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S13, S17

MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE

Cliff # 924400

PREPARED FOR: Graham Whitmarsh, Deputy Minister - **FOR INFORMATION**

TITLE: Certified Registered Nurse Anaesthetists (CRNAs)

PURPOSE: To provide an overview of the US CRNA model.

BACKGROUND:

The American Association of Nurse Anaesthetists (AANA) is the sole professional association for the nation's nurse anaesthetists. More than 90 percent (44,000) of all US nurse anaesthetists, including CRNAs and nurse anaesthesia students, belong to the Association.

The AANA has issued educational and practice standards and guidelines, developed and implemented a certification and mandatory recertification program, and developed a nationally recognized program for accreditation of nurse anaesthesia educational programs.

Approximately 80 percent of CRNAs work as partners in care with physician anaesthesiologists, while the remaining 20 percent function as sole anaesthesia providers working and collaborating with surgeons and other licensed physicians.

CRNAs practice in every setting in which anaesthesia is delivered: traditional hospital surgical suites and obstetrical delivery rooms; critical access hospitals; ambulatory surgical centers; the offices of dentists, podiatrists, ophthalmologists, plastic surgeons, and pain management specialists; and US military, Public Health Services, and Department of Veterans Affairs healthcare facilities.

CRNAs administer every type of anesthetic, and provide care for every type of surgery or procedure, from open heart to cataract to pain management.

CRNAs graduate with a Masters degree from an accredited nurse anaesthesia program (this is shifting to a Doctorate degree by 2025). Masters' level nurse anaesthesia programs vary in length from 24 – 36 months; the Doctorate level is expected to be 36 months.

Successful completion of a national certification exam administered by the Council on Certification of Nurse Anaesthetists is required after graduation to practice as a CRNA in the US, and CRNAs must be recertified every two years.

Discussions with the College of Registered Nurses of BC (CRNBC) indicate that the Canadian nursing regulators have previously looked at the nurse anaesthetist role. The regulators did not show a high degree of interest in moving this role forward, and questioned whether or not this was actually a nursing role, or a physician substitute.

DISCUSSION:

Numerous studies have shown that anaesthesia care provided by CRNAs and physician anaesthesiologists, whether working independently or together, has never been safer.

The standards and guidelines of the nurse anaesthesia profession (e.g., the AANA's *Scope and Standards for Nurse Anaesthesia Practice*) do not require CRNAs to be physician supervised. Anaesthesia outcomes are affected by factors such as provider vigilance, attention, concentration, and organization, not whether the anaesthesia professional is an anaesthesiologist or a CRNA or whether the CRNA is supervised.

In a more recent study, Cromwell *et al* compared anaesthesia team arrangements in four US hospitals. The authors concluded that "given the substantial difference in the cost of training an anaesthesiologist versus a CRNA, team anaesthesia is highly cost effective. CRNAs cost less than half as much as MDAs [physician anaesthesiologists] and are trained to perform all the anaesthesia procedures...."

The Canadian Anaesthesiologists' Society (CAS, affiliate of the Royal College of Physicians and Surgeons of Canada) does not support the use of nurse anaesthetists. CAS supports the use of General Practitioner (GP) anaesthetists in remote communities (if Anaesthesiologists are not available) and the use of Anaesthesia Assistants as supportive personnel to Anaesthesiologists.

The BC Anaesthesia Society's website is currently lobbying to train, hire, and retain more Anaesthesia Assistants for patient care in BC.

CONCLUSION:

S17

S13

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APPENDIX A – 924400

GENERAL OVERVIEW OF US BASED NURSE ANAESTHESIA PRACTICE[1]

- Certified Registered Nurse Anaesthetists (CRNAs) work in collaboration with surgeons, physician anaesthesiologists, and other qualified healthcare professionals.
- CRNAs practice in every setting in which anaesthesia is delivered: traditional hospital surgical suites and obstetrical delivery rooms; critical access hospitals; ambulatory surgical centers; the offices of dentists, podiatrists, ophthalmologists, plastic surgeons, and pain management specialists; and US military, Public Health Services, and Department of Veterans Affairs healthcare facilities. They administer every type of anaesthetic, and provide care for every type of surgery or procedure, from open heart to cataract to pain management (American Association of Nurse Anaesthetists, 2012).
- When anaesthesia is administered by a Nurse Anaesthetists, it is recognized as the practice of nursing; when administered by an Anaesthesiologist, it is recognized as the practice of medicine. Regardless of whether their educational background is in nursing or medicine, all anaesthesia professionals give anaesthesia the same way.
- CRNAs administer more than 32 million anaesthetics in the United States each year.
- CRNAs' safety record, supported by research data, is exceptional. While liability insurance rates for other anaesthesia providers have increased, CRNAs' rates have decreased.

ASSOCIATIONS

American Association of Nurse Anaesthetists (AANA)[2]

- The AANA is the sole professional association for the nation's Nurse Anaesthetists. More than 90 percent (44,000) of all US Nurse Anaesthetists, including CRNAs and nurse anaesthesia students, belong to the Association.
- Founded in 1931, the AANA has issued educational and practice standards and guidelines, developed and implemented a certification and mandatory recertification program, and developed a nationally recognized program for accreditation of nurse anaesthesia educational programs.
- Since 1975, credentialing of nurse anaesthesia educational programs and the certification/recertification of Nurse Anaesthetists has been a function of the AANA autonomous multidisciplinary councils.
- The AANA is actively involved in the development of federal and state healthcare policy, and offers consultation and data sources regarding CRNA practice to both public and private entities.

[1] http://www.aana.com/aboutus/Documents/executivesummary.pdf
[2] http://www.aana.com/aboutus/Documents/executivesummary.pdf

International Federation of Nurse Anaesthetists (IFNA) [3]

- Founded in 1989, by 11 countries with a specific nurse anaesthesia education, the IFNA has 36 country members, including the United States.
- Objectives :
    - To promote cooperation between Nurse Anaesthetists internationally.
    - To develop and promote educational standards in the field of nurse anaesthesia.
    - To develop and promote standards of practice in the field of nurse anaesthesia.
    - To provide opportunities for continuing education in anaesthesia.
    - To assist Nurse Anaesthetists' associations to improve the standards of nurse anaesthesia and the competence of nurse anaesthetists.
    - To promote the recognition of nurse anaesthesia.
    - To establish and maintain effective cooperation between Nurse Anaesthetists, Anaesthesiologists and other members of the medical profession, the nursing profession, hospitals and agencies, representing a community of interest in nurse anaesthesia.

CRNA SCOPE OF PRACTICE AND PRIVILEGING[4]

- CRNAs are qualified to make independent judgments concerning all aspects of anaesthesia care based on their education, licensure, and certification.
- Nurse anaesthesia practice includes but is not limited to pre-anaesthetic evaluation/ assessment and patient preparation; intraoperative anaesthesia management; and postoperative follow-up and evaluation.
- CRNAs provide anaesthesia and anaesthesia-related care upon request, assignment, or referral by the patient's physician or other healthcare provider authorized by law, most often to facilitate diagnostic, therapeutic, and surgical procedures. In other instances, the referral or request for consultation or assistance may be for management of pain associated with obstetrical labour and delivery, management of acute and chronic ventilatory problems, or management of acute and chronic pain through the performance of selected diagnostic and therapeutic blocks or other forms of pain management.
- CRNAs practice within a healthcare system that provides consultation, collaborative patient care management, or referral, as indicated by the health status of the client.
- AANA recommends that privileges should be appropriate to the scope and complexity of care provided by CRNAs. Clinical privileging should be so defined as to permit CRNAs to provide core procedures and selected activities under specific conditions with or without supervision.
- The clinical privileging process includes: 1) the qualifications of the provider; 2) the actual practice privileges requested and granted; 3) the conditions or limits of practice; and 4) the process for assessment of quality of work and renewal of privileges.

[3] http://ifna-int.org/ifna/page.php?16
[4] http://www.aana.com/aboutus/Documents/scopeofpractice.pdf

EDUCATION[5]

> *The first school of nurse anesthesia was formed in 1909 at St. Vincent Hospital, Portland, Oregon. Established by Agnes McGee, the course was six months long, and included courses on anatomy and physiology, pharmacology, and administration of common anesthetic agents. Within the next decade, approximately 19 schools opened. All consisted of post-graduate anesthesia training for nurses and were about six months in length. These included programs at Mayo Clinic, Johns Hopkins Hospital, Barnes Hospital, New York Post-Graduate Hospital, Charity Hospital in New Orleans, Grace Hospital in Detroit, among others.*[6]

- Current - Masters' degree level (since 1998); programs range 24 – 36 months (both academic and clinical study).
- In 2007, AANA decided that the educational preparation will be at the Doctorate level by 2025 (education program expected to be 36 months).
- Each graduate is required to complete a minimum of 550 cases encompassing a wide variety and diversity of anaesthesia experiences.
- Admission requirements to a nurse anaesthesia educational program include:
    - An earned Bachelor of Science in Nursing (BSN) or other appropriate baccalaureate degree;
    - Licensure as a Registered Nurse (RN) in at least one US state or in Puerto Rico;
    - A minimum of one year of acute care nursing experience as an RN.
- The curriculum for nurse anaesthesia educational programs is governed by the accreditation standards of the Council on Accreditation of Nurse Anaesthesia Educational Programs (COA), and recognized by the US Department of Education and the Council on Higher Education Accreditation.
- Graduates of accredited nurse anaesthesia educational programs must meet all requirements prescribed by the Council on Certification of Nurse Anaesthetists in order to write the National Certification Examination for Nurse Anaesthetists. Those who successfully pass this rigorous examination are designated as "certified" and are qualified to practice as a CRNA.
- Recertification, which includes requirements for anaesthesia practice as well as continuing education, must be successfully accomplished every two years in order to continue to practice as a CRNA.
- From the commencement of a professional education in nursing, a minimum of seven years of education and training is involved in the preparation of a CRNA.

[5] http://www.aana.com/aboutus/Documents/naeducation.pdf
[6] Thatcher, V.S. (1953) *History of Anesthesia, With Emphasis on the Nurse Specialist.* Philadelphia: J.B. Lippincott Company

QUALITY OF NURSE ANAESTHESIA PRACTICE[7]

- Numerous studies have shown that anaesthesia care provided by CRNAs and physician Anaesthesiologists, whether working independently or together, has never been safer.
    - In 1994, the Minnesota Department of Health (DOH) studied the provision of anaesthesia services by CRNAs and Anaesthesiologists. Among the department's conclusions was that "There are no studies, either national in scope or Minnesota-specific, which conclusively show a difference in patient outcomes based on type of anaesthesia provider."
    - In 2003, Dr. Michael Pine, a board-certified cardiologist widely recognized for his expertise in analyzing clinical data to evaluate healthcare outcomes, and a team of researchers, published the results of a groundbreaking study titled "Surgical Mortality and Type of Anaesthesia Provider." The study results revealed that patients are just as safe receiving their anaesthesia care from CRNAs or Anaesthesiologists working individually, or from CRNAs and Anaesthesiologists working together.
    - In 2007, a team of researchers led by Daniel Simonson, CRNA, MHPA, published the results of a retrospective analysis titled "Anaesthesia Staffing and Anaesthetic Complications During Cesarean Delivery." The study results showed that there is no difference in complication rates or mortality rates between hospitals that use only CRNAs compared with hospitals that use only Anaesthesiologists.
    - In 2008, researchers Jack Needleman, PhD, MS, and Ann Minnick, PhD, RN, FAAN, published results of a national study titled "Anaesthesia Provider Model, Hospital Resources, and Maternal Outcomes." The results of the study revealed that obstetrical anaesthesia is equally safe in hospitals that use only CRNAs or a combination of CRNAs and Anaesthesiologists, compared with hospitals that use only Anaesthesiologists.

LEGAL ISSUES OF NURSE ANAESTHESIA PRACTICE (SUPERVISION REQUIREMENTS)[8]

- The standards and guidelines of the nurse anaesthesia profession (e.g., the AANA's *Scope and Standards for Nurse Anaesthesia Practice*) do not require CRNAs to be physician supervised. Anaesthesia outcomes are affected by factors such as provider vigilance, attention, concentration, and organization, not whether the anaesthesia professional is an Anaesthesiologist or a CRNA or whether the CRNA is supervised.
- In addition, the National Council of State Boards of Nursing's (NCSBN) "APRN Model Act/Rules and Regulations" and the "Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education" do not require physician supervision of CRNAs or other advanced practice Registered Nurses.
- Neither The Joint Commission (the largest voluntary accreditor of hospitals in the US) nor Medicare requires Anaesthesiologist supervision of CRNAs.

[7] http://www.aana.com/aboutus/Documents/legalissuesnap.pdf
[8] http://www.aana.com/aboutus/Documents/legalissuesnap.pdf

- The laws of every state permit CRNAs to work directly with a physician or other authorized healthcare professional (for example, dentists and podiatrists) without being supervised by an Anaesthesiologist.
- Many states do not require physician supervision of CRNAs, demonstrating that such requirements are unnecessary as the quality of care CRNAs provide in these states is as good as elsewhere.
    - Forty states do not have a supervision requirement concerning nurse anaesthetists in nursing or medical laws or regulations.
    - Even taking into account state hospital licensing regulations, there are still thirty-three states that do not require physician supervision of CRNAs.
- Regardless of whether a state requires Nurse Anaesthetists to be supervised by a physician, Nurse Anaesthetists are always independently responsible for their actions. A surgeon or other healthcare professional is not automatically liable for the negligent actions of a CRNA; nor is the surgeon or other healthcare professional immune from liability when working with an Anaesthesiologist.
- State laws do not require a supervising physician to control the acts of a CRNA, and mere supervision is insufficient to make the supervisor legally responsible for a CRNA's negligence. The CRNA is the expert in anaesthesia and supervising physicians, other than Anaesthesiologists, are not expected to have as much knowledge of anaesthesia as the CRNA. In fact, the common practice is for surgeons to defer to CRNAs as the anaesthesia expert, rather than to attempt to instruct CRNAs concerning the particulars of anaesthesia practice.

NURSE ANAESTHETISTS AND ANAESTHESIOLOGISTS PRACTICING TOGETHER [9]

- The AANA supports mutual respect and open, forthright relations between CRNAs and Anaesthesiologists working in a collaborative fashion.
- Approximately 80 percent of CRNAs work as partners in care with physician Anaesthesiologists, while the remaining 20 percent function as sole anaesthesia providers working and collaborating with surgeons and other licensed physicians.
- When CRNAs and Anaesthesiologists work together to provide patient care, the following are key concepts:
    1. CRNAs are responsible for their actions in the care of patients and in the provision of anaesthesia services;
    2. CRNAs practice according to their licensure, certification and expertise;
    3. The Anaesthesiologist is the medical specialist who provides perioperative services and functions collaboratively with the CRNA in the provision of anaesthesia and related services.
    4. Patient care needs should dictate appropriate personnel resources of both Anaesthesiologists and CRNAs, rather than predetermined numerical ratios.

[9] http://www.aana.com/aboutus/Documents/practicing_together.pdf

ECONOMIC EFFECT[10]

- The US Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration) allows Medicare payment for the anaesthesia services and related care provided by Nurse Anaesthetists.
- In 1990, Cromwell *et al* developed a US model for anaesthesia productivity. Anaesthesiologists working in hospitals with Nurse Anaesthetists were at least twenty percent more productive than anaesthesiologists working alone. The authors estimated that the US would save almost US$500 million annually if all Anaesthesiologists worked with Nurse Anaesthetists.
- In a more recent study, Cromwell *et al* compared anaesthesia team arrangements in four US hospitals. The authors concluded that "given the substantial difference in the cost of training an anaesthesiologist versus a CRNA, team anaesthesia is highly cost effective. CRNAs cost less than half as much as MDAs [physician Anaesthesiologists] and are trained to perform all the anaesthesia procedures...."

ANTICIPATED PHYSICIAN CONCERNS

Introduction of Nurse Anaesthetists

- The BC Anaesthesia Society does not reference Nurse Anaesthetist, but lobbies to train, hire, and retain more Anaesthesia Assistants for patient care in BC.[11]
- In 2006 the Ministry developed a discussion paper on anaesthesia strategies. As part of the paper, the positions of various stakeholders groups were identified. At the time it was identified that:
    - The Canadian Anaesthesiologists' Society (CAS; affiliate of the Royal College of Physicians and Surgeons of Canada) does not support the use of Nurse Anaesthetists. CAS supports the use of GP Anaesthetists in remote communities (if Anaesthesiologists are not available) and the use of Anaesthesia Assistants as supportive personnel to Anaesthesiologists.
    - The CAS Guidelines to the Practice of Anaesthesia were recently revised to formally include the term "Anaesthesia Assistant." The guidelines describe the need for Anaesthesia Assistants to have appropriate training and a well-defined scope of practice and to work under the direction of an Anaesthesiologist.
    - Groups for which there was no formal position on the use of Nurse Anaesthetists noted on the following web sites were the:
        - Royal College of Physicians and Surgeons of Canada (RCPSC)
        - College of Physicians and Surgeons of BC (CPSBC)

[10] http://cadth.ca/media/pdf/273_No37_surgicalanesthesia_preassess_e.pdf
[11] http://wemakeitpossible.ca/solutions/

- The discussion paper also identified the level of acceptance in the US:
    - The relationship between nurse anaesthesia and medicine is reported to exist at two poles, with differences between what happens at the level of practice and what happens at the national organizational level.
    - At the level of practice, physicians have considerable respect for and acceptance of the CRNA (and vice versa), and CRNAs, attending physicians, residents, nurses and others generally work together in a friendly, mutually respectful atmosphere. In settings with a very high concentration of medical Anaesthesiologists, is some opposition to Nurse Anaesthetists.
    - At a national organizational level, the picture differs. For decades, the American Society of Anaesthesiologists has engaged in a campaign to make anaesthesia an all-physician specialty. The AANA continues to respond with outcome studies and evidence of safe practice, and there is no reported plan to change the model from the status quo.

Supervision

- The ability for CRNAs to perform various kinds of anaesthesia care, either under the medical supervision of Anaesthesiologists, or independently without medical supervision, become an ongoing source of conflict between Anaesthesiologists and CRNAs.[12]

Compensation

- Research and analyses indicate that CRNAs are less costly to train than Anaesthesiologists and have the potential for providing anaesthesia care efficiently (Anaesthesiologists and CRNAs can perform the same set of anaesthesia services, including relatively rare and difficult procedures such as open heart surgeries and organ transplantations, paediatric procedures, and others).
- CRNAs are generally salaried, their compensation lags behind Anaesthesiologists, and they generally receive no overtime pay. As the demand for health care continues to grow, increasing the number of CRNAs, and permitting them to practice in the most efficient delivery models, will be a key to containing costs while maintaining quality care.[13]

[12] Matsusaki T, Sakai T. *The role of Certified Registered Nurse Anesthetists in the United States.* Anesth. 2011 Oct;25(5):734-40. Epub 2011 Jun 30.
[13] Hogan PF, Seifert RF, Moore CS, Simonson BE; *The Cost Effectiveness Analysis of Anaesthesia Providers*; Nurs Econ. 2010 May-Jun;28(3):159-69.

March 21, 2012 (News Release)

Access to Safe Anesthesia Care Protected for California Hospital Patients

California Court of Appeal

- California state law does not require Certified Registered Nurse Anesthetists (CRNAs) to be supervised by a physician;
- important for rural and other medically underserved areas of California where CRNAs commonly administer anesthesia without supervision;
- California Association of Nurse Anesthetists (CANA), unanimously affirming the trial court's ruling that California law does not require physician supervision of CRNAs, and upholding the validity of the state's opt-out from the federal physician supervision requirement for nurse anesthetists;
- CRNAs administer anesthesia pursuant to a physician order, but that the order is not a requirement to administer anesthesia under physician supervision;
- 16 states (incl. Calif.) opted out of the federal requirement in June 2009;
- California law authorizes nurse anesthetists to provide safe anesthesia care with no requirement for physician supervision;
- confirms the legality of decades-long custom and practice in the state, but recognizes the key role that CRNAs play in California's and modern medicine's efforts to expand access to high quality, cost-effective anesthesia services;
- appellate opinion ruled against the California Medical Association (CMA) and California Society of Anesthesiologists (CSA), which in January 2011 appealed the trial court's December 2010 ruling that similarly upheld the legality of the supervision opt-out;
- while the CMA and CSA seemed to suggest that the opt-out creates safety risks for patients, they "did not present any evidence on that point nor did they substantively rebut the evidence presented by [CANA] demonstrating that the opt-out does not present safety risks." Evidence presented by CANA included two national anesthesia studies published in 2010 that confirmed the safety and cost-effectiveness of nurse anesthetists;
- As the 15th state to opt out of the federal supervision rule, California followed Iowa, Nebraska, Idaho, Minnesota, New Hampshire, New Mexico, Kansas, North Dakota, Washington, Alaska, Oregon, Montana, South Dakota, and Wisconsin. In September 2010, Colorado became the 16th opt-out state.
- Currently CRNAs work independently of anesthesiologists in a wide variety of practice settings in more than 80 percent of California counties that provide surgical and obstetric services in the state. California is home to seven rural counties that depend solely upon nurse anesthetists.

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INFORMATION BULLETS

For Minister Michael de Jong

Cliff #: **925041**

Subject: **Information Bullets for Minister de Jong and (Minister) Terry Lake, MLA (Kamloops – North Thompson) – Anaesthesia Assistants, Anaesthesia Delivery in BC Hospitals**

Main Points:

- As mentioned by Minister de Jong on March 28th, 2012[1], the Ministry of Health has been exploring a variety options to improve timely access to quality anaesthesia services across BC, delivered through collaborative team-based approaches.
- S13

- Currently in Canada, there are no independent practicing health professionals (such as nurses or respiratory therapists) providing anaesthesia services – all require physician supervision at all times. While the skill sets of anaesthetist assistants have been informally utilized in many practice settings in BC and elsewhere in Canada, as members of collaborative anaesthesia care teams for some time now, the role has never been formally recognized.
- The College of Nurses of Ontario (CNO) is the first regulatory body in Canada authorized to register NPs with the NP–A (Anaesthesia) specialty certificate, however, registration for independent practice in the NP-A specialty is not yet fully available. The model still requires physician supervision, and there has been limited uptake (only 4 base funded positions).
- There are three institutions in Canada that train anaesthetist assistants[2], including Thompson Rivers University in Kamloops – South Thompson (adjacent to Minister Lake's constituency of Kamloops – North Thompson).
- S13

- Evidence in the US demonstrates that independently practicing CRNAs are not only as safe as their anaesthesiologist counterparts, but CRNA-only practice is the most cost effective model for the delivery of anaesthesia services[3].

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[1] http://www.theglobeandmail.com/news/national/british-columbia/british-columbia-ponders-creation-of-nurse-anesthetists/article2385108/

[2] Canadian Society of Respiratory Therapists (CSRT) Position Paper: Anaesthesia Assistants (2008). http://www.csrt.com/en/professional/anesthesia_assistants.asp

[3] The Lewin Group (2010). Cost Effectiveness Analysis of Anaesthesia Providers. Retrieved October 17, 2010 from http://www.aana.com/lewinstudy.aspx#Lewin

- Studies also show that anaesthesia outcomes are not affected by factors such as whether the anaesthesia professional is an anaesthesiologist or a CRNA, or whether the CRNA is supervised[4]. Regardless of whether their educational background is in nursing, medicine, or other related discipline, all anaesthesia professionals administer anaesthesia the same way.
- The Ministry will continue discussions with the College of Registered Nurses of BC regarding the introduction of NP-As in BC, with the objective of developing a taskforce to provide advice on how best to move forward with this initiative that considers the roles of all healthcare professionals able to work together collaboratively to provide anaesthesia services (Anaesthesiologists, General Practitioner-Anaesthesiologists, Anaesthetist Assistants, and Nurse Practitioner-Anaesthetists).

Program Area: **Health Human Resources Planning – Nursing & Allied Professions**

Date: **April 27, 2012**

[4] http://www.aana.com/aboutus/Documents/legalissuesnap.pdf

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MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE

Cliff # 937226

PREPARED FOR: Honourable Michael de Jong, QC, Minister
- FOR INFORMATION

TITLE: Nurse Practitioner-Anesthetists

PURPOSE: To provide an update regarding creating a Nurse Practitioner-Anesthetist (NP-A) role in British Columbia.

BACKGROUND:

S13

DISCUSSION:

The Ministry is proceeding with the introduction and implementation of the NP role. Progress to date includes:

- Ongoing consultation and discussions with CRBNC to scope out and define the NP-A roles. CRNBC has the statutory authority to develop the necessary qualifications, appropriate practice standards and quality assurance requirements to introduce all new nursing roles in BC. CRNBC has identified initial resources and is currently gathering information on the American Certified Registered Nurse Anesthetist (CRNA) role, implementation challenges faced in US, and regulatory considerations. CRNA's are the US version of the NP-A.

- S13

- Discussions with organizations representing Respiratory Therapist and Anesthetist Assistants are underway to determine if these professionals could also play a part in anesthetic service delivery models.

- Both CRNBC and Ministry senior staff will be attending the American Association of Nurse Anesthetists annual meeting on August 4-8, 2012 in San Francisco. The conference is a forum where research pertinent to the specialty of nurse anesthesia is presented and includes the latest medical equipment, technology, and pharmacological products, as well as discusses education, workforce planning, promoting and the role of CRNA, and workplace challenges. The meeting also provides the opportunity to connect directly with educators, regulators and clinicians from across the US.

- A multi-phased NP-A implementation plan is in draft:
    - Phase One pulls together a small working group with clear objectives to deliver upon over the next 90 days (see Appendix A - Terms of Reference and 30/60/90 Day Plan). The focus will be on information gathering to address key policy questions related to projected anesthesia service requirements, service delivery options/models, initial workforce planning forecasting implications (e.g. will we have enough nurses to implement), and providing advice on how best to move forward with an initiative that considers the introduction and implementation of a new nursing role, NP-A, in an interdisciplinary environment.
    - Phase Two requires broader working group representation and will focus on role definition, competency development, educational delivery options, stakeholder consultation, and implementation requirements (e.g. funding, communications, marketing, etc.).

- It will take approximately 2 years for a NP-A to begin practicing within the BC health care system.

- The Ministry is currently analyzing data reports that explore the proportion of services billed by Anesthesiologists for broad service groups such as surgery, acute pain, chronic pain, and critical care. This will assist with discussions regarding future anesthetic service delivery model options, as well as areas of need/system gaps to inform initial areas of focus (e.g. maternal care).

- The Ministry is reviewing the proposed changes to the federal *Controlled Drug and Substances Act* to identify if the changes will support the new role or identify if there are additional barriers that would need to be addressed.

- A multi-stakeholder working group will be meeting in late August early September 2012. Representatives will include the Ministry, CRNBC, Health Authority Chief Nursing Officers, and potentially two CRNA members.

CONCLUSION:

The Ministry had identified the key deliverables to be completed in the next 30/60/90 days for the roll out of the NP-A role.

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Filename:	Z:\Clinical\Admin 100-499\Executive Services 280\20 Bns, Bullets & ADM Asgnmts\2012\Briefing Notes\937226 - INFO BN For The Minister - Nurse Practitioner-Anaesthetist Role Update Aug 01 - COO,DM APRVD.Docx

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