands through a standardized departmental informed consent process that the patient may be in the procedure room with only a non-physician student physically present, although still directed by the responsible anesthesiologist. In the best interest of all involved parties, documentation of this aspect of informed consent must be included in the informed consent statement.

6. **Disclosure to Professional Liability Carrier**: To be assured of reliable professional liability insurance coverage for all involved (qualified anesthesia practitioners, their employers and the institution), the chair of anesthesiology must notify the responsible professional liability carrier(s) of the practice of allowing non-physician anesthesia students to provide care without continuous direct supervision by a fully trained, credentialed and qualified anesthesia practitioner.

ADDENDUM A

1. **Other personnel involved in perianesthetic care:**

   POSTANESTHESIA NURSE: A **registered nurse** who cares for patients recovering from anesthesia.

   PERIOPERATIVE NURSE: A **registered nurse** who cares for the patient in the procedure room.

   CRITICAL CARE NURSE: A **registered nurse** who cares for patients in a special care area such as an intensive care unit.
   OBSTETRIC NURSE: A **registered nurse** who provides care to patients during labor and delivery.

   NEONATAL NURSE: A **registered nurse** who provides cares to neonates in special care units.

   RESPIRATORY THERAPIST: An **allied health professional** who provides respiratory care to patients.

   CARDIOVASCULAR PERFUSIONIST: An **allied health professional** who operates cardiopulmonary bypass machines.

2. **Support personnel for technical procedures, equipment, supply and maintenance:**

   ANESTHESIA TECHNOLOGISTS AND TECHNICIANS
   ANESTHESIA AIDES
   BLOOD GAS TECHNICIANS
   RESPIRATORY TECHNICIANS
   MONITORING TECHNICIANS

ADDENDUM B

Commonly Used Payment Rules and Definitions

ASA recognizes the existence of commercial and governmental payer rules applicable to payment for anesthesia services and encourages its members to comply with them. Commonly prescribed duties include:

- Performing a preanesthetic history and physical examination of the patient;
- Prescribing the anesthetic plan;
- Personal participation in the most demanding portions of the anesthetic, including induction and emergence, where applicable;
- Delegation of anesthesia care only to qualified anesthesia practitioners;

- Monitoring the course of anesthesia at frequent intervals;
- Remaining immediately available for diagnosis and treatment while medically responsible;
- Providing indicated postanesthesia care;
- Performing and documenting a post-anesthesia evaluation.

ASA also recognizes the lack of total predictability in anesthesia care and the variability in patient needs. In certain rare circumstances, it may be inappropriate from the viewpoint of overall patient safety and quality to comply with all payment rules at every moment in time. Reporting of services for payment must accurately reflect the services provided. The ability to prioritize duties and patient care needs, moment to moment, is a crucial skill of the anesthesiologist functioning safely within the Anesthesia Care Team. Anesthesiologists must strive to provide the highest quality of care and greatest degree of patient safety to all patients in the perioperative environment at all times.

MEDICAL "DIRECTION" by anesthesiologists: A payment term describing the specific anesthesiologist work required and restrictions involved in billing payers for the management and oversight of non-physician anesthesia practitioners. This pertains to situations where anesthesiologists are involved in not more than four concurrent anesthetics.

MEDICAL "SUPERVISION" by anesthesiologists: Medicare payment policy contains a special payment formula for "medical supervision" which applies "when the anesthesiologist is involved in furnishing more than four procedures concurrently or is performing other services while directing the concurrent procedures." [Note: The word "supervision" may also be used outside of the Anesthesia Care Team to describe the perioperative medical oversight of non-physician anesthesia practitioners by the operating practitioner/surgeon. Surgeon-provided supervision pertains to general medical management and to the components of anesthesia care that are physician and not nursing functions (e.g., determining medical readiness of patients for anesthesia and surgery, and providing critical medical management of unexpected emergencies).]

See the Medicare Claims Processing Manual (Chapter 12, Section 50.C-D) and individual payer manuals for additional information.

ADDENDUM C

Definition of "Immediately Available" When Medically Directing (HOD 2012)

A medically directing anesthesiologist is immediately available if s/he is in physical proximity that allows the anesthesiologist to return to re-establish direct contact with the patient to meet medical needs and address any urgent or emergent clinical problems. These responsibilities may also be met through coordination among anesthesiologists of the same group or department.

Differences in the design and size of various facilities and demands of the particular surgical procedures make it impossible to define a specific time or distance for physical proximity.

STATEMENT COMPARING ANESTHESIOLOGIST ASSISTANT AND NURSE ANESTHETIST EDUCATION AND PRACTICE

Committee of Origin: Anesthesia Care Team

(Approved by the ASA House of Delegates on October 17, 2007, and last amended on October 17, 2012)

Anesthesiologist Assistants (AA) and nurse anesthetists are both non-physician members of the Anesthesia Care Team. Their role in patient care is described in the American Society of Anesthesiologists' (ASA) Statement on the Anesthesia Care Team. The ASA document entitled Recommended Scope of Practice of Nurse Anesthetists and Anesthesiologist Assistants further details the safe limits of clinical practice. These documents state ASA's view that both AAs and anesthesia nurses have identical patient care responsibilities and technical capabilities--a view in harmony with their equivalent treatment under the Medicare Program. The proven safety of the anesthesia care team approach to anesthesia with either anesthesia nurses or AAs as the non-physician anesthetists confirms the wisdom of this view. Nevertheless, certain differences do exist between AAs and anesthesia nurses in regard to educational program prerequisites, instruction, and requirements for supervised clinical practice. Some of these differences are mischaracterized and misrepresented for the benefit of one category of provider over the other. The question that must be addressed is whether these differences in education and practice indicate superiority of one category of provider over the other in either innate ability or clinical capability.

Historical Background of Nurse Anesthetists and Anesthesiologist Assistants-

The Nurse Anesthesia discipline developed in the late 1800s and early 1900s out of surgeons' requests for more anesthesia providers since few physicians focused on anesthesia at that time. Surgeons directed the care provided by anesthesia nurses. As early as 1916 and 1917, nurse anesthetists fought their first legal battles to create and maintain the right to provide anesthesia under the direction of surgeons. Current issues related to registered nurse anesthetists' legal right to practice without the supervision of an anesthesiologist are due to their history, tradition, philosophy of education and political efforts, rather than the quality and scope of their education.

The AA profession was established in the late 1960s by anesthesiologists addressing another shortage of anesthesiologists in the country. After studying the educational pathway for anesthesiologists and nurse anesthetists, anesthesiologists created a new educational paradigm for a mid-level anesthesia practitioner emphasizing a science/pre-medical rather than nursing background in college. This person would perform the same job as the anesthesia nurses but could readily attend medical school if appropriate. This new professional, the anesthesiologist assistant, or AA, thus had the potential to alleviate the shortage of anesthesiologists. Trained specifically to share a common practice philosophy with anesthesiologists and to work only with anesthesiologists, AA education was designed to incorporate the basic principles supportive of the Anesthesia Care Team (ACT). The founders recognized early on the advantage of a strong pre-medical background in comparison to the nursing education backgrounds of the anesthesia nurse profession. The wisdom of this view has been confirmed by the increased focus on pre-medical course work as a prerequisite for admission to anesthesia nurse programs that occurred in response to the success of the AA profession. Thus by history, tradition, philosophy of education and desire, the AA is trained to work within the ACT under the supervision of an anesthesiologist alone. The quality and scope of their education has nothing to do with this decision.

STATEMENT COMPARING ANESTHESIOLOGIST ASSISTANT AND NURSE ANESTHETIST EDUCATION AND PRACTICE

The Committee on the Anesthesia Care Team studied and compared the prerequisites for program admission and curriculum of both AA and anesthesia nurse educational programs and the clinical practice in regards to scope of practice and overall quality. Reference was made to published program prerequisites, curricula, and graduation requirements for both AA and anesthesia nurse education programs; the laws and regulations governing clinical practice; requirements for maintenance of certification and available studies on the safety of anesthesia nurses and AA practice. In addition, the Committee reviewed an impartial study comparing AA and anesthesia nurse education and practice commissioned by the Kentucky legislature and published in February 2007, as well as a white paper from the American Association of Anesthesiologists' Assistants (AAAA) entitled "Comparison of AA and NA Education and Practice." The Committee came to the following conclusions:

Differences do exist between Anesthesiologist Assistants and Registered Nurse Anesthetists in regard to the educational program prerequisites, instruction, and requirements for supervision in practice as well as maintenance of certification. These differences are a product of the different manner in which the two professions developed and the desire of Anesthesiologist Assistants to work only with anesthesiologists.

Table 1 provides itemized comparisons. This table is used with permission from AAAA and can be found at the end of this statement.

The major differences between AAs and anesthesia nurses are summarized here:

1. Prerequisites to Anesthesia Training-

   Anesthesia nurse schools require a nursing degree and one year of critical care experience, while AA programs require a bachelor's degree emphasizing pre-medical, science-based coursework. The Committee agrees with the impartial findings of the study commissioned by the Kentucky legislature that the requirement for clinical experience, while it may constitute a temporary aid to those beginning their anesthesia nurse or AA education, makes no difference to the final outcome of that training. This conclusion is born out by the clinical experiences of anesthesiologists who work simultaneously with AA and anesthesia nurses and find no significant difference in clinical practice ability between the two professions.

2. Performance of Regional Anesthesia and Insertion of Invasive Catheters-

   Data compiled by AAAA in its "Comparison of AA and NA education and Practice" show that more anesthesia nurse education programs provide instruction in the technical aspects of regional anesthesia, but that a higher percentage of AA programs provide instruction in the placement of invasive monitoring lines. There is no evidence to suggest that the innate abilities or clinical capabilities of the students have any bearing on their suitability for this aspect of practice. Rather, the decision by some AA programs to limit the teaching of these techniques is based on the reservations expressed by some anesthesiologists about the safety of this practice by either AAs or anesthesia nurses. That limitation is voluntary, consistent with ASA policy and done with a view to enhancing patient safety. The ASA Statement on Regional Anesthesia recognizes that the supervising anesthesiologist may, when appropriate, delegate certain technical aspects of these procedures to a non-physician anesthetist. Nevertheless, as neither anesthesia nurses nor AAs receive the medical education necessary to safely evaluate patients for the appropriateness of these procedures or manage complications when they occur, regional anesthesia is "best performed by an anesthesiologist who

STATEMENT COMPARING ANESTHESIOLOGIST ASSISTANT AND NURSE ANESTHETIST EDUCATION AND PRACTICE

possesses the competence and skills necessary for safe and effective performance." Training in and experience using technical skills are not equivalent to a medical degree.

3. Supervision and Independent Practice-

   AAs must be supervised by an anesthesiologist. The fact that anesthesiologists must supervise AAs does not constitute a mark of inferiority. On the contrary, and as noted in the Kentucky study, AAs work under the direction of anesthesiologists only because that is the history of their profession and their professional expectation.

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American Society of Anesthesiologists

STATEMENT COMPARING ANESTHESIOLOGIST ASSISTANT AND NURSE ANESTHETIST EDUCATION AND PRACTICE

Table 1:

COMPARISON OF AAs AND CRNAs EDUCATION AND PRACTICE
(Used with Permission from the American Academy of Anesthesiologist Assistants)
Updated February 2011

	Anesthesiologist Assistants	CRNA
Description of Practice	Supervision by an anesthesiologist	Supervision by physician of unspecified specialty (excluding Opt-Out states
Model of Practice	Anesthesia Care Team	Anesthesia Care Team- supervision by an anesthesiologist, or without supervision (Medicare Opt Out states)
Distribution of Providers	1800 AAs in 17 states (plus District of Columbia) and Veteran's Administration system	32,000 CRNAs in all 50 states and Veteran's Administration system
Number of Programs	7 (in 5 states)	110 (in 37 states plus D.C. and Puerto Rico)
Length of Program	24-28 months	24-36 months
Type of Program	Master's degree required (specific degree title unique to each program)	Master's degree required (specific degree title unique to each program)
Certifying Body	National Commission for Certification of Anesthesiologist Assistants National Board of Medical Examiners	Council on Certification of Nurse Anesthetists
National Organization	American Academy of Anesthesiologists Assistants (AAAA)	American Association of Nurse Anesthetists (AANA)

American Society of Anesthesiologists

STATEMENT COMPARING ANESTHESIOLOGIST ASSISTANT AND NURSE ANESTHETIST EDUCATION AND PRACTICE

Admission Requirements	BS Degree Premedical curriculum required (two semesters of biology with laboratory; two semesters of vertebrate anatomy and physiology (or other advanced biology) with laboratory, two semesters of general chemistry or biochemistry with laboratory, two semesters of general physics with laboratory, two semesters of advanced college mathematics including calculus) GPA > 3.0 Completion of Medical College Admissions Test (MCAT) or Graduate Record Exam (GRE), dependent on each program's individual requirements Previous health care experience preferable Personal interview	BN Degree Science curriculum for general practice nursing (courses vary greatly depending on the program) GPA 3.0 Licensure as a registered nurse Minimum 1 year of nursing experience in acute care setting Personal interview
Program Requirements	Academic faculty with medical school appointments Medical Director is a board-certified anesthesiologist Programs located in academic facilities that meet anesthesia residency requirements for physicians	Faculty include MDs, CRNAs, and graduate nurses Program Director must possess a Master's degree
Program Accreditation	Commission for Accreditation of Allied Health Education Programs (CAAHEP) Accreditation Review Committee for Anesthesiologist Assistants (ARC-AA)	Council on Accreditation of Nurse Anesthesia Programs
Didactic Education (Classroom)	56-132 classroom hours (depending on program)	34-80 classroom hours (depending on program)

American Society of Anesthesiologists

STATEMENT COMPARING ANESTHESIOLOGIST ASSISTANT AND NURSE ANESTHETIST EDUCATION AND PRACTICE

Clinical Education	Minimum of 600 cases and 2000 clinical hours (average ~2500+ hours)	Minimum of 550 cases (average ~1000+ hours)
Clinical Rotations	All sub-specialties of anesthesia	All sub-specialties of anesthesia
Advanced Skills	Regional anesthesia and invasive line placement	Regional anesthesia and invasive line placement
Clinical Instructors	AAs, CRNAs, Anesthesiologists, Anesthesiology Residents in training.	CRNAs and Anesthesiologists
Recertification	40 hours CMEs submitted biannually + sit for Continued Demonstration of Qualifications Exam (CDQ) every six years administered by the National Board of Medical Examiners	40 hours CEUs submitted biannually (no recertification by exam)
Graduation Requirements	3.0 GPA or better and in good class standing All course semester and clinical requirements completed	All course semester and clinical requirements completed

American Society of Anesthesiologists®

STATEMENT ON THE ROLE OF REGISTERED NURSES IN THE MANAGEMENT OF CONTINUOUS REGIONAL ANALGESIA

Committee of Origin: Pain Medicine

Transferred to: Committee on Regional Anesthesia (2013)

(Approved by the ASA House of Delegates on October 16, 2002, and last amended on October 16, 2013)

The management of acute and chronic pain via continuous epidural, intrathecal and peripheral nerve catheter techniques is safe and effective. In order to provide optimum patient care, it is essential that registered nurses participate in the management of these analgesic modalities. This is the current and established standard of care.

A registered nurse (RN) qualified by education, experience, credentials and on-going competency assessment who follows a patient-specific protocol written by a qualified physician should, under the direction of a physician, be allowed to:

- Initiate, adjust and discontinue catheter infusions,
- Administered analgesic boluses through the catheter as prescribed by a physician,
- Replace empty medication syringes and bags with new pre-filled syringes and bags using proper aseptic technique,
- Monitor the catheter insertion site,
- Remove the catheter,
- Monitor the patient for analgesic efficacy and side effects,
- Treat analgesic-related side effects.

The role of the RN in actively and safely participating in these aspects of acute and chronic pain management has been well-established. Major nursing organizations strongly support involvement of the RN in these specific aspects of continuous regional analgesia. Their participation in small community hospitals, large medical centers, hospices, long-term care centers and patient homes has contributed significantly to the success of these techniques in the management of pain. The RN has been active in all aspects of established catheter and infusion care in all settings where the techniques are employed, including the post anesthesia care unit, intensive care unit, hospital ward and within the outpatient setting.

The safe and excellent pain control achieved by this team approach to pain care has been thoroughly evaluated by scientific study published in peer-reviewed literature and has become well established in routine clinical practice throughout the world.

Refer to the "Statement on Pain Relief During Labor" (Committee of Origin: Obstetric Anesthesia) for the role of registered nurses in the management of continuous regional analgesia in labor and delivery units.

OPTIMAL GOALS FOR ANESTHESIA CARE IN OBSTETRICS

Committee of Origin: Obstetrical Anesthesia

(Approved by the ASA House of Delegates on October 17, 2007 and last amended on October 20, 2010)

This joint statement from the American Society of Anesthesiologists (ASA) and the American College of Obstetricians and Gynecologists (ACOG) has been designed to address issues of concern to both specialties. Good obstetric care requires the availability of qualified personnel and equipment to administer general or neuraxial anesthesia both electively and emergently. The extent and degree to which anesthesia services are available varies widely among hospitals. However, for any hospital providing obstetric care, certain optimal anesthesia goals should be sought. These include:

1. Availability of a licensed practitioner who is credentialed to administer an appropriate anesthetic whenever necessary. For many women, neuraxial anesthesia (epidural, spinal, or combined spinal epidural) will be the most appropriate anesthetic.

2. Availability of a licensed practitioner who is credentialed to maintain support of vital functions in any obstetric emergency.

3. Availability of anesthesia and surgical personnel to permit the start of a cesarean delivery within 30 minutes of the decision to perform the procedure.

4. Because the risks associated with trial of labor after cesarean delivery (TOLAC) and uterine rupture may be unpredictable, the immediate availability of appropriate facilities and personnel, (including obstetric anesthesia, nursing personnel, and a physician capable of monitoring labor and performing cesarean delivery, including an emergency cesarean delivery) is optimal. When resources for immediate cesarean delivery are not available, patients considering TOLAC should discuss the hospital's resources and availability of obstetric, anesthetic, pediatric and nursing staff with their obstetric provider (1); patients should be clearly informed of the potential increase in risk and the management alternatives. The definition of immediately available personnel and facilities remains a local decision based on each institution's available resources and geographic location.

5. Appointment of a qualified anesthesiologist to be responsible for all anesthetics administered. There are many obstetric units where obstetricians or obstetrician-supervised nurse anesthetists administer labor anesthetics. The administration of general or neuraxial anesthesia requires both medical judgment and technical skills. Thus, a physician with privileges in anesthesiology should be readily available.

Persons administering or supervising obstetric anesthesia should be qualified to manage the infrequent but occasionally life-threatening complications of neuraxial anesthesia such as respiratory and cardiovascular failure, toxic local anesthetic convulsions, or vomiting and aspiration. Mastering and retaining the skills and knowledge necessary to manage these complications require adequate training and frequent application.

To ensure the safest and most effective anesthesia for obstetric patients, the Director of Anesthesia Services, with the approval of the medical staff, should develop and enforce written policies regarding provision of obstetric anesthesia. These include:

OPTIMAL GOALS FOR ANESTHESIA CARE IN OBSTETRICS

1. A qualified physician with obstetric privileges to perform operative vaginal or cesarean delivery should be readily available during administration of anesthesia. Readily available should be defined by each institution within the context of its resources and geographic location. Neuraxial and/or general anesthesia should not be administered until the patient has been examined and the fetal status and progress of labor evaluated by a qualified individual. A physician with obstetric privileges who concurs with the patient's management and has knowledge of the maternal and fetal status and the progress of labor should be readily available to deal with any obstetric complications that may arise. A physician with obstetric privileges should be responsible for midwifery back up in hospital settings that utilize certified nurse midwives/ certified midwives as obstetric providers.

2. Availability of equipment, facilities, and support personnel equal to that provided in the surgical suite. This should include the availability of a properly equipped and staffed recovery room capable of receiving and caring for all patients recovering from neuraxial or general anesthesia. Birthing facilities, when used for labor anesthesia services or surgical anesthesia, must be appropriately equipped to provide safe anesthetic care during labor and delivery or postanesthesia recovery care.

3. Personnel, other than the surgical team, should be immediately available to assume responsibility for resuscitation of the depressed newborn. The surgeon and anesthesiologist are responsible for the mother and may not be able to leave her to care for the newborn, even when a neuraxial anesthetic is functioning adequately. Individuals qualified to perform neonatal resuscitation should demonstrate:

    3.1 Proficiency in rapid and accurate evaluation of the newborn condition, including Apgar scoring.
    3.2 Knowledge of the pathogenesis of a depressed newborn (acidosis, drugs, hypovolemia, trauma, anomalies, and infection), as well as specific indications for resuscitation
    3.3 Proficiency in newborn airway management, laryngoscopy, endotracheal intubations, suctioning of airways, artificial ventilation, cardiac massage, and maintenance of thermal stability.

In larger maternity units and those functioning as high-risk centers, 24-hour in-house anesthesia, obstetric and neonatal specialists are usually necessary. Preferably, the obstetric anesthesia services should be directed by an anesthesiologist with special training or experience in obstetric anesthesia. These units will also frequently require the availability of more sophisticated monitoring equipment and specially trained nursing personnel.

A survey jointly sponsored by ASA and ACOG found that many hospitals in the United States have not yet achieved the goals mentioned previously. Deficiencies were most evident in smaller delivery units. Some small delivery units are necessary because of geographic considerations. Currently, approximately 34% of hospitals providing obstetric care have fewer than 500 deliveries per year (2). Providing comprehensive care for obstetric patients in these small units is extremely inefficient, not cost-effective and frequently impossible. Thus, the following recommendations are made:

1. Whenever possible, small units should consolidate.

2. When geographic factors require the existence of smaller units, these units should be part of a well-established regional perinatal system.

OPTIMAL GOALS FOR ANESTHESIA CARE IN OBSTETRICS

The availability of the appropriate personnel to assist in the management of a variety of obstetric problems is a necessary feature of good obstetric care. The presence of a pediatrician or other trained physician at a high-risk cesarean delivery to care for the newborn or the availability of an anesthesiologist during active labor and delivery when TOLAC is attempted and at a breech or multifetal delivery are examples. Frequently, these physicians spend a considerable amount of time standing by for the possibility that their services may be needed emergently, but may ultimately not be required to perform the tasks for which they are present. Reasonable compensation for these standby services is justifiable and necessary.

A variety of other mechanisms have been suggested to increase the availability and quality of anesthesia services in obstetrics. Improved hospital design, to place labor and delivery suites closer to the operating rooms, would allow for safer and more efficient anesthesia care, including supervision of nurse anesthetists. Anesthesia equipment in the labor and delivery area must be comparable to that in the operating room.

Finally, good interpersonal relations between obstetricians and anesthesiologists are important. Joint meetings between the two departments should be encouraged. Anesthesiologists should recognize the special needs and concerns of the obstetrician and obstetricians should recognize the anesthesiologist as a consultant in the management of pain and life-support measures. Both should recognize the need to provide high quality care for all patients.

REFERENCES

(1) Vaginal birth after previous cesarean delivery. ACOG Practice Bulletin No. 115. American College of Obstetricians and Gynecologists. Obstet Gynecol 2010; 116: 450-463.

(2) Bucklin BA, Hawkins JL, Anderson JR, et. al. Obstetric anesthesia workforce survey: twenty-year update. *Anesthesiology* 2005;103:645-53.

ACOG
THE AMERICAN CONGRESS
OF OBSTETRICIANS
AND GYNECOLOGISTS

April 30, 2014

Mr. Donald S. Clark
Secretary
Federal Trade Commission
Office of the Secretary
Room H–113 (Annex X)
600 Pennsylvania Avenue NW
Washington, DC 20580

RE: FTC Health Care Workshop, Project No. P131207

Dear Secretary Clark:

The American Congress of Obstetricians and Gynecologists (ACOG) welcomes the opportunity to submit comments in response to the notice of public workshop examining health care competition, dated February 24, 2014 ("Notice").

ACOG is a non-profit professional organization. ACOG's companion charitable organization, the American College of Obstetricians and Gynecologists, was founded in 1951. Together, ACOG and the College share more than 57,000 members, representing approximately 90 percent of all board-certified obstetricians and gynecologists practicing in the United States. ACOG welcomes certified nurse midwives (CNMs), certified midwives (CMs), nurse practitioners, and physician assistants to join its membership as Educational Affiliate members. It is ACOG's mission to foster improvements in all aspects of health care for women and to promote the highest standards of clinical practice and ethical conduct. Educational Affiliate members help ACOG maintain the best standards of health care for women.

ACOG's comments respond to questions posed in the Notice regarding the extent to which professional regulation of health care providers is necessary to protect patient safety, with a focus on maternity care and midwife providers.

ACOG supports the full scope of practice for CNMs and CMs as reflected in our Joint Statement with the American College of Nurse-Midwives (ACNM).

ACOG's comments are also prompted by comments submitted by proponents of other midwives who are not CNMs or CMs. These midwives lack formal academic education and training, and provide services in home birth settings with no connection to the rest of the maternity care system, but nonetheless are legally authorized to practice midwifery in over half of the states.

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Critical consumer safety concerns with this type of midwifery care are an appropriate focus for government attention. These safety concerns should take priority over considerations of cost or maximizing competition, and any consideration of expanding competition among healthcare providers must include mechanisms for protecting consumer safety.

The comments below focus on the following topics:

- Principles that ACOG holds in common with the American College of Nurse-Midwives (ACNM) for education, training, licensure, and practice of midwives.
- Recommended improvements in state licensure and regulation of midwives to benefit consumers. FTC advocacy and other actions should support—not inhibit—implementation of a single, unified regulatory framework for midwifery care in the United States.
- Critical safety data that should inform decisions by lawmakers and regulators. In any examination of the market specific to maternity care and midwife providers, the FTC should be guided by critical safety data on out-of-hospital births, and promote improvements in the collection and reporting of patient safety and outcomes data on midwife-assisted home births.

I. ACOG and ACNM: Shared Principles and Collaboration.

ACOG and its ob-gyn physician members have a close and long-standing partnership with certified nurse-midwives, certified midwives, and their professional organization, the American College of Nurse-Midwives (ACNM). CNMs and CMs can join ACOG as members; they serve on ACOG clinical committees and task forces, attend meetings of the ACOG Executive Board, and assist in training ob-gyn residents.

ACOG's and ACNM's "Joint Statement of Practice Relationships," first adopted in 1971, affirms shared goals in women's health care for overall safety and excellence of services, for ensuring access to fully qualified and skilled providers at all levels of maternity care across the United States, and for maintaining the viability of ob-gyn and CNM/CM practices. (The joint statement is attached).

ACOG and ACNM advocate for medical and midwifery practice laws and regulations that support ob-gyns and CNMs/CMs working collaboratively in an integrated maternity care system that facilitates communication and collaboration across care settings and among fully qualified and licensed providers. To establish and sustain viable ob-gyn and CNM/CM practices, ACOG and ACNM are jointly committed to advocating on behalf of members of both groups for (i) affordable professional liability insurance coverage, (ii) hospital privileges, (iii) equivalent reimbursement from private payers and government programs, and (iv) access to support services, e.g., laboratory, obstetrical imaging, anesthesia.

Recent examples of joint efforts by ACOG and ACNM include: (i) *2011 ACOG-ACNM Issue of the Year*, which recognized best practices in maternity care across the United States involving obstetrician-gynecologists and nurse-midwives, and successful models of collaborative practice in both academic and community settings; and (ii) ACOG-ACNM support for H.R. 4385 in the US Congress, which would address the shortage of maternity care providers, in particular in underserved urban and rural communities.

II. Improved State Licensure and Regulation of Midwives is Needed.

State licensure laws should serve as a reliable authority for consumers and regulators to understand and assess not only the cost, but also the quality and safety of services.

ACOG and ACNM support uniform state licensure and regulatory requirements to assure that consumers and regulators have a common understanding of the term "midwife" and the education and training of midwife providers.

In their joint statement, ACOG and ACNM "affirm[ed] their commitment to promote the highest standards for education, national professional certification, and recertification of their respective members and to support evidence-based practice. Accredited education and professional certification preceding licensure are essential to ensure skilled providers at all levels of care across the United States." ACOG & ACNM, *Joint Statement of Practice Relationships*, Feb. 2011, at 1.

State licensure and regulation do not presently meet these goals and should be improved.

A. The lack of a common title and scope of practice for midwives means that female consumers do not get adequate, clear information on benefits, risks, limitations, and advantages of their care location, care practices, and maternity care provider.

Midwifery groups in the United States do not accept a common definition of a midwife. Midwives use three different professional designations and numerous titles, resulting in confusion among consumers regarding the education, training, and other credentials of midwife providers.

States have not adopted a unified, transparent regulatory scheme governing midwifery care, which is necessary to assure access to safe, qualified, highly skilled midwife providers across the United States. State licensure and scope of practice laws should—but unfortunately do not—support a common minimum education and training requirement that all midwives must meet whatever their title or professional designation, and regardless of where they practice.

There are three separate midwifery credentials in the US: certified nurse-midwives (CNM), certified midwives (CM) and certified professional midwives (CPM). Each credential accepts different levels of education, training and experience. Marked variation in qualifications also exists among midwives who use the CPM designation.

Midwives also use many different titles, even within the same state, and midwives use some titles in multiple ways (e.g., Licensed Midwives, or LMs), due to variations in the level of education and training required by various states.

ACNM has a chart posted on its website that compares education, training, and other attributes of the three main midwifery credentials:

http://www.midwife.org/acnm/files/cclibraryfiles/filename/000000001031/cnm%20cm%20cpm%20comparison%20chart%20march%202011.pdf.

1. **Certified Nurse-Midwives (CNMs).** CNMs are advance practice nurses (APRNs) dually educated at the graduate level in both nursing and midwifery. CNMs are the only category of midwives that are trained and licensed as APRNs. CNMs meet educational and professional standards of the ACNM. CNMs comprise the majority of midwives in the United States and are licensed in all 50 states and the District of Columbia. CNMs practice primarily in hospitals and also birth center facilities.

2. **Certified Midwives (CMs).** CMs do not have nursing credentials and are not APRNs, but otherwise meet the educational and professional standards of the ACNM, and sit for the same certification exams as CNMs. Three states license CMs (New Jersey, New York, Rhode Island), and in Delaware CMs practice by permit.

3. **Certified Professional Midwives (CPMs).** CPMs do not meet the educational and professional standards of the ACNM. Unlike academically trained and credentialed CNMs and CMs, the majority of CPMs have only a high-school diploma or equivalent, and are trained in one-on-one apprenticeships and self-study models with no university or hospital-based education or training. In fact, the CPM apprenticeship training model does not meet accreditation standards of the US Department of Education (USDE).

Notably, CPMs who are apprentice-trained, and CPMs who have some formal university–affiliated training both use the same CPM designation without distinction. This is problematic for state legislators who must make important licensure decisions that affect public safety. This is also a consumer safety issue, particularly as CPMs practice outside of the hospital setting and are unconnected to the rest of the maternity care system, delivering babies in consumers' homes (which clearly lack the safety infrastructure found in hospitals and accredited birth centers).

Despite their lack of academic training and the absence of transparent and accredited credentials, CPMs are authorized to practice in over half of the states, either by mandatory licensure, certification, registration, permit, or voluntary licensure.

4. **Other Titles for Licensed and Unlicensed Midwives.** Compounding the problem for consumers, many midwives use a variety of other titles even within the same state. This is confusing for everyone – lawmakers, patients, consumers, and even physicians and other health care practitioners. These titles include: direct-entry midwife (DEM); licensed direct-entry midwife (LDEM); licensed midwife (LM); registered midwife (RM); lay midwife; granny midwife; traditional midwife; naturopathic midwife; and natural midwife, among others.

With some titles (e.g., LM), the level of education and training can vary among states. In some states (e.g., Hawaii), there is no state licensure, certification, or registration of midwives or other providers who deliver babies at home. Voluntary licensure of midwives who are not nurses is also permitted in a few states (e.g., Missouri, and until recently, Oregon).

B. Most US home births are attended by midwives who lack the formal education, clinical training, and collaborative practice philosophy of CNMs and CMs.

See Wax JR, Pinette MG, Cartin A. Home versus hospital birth – process and outcome. Obstet Gynecol Surv. 2010;65:132-140 (CPMs attend 73.3% of US home births).

C. Current regulations in many states do not adequately restrict selection of home settings for high-risk childbirths.

Some states (e.g., Oregon), restrict birthing center facilities from performing certain high-risk births such as multiple gestations and breech presentation, but do not similarly restrict CPMs from attending high risk births in home settings.

In some states, the most highly trained midwives (CNMs), are restricted from practicing in the home setting, but less qualified, apprentice-trained, non-nurse-midwives are authorized to attend home births.

D. There are legitimate and serious consumer safety concerns with State decisions to authorize practice or permit voluntary licensure by unqualified midwives in unregulated settings, with no connection to the rest of the health care system.

CPMs are authorized to practice midwifery in over half of the states, as noted above, but women seeking a home birth in these states are unlikely to know that education and training qualifications vary among midwives—even those who use the same title—and thus that a CPM is unlikely to have the education, training, and collaborative practice experience (in particular formal academic, university and hospital-based training and experience), that the patient desires or expects.

Safety concerns for consumers of maternity care are greater in states where there is no requirement for the CPM to work collaboratively with hospital-based and privileged providers, or under state sanctioned practice guidelines and safety and transport protocols.

To ensure patient safety and the best possible care for women who are pregnant, state legislators should license only fully qualified, academically trained midwives who are credentialed by ACNM and the American Midwifery Certification Board (AMCB). ACOG supports the ACNM and AMCB standards for this purpose, as these standards are best suited to assure patient safety.

E. Effective state government oversight is critical.

State licensing agencies should verify that all licensed midwives meet minimum requirements, collect and report safety measures and outcomes for out-of-hospital births, aggregate and report this information annually to the state legislature, and monitor and act promptly on consumer complaints.

F. Uniform minimum practice standards are needed for all midwives across all states.

State regulations vary widely as to the legal status and level of practice authority of midwives. Most states lack a common minimum requirement for education and training that all midwives must meet to practice legally in the state regardless of title or professional designation.

Only one state (New York), now requires all midwives—regardless of educational pathway, professional designation, or title—to meet the same minimum level of education and training (New York Professional Midwifery Practice Act, Article 40, Sec. 6950, 1992). CNMs and CMs meet the New York standard, but CPMs do not.

1. Uniformity of regulation would greatly benefit consumers who currently may not be able to distinguish the qualifications of midwives who use different titles, and even those who use the same title.

Uniformity of regulation would mean that consumers could depend on their midwife to follow standardized safety, transfer, and transport protocols that are widely accepted and in use by the rest of maternity care providers, including other midwives. When standards of education and practice are not held in common, optimal transfer and transport systems break down. When a home birth patient's condition and risk status changes, care of the patient should be transferred to another provider in accordance with previously agreed-upon protocols to assure continuity of care. In the case of an emergency, the patient should be promptly transported to a hospital with emergency obstetric capability in accordance with system-wide safety protocols.

Consumers in New York State have a greater assurance of utilizing the services of a fully qualified midwife than do consumers in other states, due to New York State's unique and uniform midwifery licensure rules.

Federal and state governments should set minimum requirements for midwife participation in Medicaid and other government subsidized programs that include certification by AMCB.

2. Uniformity of regulation and common education and practice standards would assist state regulators to conduct appropriate oversight and hold midwifery care accountable to consumers and the public.

Evaluation by state licensing bodies of provider skills and credentials is greatly facilitated by common education standards (e.g., length of program, content of curriculum, accreditation). Information about midwives' education and training should be transparent and available to lawmakers to make sound decisions on scope of practice legislation and regulations.

3. Uniformity of regulation would assure a common scope of practice for all midwives, making it possible for outcomes data and impact studies to be correctly interpreted and tracked to a specific midwife provider.

Current limitations in the collection and reporting of data on home births (discussed below) severely compromise any analysis of safety and outcomes data on which legislators and regulators—including the FTC—rely when enacting or enforcing licensure and scope of practice laws.

III. Critical Safety Data: Improved Data Collection and Reporting of Patient Safety and Outcomes Data on Midwife-Assisted Home Births is Needed to Better Inform State Scope of Practice and Licensure Decisions.

A. Birth certificate data obscure the risks attendant to home birth.

The Centers for Disease Control and Prevention (CDC), through its National Center for Health Statistics (NCHS), compiles detailed information on the approximately 4 million US births each year. Birth certificate data for 2012 are the most recent available. Unfortunately, the CDC-NCHS data have material limitations—due in part to inconsistent, inadequate state licensing standards for midwives— that should be corrected:

1. Misclassification of the mother's intended place of delivery. For example, the CDC-NCHS data do not always distinguish between midwife-attended planned home births where the mother was transferred to a hospital due to complications, and hospital births that were planned to occur in a hospital.

2. Lack of information regarding whether a home birth was planned or unplanned.

3. Inadequate data regarding the professional designations, licensure, education, and skills level of midwives who attend out-of-hospital births. Accurate and detailed data on these metrics is especially important to identify and study instances where a mother planned a midwife-assisted home birth, but the mother was transferred to the hospital due to complications or an emergency.

These limitations severely compromise any analysis of data to evaluate the safety of home birth and the outcomes achieved by midwives with different professional and licensing designations. As a result, legislative decisions occur in a vacuum, thereby placing consumer health and safety at risk.

B. Consumer safety concerns warrant restrictions on high-risk births at home, including vaginal birth after cesarean (VBAC), twin gestation, breech delivery, and post-term pregnancy.

There are well-founded patient safety concerns with attempting a VBAC delivery at home with any provider. Indeed, the National Institutes of Health (NIH) 2010 Consensus Development Conference on VBAC summarized an imposing list of life-threatening complications to both mother and baby that can occur even for women who undertake a trial of labor in a high-volume, fully staffed hospital labor and delivery unit.

NIH recommends that VBAC should be done in well-equipped facilities ready to perform an emergent cesarean delivery with surgeons, anesthesia personnel, surgical nurses, operating

rooms, blood transfusions, and post-operative care. *See* National Institutes of Health Consensus Development Conference Statement, "Vaginal Birth After Cesarean: New Insights," March 8-10, 2010. http://consensus.nih.gov/2010/images/vbac/vbac_statement.pdf.

The attached statements of F. Gary Cunningham, MD, chair of the NIH expert panel, submitted to the Arizona Midwifery Scope of Practice Advisory Committee and the Oregon Board of Direct-Entry Midwifery, identify patient safety concerns with high-risk births at home.

C. New safety data from Oregon on out-of-hospital births supports mandatory licensure requirements for home birth providers, restrictions on high-risk out-of-hospital births, and better state oversight of safety protocols to protect home birth consumers.

Oregon ranks among the top ten states in the percentage of births that occur out-of-hospital. In 2011, the Oregon Legislature passed an ACOG-backed bill (HB 2380), requiring the state public health division to collect data on planned place of birth and planned birth attendant, and report annually on the outcomes of these births. A previous law requiring data collection on the maternal-fetal outcomes of licensed and unlicensed DEMs attending home births had not been enforced. Licensure of DEMs in Oregon has been voluntary, but as of January 1, 2015, all midwife providers except a few traditional midwives must be licensed.

The scope of practice for DEMs in Oregon includes twins, breech presentation (excluding footling), post-term pregnancies up to 43 weeks, presence of meconium, and rupture of membrane greater than 24 hours. *See* Oregon Administrative Rules (OAR). Oregon Board of Direct Entry Midwifery Act, Health Division, Risk Criteria sections 332-015-0021. (2002)

The 2012 summary report of the Oregon Health Authority, Public Health Division analyzed the data and found a much higher mortality rate for out-of-hospital births:

"Sixty-two term fetal and 30 early neonatal deaths occurred in Oregon during 2012; of these 8 (4 fetal, 4 early neonatal) occurred among planned out-of-hospital births. The term perinatal mortality rate for planned out-of-hospital births (4.0/1,000 pregnancies) was nearly twice that of in-hospital births (2.1/1,000). ...6 of 8 pregnancies did not meet low risk criteria. These pregnancies included: more than 40 weeks gestation (4); twin gestation (2); morbid obesity (1). Planned attendants among these 6: CNMs (1), licensed DEMs (3), unlicensed midwife (1) and ND (1)."

http://public.health.oregon.gov/BirthDeathCertificates/VitalStatistics/birth/Pages/planned-birth-place.aspx

D. Studies from other developed countries suggesting that planned home births are safe involved only low-risk births and healthy pregnant women.

For example, Canada and the Netherlands have strict criteria for selecting appropriate low-risk candidates for planned home birth, e.g., no pre-existing maternal disease; no disease arising during pregnancy; singleton fetus; cephalic presentation; gestational age greater than 36 weeks and less than 41 completed weeks of pregnancy; labor that is spontaneous or induced as an outpatient; mother has not been transferred from a hospital.

See Johnson KC, Daviss BA. Outcomes of planned home births with certified professional midwives: large prospective study in North America. BMJ. 2005;330:1416; de Jong A, van der Goes BY, Ravelli AC, et al. Perinatal mortality and morbidity in a nationwide cohort of 529,688 low-risk planned home and hospital births. BJOG. 2009;116:1177-1184; Amelink-Verburg MP, Verloove-Vanhorick SP, Hakkenberg RM, Veldhuijzen IM, Bennebroek Gravenhorts J, Buitendijk SE. Evaluation of 280,000 cases in Dutch midwifery practices: a descriptive study. BJOG. 2008; 115:570-578.

While women in Canada with one previous cesarean delivery are considered candidates for home birth, no safety data exists to support this practice. Canadian studies do not provide details on outcomes of women who have attempted a vaginal birth at home after a prior cesarean birth. *See* Janssen PA, Saxell L, Page LA, Klein MC, Liston RM, Lee SK. Outcomes of planned home birth with registered midwife versus planned hospital birth with midwife or physician. CMAJ 2009;181:377-83; Hutton EK, Reitsma AH, Kaufman K. Outcomes associated with planned home and planned hospital births in low-risk women attended by midwives in Ontario, Canada, 2003-2006: A retrospective cohort study. Birth 2009;36:180-9.

E. Conditions that make home birth relatively safe in some countries are not applicable to much of the United States.

For example, the Netherlands has a long tradition of optimally organized home birth. Well-trained midwives provide care only for low-risk births and they practice in an integrated maternity care system with a highly-developed transport system. High-risk births are not performed or sanctioned out-of-hospital in the Netherlands.

These conditions do not exist today in the United States. Several states (including Oregon), permit midwives to do high-risk births at home (e.g., VBACs, breeches, twin gestations, post-term pregnancies), despite evidence against the safety of a home setting for these births. The United States has emergency services but lacks a well-developed system of dedicated maternal transport services. Notably, the Netherlands is geographically small and densely populated, with virtually the entire population living within 20 minutes of a hospital, far shorter than in much of the United States.

F. The 2011 ACOG Committee Opinion, "Planned Home Birth," provides a useful review of the safety data on home birth.

"Although the [ACOG] Committee on Obstetric Practice believes that hospitals and birthing centers are the safest setting for birth, it respects the right of a woman to make a medically informed decision about delivery. Women inquiring about planned home birth should be informed of its risks and benefits based on recent evidence. Specifically, they should be informed that although the absolute risk may be low, planned home birth is associated with a twofold to threefold increased risk of neonatal death when compared with planned hospital birth. Importantly, women should be informed that the appropriate selection of candidates for home birth; the availability of a certified nurse–midwife, certified midwife, or physician practicing within an integrated and regulated health system; ready access to consultation; and assurance of safe and timely transport to nearby hospitals are critical to reducing perinatal mortality rates and achieving favorable home

birth outcomes." Planned home birth. Committee Opinion No. 476. American College of Obstetricians and Gynecologists. Obstet Gynecol 2011;117:425–8.

The complete ACOG Committee Opinion on Planned Home Birth is available at the link below:

http://www.acog.org/~/media/Committee%20Opinions/Committee%20on%20Obstetric%20Practice/co476.pdf?dmc=1&ts=20140424T1343517701

Conclusion

ACOG and its members have long-standing and positive working relationships with certified nurse-midwives and certified midwives, and with ACNM, their principal professional organization.

ACOG's recommendations stated above for broader and uniform state licensure and regulation of midwives are grounded in legitimate and serious patient safety concerns. The recommendations warrant prompt attention by state regulators and other constituencies, including private and government payers, hospitals, and other organizations that set credentialing standards for midwives, monitor the manner in which they provide services, and evaluate outcomes for out-of-hospital deliveries.

ACOG's recommendations for limits on out-of-hospital births for high-risk pregnancies seek to avoid unwarranted risk and confusion to women who may consider home birth, and establish limits on out-of-hospital deliveries for high-risk pregnancies where the risk of complications is great.

Such measures will eliminate consumer confusion and ensure that all patients receive health care from providers with the essential education, training, experience, and collaborative arrangements with other health care providers that are needed to meet the critical patient safety considerations inherent in childbirth.

Sincerely,

Hal C. Lawrence, III, MD, FACOG
Executive Vice President and
Chief Executive Office

COMMITTEE ON RULES

I Mina'trentai Dos na Liheslaturan Guåhan • The 32nd Guam Legislature
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Certification of Waiver of Fiscal Note Requirement

This is to certify that the Committee on Rules submitted to the Bureau of Budget and Management Research (BBMR) a request for a fiscal note, or applicable waiver, on **Bill No. 381-32 (COR) – D.G. Rodriguez, Jr., "An act to establish the Anesthesiologist Assistant Act, by adding a new Article 25 to Chapter 12, Part 2, Title 10, Guam Code Annotated."**– on July 17, 2014. COR hereby certifies that BBMR confirmed receipt of this request July 17, 2014 at 1:36 P.M.

COR further certifies that a response to this request was not received. **Therefore, pursuant to 2 GCA §9105, the requirement for a fiscal note, or waiver thereof, on Bill 381-32 (COR) to be included in the committee report on said bill, is hereby waived.**

Certified by:

Rory J. Respicio

Senator Rory J. Respicio
Chairperson, Committee on Rules

December 11, 2014
Date

COMMITTEE ON RULES

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July 17, 2014

VIA E-MAIL
joey.calvo@bbmr.guam.gov

Jose S. Calvo
Acting Director
Bureau of Budget & Management Research
P.O. Box 2950
Hagåtña, Guam 96910

RE: Request for Fiscal Notes– Bill Nos. 381-32 (COR) and 382-32(COR)

Hafa Adai Mr. Calvo:

Transmitted herewith is a listing of *I Mina'trentai Dos na Liheslaturan Guåhan's* most recently introduced bills. Pursuant to 2 GCA §9103, I respectfully request the preparation of fiscal notes for the referenced bills.

Si Yu'os ma'åse' for your attention to this matter.

Very Truly Yours,

Senator Thomas C. Ada
Acting Chairperson of the Committee on Rules

Attachment (1)

Cc: Clerk of the Legislature

Bill Nos.	Sponsors	Title
381-32 (COR)	Dennis G. Rodriguez, Jr.	AN ACT TO ESTABLISH THE ANESTHESIOLOGIST ASSISTANT ACT, BY ADDING A NEW ARTICLE 25 TO CHAPTER 12, PART 2, TITLE 10, GUAM CODE ANNOTATED.
382-32(COR)	Michael F.Q. San Nicolas	AN ACT TO REQUIRE THAT THE GUAM REGIONAL TRANSIT AUTHORITY CREATE AN EMERGENCY PUBLIC TRANSPORTATION PROTOCOL IN CONSULTATION WITH THE GUAM HOMELAND SECURITY OFFICE OF CIVIL DEFENSE BY AMENDING §6105 OF ARTICLE 1 OF CHAPTER 6, TITLE 12, GUAM CODE ANNOTATED.

COMMITTEE ON RULES

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July 16, 2014

MEMORANDUM

To: **Rennae Meno**
Clerk of the Legislature

Attorney Therese M. Terlaje
Legislative Legal Counsel

From: **Senator Thomas C. Ada**
Acting Chairperson of the Committee on Rules

Subject: **Referral of Bill No. 381-32(COR)**

As the Acting Chairperson of the Committee on Rules, I am forwarding my referral of **Bill No. 381-32(COR).**

Please ensure that the subject bill is referred, in my name, to the respective committee, as shown on the attachment. I also request that the same be forwarded to all members of *I Mina'trentai Dos na Liheslaturan Guåhan.*

Should you have any questions, please feel free to contact our office at 472-7679.

Si Yu'os Ma'åse!

Attachment

I Mina'Trentai Dos Na Liheslaturan Received

Bill Log Sheet

BILL NO.	SPONSOR	TITLE	DATE INTRODUCED	DATE REFERRED	CMTE REFERRED	PUBLIC HEARING DATE	DATE COMMITTEE REPORT FILED	FISCAL NOTES
381-32 (COR)	Dennis G. Rodriguez, Jr.	AN ACT TO ESTABLISH THE ANESTHESIOLOGIST ASSISTANT ACT, BY ADDING A NEW ARTICLE 25 TO CHAPTER 12, PART 2, TITLE 10, GUAM CODE ANNOTATED.	7/11/14 9:05 a.m.	07/16/14	Committee on Health & Human Services, Health Insurance Reform, Economic Development, and Senior Citizens			

Todu Guam Mail

Joe Mesngon <joe@toduguam.com>

FIRST NOTICE of Public Hearing on Wednesday, September 10, 2014

1 message

Nicole Ramos <nicoleramos@toduguam.com> Tue, Sep 2, 2014 at 2:33 PM
To: phnotice@guamlegislature.org
Cc: "Dennis Rodriguez, Jr." <senator@toduguam.com>, Joe Mesngon <joe@toduguam.com>, Natasha Cepeda <natasha@toduguam.com>

MEMORANDUM

To: **All Senators, Stakeholders and Media**

From: **Senator Dennis G. Rodriguez, Jr.**

Subject: **FIRST NOTICE of Public Hearing**

Hafa Adai!

The Committee on Health and Human Services, and Economic Development will be conducting a Public Hearing on Wednesday, September 10, 2014 at 2pm in the Legislature's Public Hearing Room on the following:

1) Bill 381-32 (COR)- An act to establish the Anesthesiologist Assistant Act, by adding a new Article 25 to Chapter 12, Part 2, Title 10, Guam Code Annotated.

2) Continuation of August 7, 2014 Informational Hearing on The Guam Economic Development Authority relative to the status of all Hotel Occupancy Tax (HOT) Bond projects.

3) Executive Appointment of Mr. John A. Rios as Administrator of the Guam Economic Development Authority.

Written testimonies may be addressed to Sen. Dennis G. Rodriguez, Jr. and submitted via email to senatordrodriguez@gmail.com, or deliver to 176 Serenu Ave. Suite 107, Tamuning or 155 Hesler Pl. Hagatna, Guam.

Individuals requiring special accommodations are asked to contact the office of Sen. Rodriguez no later than 48

hours prior to the hearing by calling 649-8638/0511.

Si Yu'os Ma'ase'!

Todu Guam Mail

Joe Mesngon <joe@toduguam.com>

SECOND NOTICE of Public Hearing on Wednesday, September 10, 2014

1 message

Nicole Ramos <nicoleramos@toduguam.com> Fri, Sep 5, 2014 at 10:04 AM
To: phnotice@guamlegislature.org
Cc: "Dennis Rodriguez, Jr." <senator@toduguam.com>, Joe Mesngon <joe@toduguam.com>, Menchu Suarez <menchu@toduguam.com>, Natasha Cepeda <natasha@toduguam.com>

September 5, 2014

MEMORANDUM

To: All Senators, Stakeholders and Media

From: Senator Dennis G. Rodriguez, Jr.

Subject: SECOND NOTICE of Public Hearing

Hafa Adai!

The Committee on Health and Human Services, and Economic Development will be conducting a Public Hearing on Wednesday, September 10, 2014 at 2pm in the Legislature's Public Hearing Room on the following:

1) Bill 381-32 (COR)- An act to establish the Anesthesiologist Assistant Act, by adding a new Article 25 to Chapter 12, Part 2, Title 10, Guam Code Annotated.

2) Continuation of August 7, 2014 Informational Hearing on The Guam Economic Development Authority relative to the status of all Hotel Occupancy Tax (HOT) Bond projects.

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Individuals requiring special accommodations are asked to contact the office of Sen. Rodriguez no later than 48 hours prior to the hearing by calling 649-8638/0511.

Si Yu'os Ma'ase'!

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As of October 2, 2014

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SENATOR DENNIS G. RODRIGUEZ, JR.

PUBLIC HEARING AGENDA

Wednesday, September 10, 2014 2pm Public Hearing Room, *I Liheslatura*

I. Call to order

II. Items for public consideration:

1) Bill 381-32 (COR)- An act to establish the Anesthesiologist Assistant Act, by adding a new Article 25 to Chapter 12, Part 2, Title 10, Guam Code Annotated. Introduced by Sen. Dennis G. Rodriguez, Jr.

2) Continuation of August 7, 2014 Informational Hearing on The Guam Economic Development Authority relative to the status of all Hotel Occupancy Tax (HOT) Bond projects.

3) Executive Appointment of Mr. John A. Rios as Administrator of the Guam Economic Development Authority.

III. Adjournment

Thank you for your participation in today's hearing.

Chairman, Committee on Health & Human Services, Health Insurance Reform, Economic Development, & Senior Citizens
Ufisinan Todu Guam • I Mina' Trenta Dos Na Liheslaturan Guåhan • 32nd Guam Legislature
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