Legislative Analysis

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LICENSURE OF CERTIFIED ANESTHESIOLOGIST ASSISTANTS; SUPERVISION OF NURSE ANESTHETISTS BY PHYSICIANS

House Bill 4709 as introduced
Sponsor: Rep. Rep. Hank Vaupel
Committee: Health Policy
Complete to 10-3-17

SUMMARY:

House Bill 4709 would amend the Public Health Code to create a new, state-licensed "certified anesthesiologist assistant" (CAA), who would practice anesthesiology under the supervision of an anesthesiologist. The bill also would allow nurse anesthetists to administer anesthesia or analgesia services without a physician being physically present (the physician may sign the patient's chart as evidence of supervision), as long as the patient is informed. It would also make complimentary additions and changes to the sections of the Code that apply to medical doctors and doctors of osteopathy (D.O.s), and the corresponding Board of Medicine and Board of Osteopathic Medicine and Surgery. The bill would take effect 90 days after enactment.

CAA Qualification for licensure

The bill would authorize the Board of Medicine or the Board of Osteopathic Medicine and Surgery to grant a license as a certified anesthesiologist assistant to an individual who provides satisfactory evidence of completion of all of the following:

- A graduate level training program approved by the Board.
- A certifying examination for certified anesthesiologist assistants administered by the National Commission for CAAs approved by the Board.
- A course in advanced cardiac life-support techniques approved by the Board.

CAA Educational limited license

The bill would allow either Board to grant an educational limited license (ELL) to an individual who provides satisfactory evidence of meeting the above requirements for licensure except the certifying examination. An ELL would be valid for the term determined by the Board, which may not exceed one year, or until the results of the certifying exam are made available, whichever is earlier.

Board of Medicine and Board of Osteopathic Medicine and Surgery must promulgate rules concerning CAAs

The bill would require the Boards, in consultation with the Michigan Department of Licensing and Regulatory Affairs (LARA), to promulgate rules to do all of the following:

- Establish and, where appropriate, limit the duties and activities related to the practice of anesthesiology that may be performed by CAAs.
- Establish an appropriate ratio of supervising anesthesiologists to certified anesthesiologist assistants, except in emergency cases.

- Prescribe continuing education requirements as a condition for renewal of a CAA license, subject to Section 16204 of the Public Health Code.

In order for an individual to practice as a CAA after 90 days after these rules took effect, he or she would need to be licensed or otherwise authorized as a CAA under the licensure rules listed above.

Once these rules took effect, an individual would not be allowed to engage in practice as a CAA unless licensed or otherwise authorized. Additionally, the bill would prohibit anyone without the requisite training from using the terms "certified anesthesiologist assistant" and "C.A.A."

Supervision of CAAs

The bill would require an anesthesiologist who supervises a CAA to be immediately available at all times (see definition, below) and to ensure that all activities, functions, services, and treatment measures performed by the CAA are properly documented by the CAA.

The bill would define these terms as follows:

An ***anesthesiologist*** is a physician who has been trained in the specialty of anesthesiology by completing a residency in anesthesiology that is approved by the board.

Practice as a certified anesthesiologist assistant means the practice of anesthesiology performed under the supervision of an anesthesiologist.

Immediately available means that a supervising anesthesiologist is in the physical proximity of an certified anesthesiologist assistant that allows the anesthesiologist to return and reestablish direct contact with the patient to meet the patient's medical needs and address any of the patient's urgent or emergent clinical problems.

Fees for a CAA

The bill would establish the applicable fees for a person licensed or seeking licensure as a CAA as follows:

- $75 application processing fee to apply for licensure,
- $60 license fee per year of licensure, and
- $25 educational limited license. The **educational limited license** may be issued by the Board of Medicine for otherwise qualified individuals who have not taken the certifying examination, and would be valid for up to one year, as determined by the Board, or until the results of the certifying examination.

[The bill would also raise the fees for specialty certification as a registered professional nurse (RN) from $24 to $50 for the application processing fee, and from $14 to $30 for the specialty certification per year of licensure.]

CAAs may administer schedule II to V controlled substances

Under the bill, the requirement that a person who manufactures, distributes, prescribes or dispenses a controlled substance must possess a controlled substances license would be waived for CAAs. Currently, the license requirement is waived when practical nurses or registered professional nurses administer schedule II to V controlled substances on the order of a licensed prescriber (as well as in certain hospice and methadone treatment program situations).

Supervision of nurse anesthetists

The bill would allow a physician in a practice agreement with a nurse anesthetist would be allowed to sign a patient's chart regarding an anesthesia or analgesia service provided by the nurse anesthetist, as evidence of supervision.

The bill would allow a hospital to enter into and implement a collaborative agreement with an anesthesiologist if all of the following requirements are met:

- The hospital is certified as a critical access hospital.
- The study described below has found a shortage of anesthesiologists at the hospital that is detrimental to the public health.
- The hospital provides documentation to the Michigan Department of Health and Human Services (MDHHS) that a physician refuses to supervise the nurse anesthetist and that a reasonable effort to recruit an anesthesiologist to supervise the nurse anesthetist has failed.
- The collaborative agreement is approved by applicable hospital staff as well as the Michigan boards of medicine and osteopathic medicine and surgery, and MDHHS.
- The collaborative agreement contains all of the following:
    - An agreement by the anesthesiologist to monitor the quality of anesthesia and analgesia services provided by the nurse anesthetist and to serve as, or collaborate with, the medical director of anesthesia services for the hospital.
    - An agreement by the anesthesiologist to be immediately available for direct communication with the nurse anesthetist either in person or by radio, telephone, or telecommunication.
    - A list of circumstances (specified in the bill) under which the supervising physician must be physically present when the anesthesia or analgesia service is performed.

If the hospital has entered into such a collaborative agreement, the bill would allow the nurse anesthetist to provide an anesthesia or analgesia service under the terms of the agreement without being supervised by a physician who is physically present. However, the nurse anesthetist would be required to inform the patient in writing that the service would be provided without the supervising physician physically present.

The bill would also require MDHHS to conduct a ***study to assess the anesthesia workforce*** at each hospital in the state, whether a shortage of anesthesiologists exists, and whether that shortage is detrimental to public health. That study would need to be complete by 24 months after the bill takes effect, and to include a review of a community health needs

assessment for each hospital, if applicable; consideration of the number of anesthesiologist residency training positions available in the state, and consideration of whether a collaborative agreement is beneficial to public health.

Hospital reporting requirement

Finally, the bill would require a hospital that enters into a collaborative agreement to submit an annual report to the Michigan Board of Medicine and Michigan Board of Osteopathic Medicine and Surgery that addresses metrics for anesthesia and analgesia services, as required by the Boards by rule. The report would be submitted to the Board in the prescribed form and manner, and provided to the public in written or electronic form upon request.

MCL 333.7303a et al

FISCAL IMPACT:

House Bill 4709 would have an indeterminate fiscal impact on the Department of Licensing and Regulatory Affairs (LARA), and no fiscal impact on units of local government. LARA would incur costs for the administration of the licensing program and for rules promulgation related to the professional practices of anesthesiologist assistants. The bill would establish a $75.00 application processing fee, a $60.00 annual licensing fee, and a $25.00 fee for an educational limited license; it is unclear whether these fees would be sufficient to completely cover the administrative costs of the department. Fees from licensure would be deposited to the Health Professions Regulatory Fund, which is used (subject to appropriation) to cover LARA's various expenses for regulating the health professions. The bill would also amend fees currently collected for specialty certifications for registered nurses; the application processing fee would be increased from $24.00 to $50.00, and the annual specialty certification fee would be increased from $14.00 to $30.00. According to the department, there were 9,064 individuals holding specialty licensure as registered nurses in Fiscal Year 2015. Using that total, this bill would increase revenues for this type of licensure by approximately $290,000 over the biennial renewal period.

Department of Health and Human Services (DHHS) - The bill's requirement for a one-time study by DHHS under Sec. 17215(4) is compatible with current functions of the Department related to health policy and health workforce planning. It is possible that the costs for the DHHS to carry out this one-time function would be modest or negligible given the Department's current functions in health workforce policy and planning, and ongoing relationship with hospitals in the state.

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