Virginia Department of Health Professions

DRAFT

Agenda

Board of Health Professions
Regulatory Research Committee Meeting

August 10, 2017
Board Room 3
10:00 a.m.

▪ Call to Order	Mr. Wells
▪ Emergency Egress	Dr. Carter
▪ Approval of Minutes – June 27, 2017 – page2 ○ Request for revision – Michele Satterlund, McGuire Woods Consulting LLC – **page 7**	Mr. Wells
▪ Findings of Certified Anesthesiologist Assistant Study – page 20	Mr. Wells
▪ Adjournment	

*** Public comment regarding the Certified Anesthesiologist Assistant study has closed, therefore, no public comment regarding this study will be received on this date.**

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Board of Health Professions
Regulatory Research Committee Public Hearing - Certified Anesthesiology Assistant

June 27, 2017
9:00 a.m. - Board Room 4
9960 Mayland Dr, Henrico, VA 23233

In Attendance	Barbara Allison-Bryan, MD, Board of Medicine
	Yvonne Haynes, LCSW, Board of Social Work
	Jacquelyn M. Tyler, RN, Citizen Member
	James Wells, RPH, Citizen Member
Absent	Martha S. Perry, MS, Citizen Member
DHP Staff	Elizabeth A. Carter, Ph.D., Executive Director BHP
	Laura L. Jackson, Operations Manager BHP
	Yetty Shobo, Ph.D., Deputy Executive Director BHP
	David Brown, DC, Director DHP
Observers	Katie Payne, VSA
	Jessica Bowman, VSA
	Brian Ball, VSA
	Emil Engels, VSA
	Randi Neubeck, VSA, CAA
	Rhiannan Haihds, CWRU
	Addison Cain, CWRU
	Emilia Morales, CWRU
	Maria Fortner, CWRU
	Trara Rlegadid, CWRU
	Mark Wheeler, AAPA, AAA, VSA
	Louise Hershkoartz,
	Tom Watters, VANA
	Cathy Harrison, VANA
	Martha Kelley, VSA
	Akash Sinha,

Mohammad Pradhan, CWRU
Nancy Long, CWRU
Zain Attir, CWRU
Alex Jurcisin, CWRU
Scott Vazquez, CWRU
Sabrina Cirino, DCAAA, AAAA
Nick Peterson, CWRU
Andrew, CWRU
Ashleigh Dechow, DCAAA, AAAA
Mariana Habib, DCAAA, AAAA
Daphne Tolentino, DCAAA, AAAA
Aldijana Mekic, DCAAA, AAAA
Parth Kalola, CWRU
Kevin Sistani, CWRU
Catherine Olumba, CWRU, MSA
Richard Davies, CWRU, MSA
Michael Diskin, CWRU, MSA
Priya Neti, DCAAA, VAAA
W. Scott Johnson, Esq., The Medical Society of Virginia
Ralston King, MSV
Julia Chambers, BHP Intern
Raymond Lindsey, VANA
Chelsea Miller, MedNax
R. Brent Rawlings, VHHA
Alexandra Fine, DCAAA, AAAA
Richard Grossman, VCNP
Abigail Moore, CWRU
Caitlin Burley, VAAA

Speakers

Katie Payne, Virginia Society of Anesthesiologists (VSA)
Layne DiLoreto, VAAA
Jeremy Betts, AAAA

Shane Angus, AAAA
Rose Wilson, VAAA
Dr. Matthew Pinegar, ASA
Dr. Scott Frank, ASA
Jason Hansen, ASA
Danny Mosaros, AAAA
Dr. Emil Engels, VSA
Brian Ball, VSA
Peter DeForest, VANA
Janet Setnor, VANA-Military CRNA
Dr. Fallacaro, VCU
Dr. Apatov, ODU
Michelle Satterlund, VANA
Thomas Davis, ODU
Ray Lindsey, CRNA
Trina Beyard, Case Western Student
Martha Kelly

Emergency Egress Dr. Carter

Court Reporter Anne Marie Nelson

Call to Order

Chair Mr. Wells **Time** 9:00 a.m.

Quorum Quorum

Public Comment

Discussion

Ms. Payne is with the Virginia Society of Anesthesiologists and stated that they are in support of licensure of certified anesthesiology assistants.

Layne DiLoreto, is with VAAA and supports licensure of certified anesthesiology assistants.

Mr. Betts is with AAAA and supports licensure of certified anesthesiology assistants.

Mr. Angus is with AAAA and supports licensure of certified anesthesiology assistants.

Ms. Wilson is with VAAA and supports licensure of certified anesthesiology assistants.

Mr. Pinegar is with ASA and supports licensure of certified anesthesiology assistants.

Dr. Frank is with ASA and supports licensure of certified anesthesiology assistants.

Mr. Hansen is with ASA and supports licensure of certified anesthesiology assistants.

Mr. Mosaros is with AAAA and supports licensure of certified anesthesiology assistants.

Dr. Engels is with VSA and supports licensure of certified anesthesiology assistants.

Mr. Ball is with VSA and supports licensure of certified anesthesiology assistants. Mr. Ball provided a handout with anesthetist practice locations in Virginia.

Mr. DeForest is with VANA and not opposed to licensure of certified anesthesiology assistants.

Ms. Setnor is with VANA and is a military CRNA. She stated that CRNAs are trained to work independently where CAAs are not. She believes it is very unlikely CAAs would be permitted to practice in the military.

Dr. Fallacaro is with VCU and stated that adding the CAA profession would create issues with already finite resources for training.

Dr. Apatov is with ODU and stated that training is key. He stated that CRNAs make care plans for each patient, whereas CAAs are dependent on a physician anesthesiologist.

Ms. Satterlund is with VANA and stated that VANA is not opposed to CAAs.

Mr. Davis with ODU stated that AA programs must be associated with medical universities and that new programs for CAAs will reduce CRNA slots.

Mr. Lindsay is a CRNA and stated that Gas Works is not a reliable source for CRNA job openings.

Trina Beyard is a first year student at Case Western residing in Virginia. She would like to see Virginia license CAAs so that she may work where she lives.

Ms. Kelly stated that her office has not been fully staffed with CRNAs in three years. She would like to see CAAs licensed as it would create a new pool of applicants for her to potentially hire.

Virginia Department of
Health Professions

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Hearing Conclusion

Presenter Mr. Wells

Public comment will be received until 5:00 p.m. on July 31, 2017. A court reporter transcribed the oral comments. Once completed, a copy of the transcript will be available by contacting the Board office.

Adjourned

Adjourned 11:24 a.m.

Chair James Wells, R.Ph.

Signature: _____ Date: _____/_____/_____

Board Executive Director Elizabeth A. Carter, Ph.D.

Signature: _____ Date: _____/_____/_____

Jackson, Laura (DHP)

From: Jackson, Laura (DHP)
Sent: Friday, July 21, 2017 2:45 PM
To: 'Satterlund, Michele'
Cc: Carter, Elizabeth A. (DHP)
Subject: FW: Correction

Ms. Satterlund,

Your comments on the minutes will be provided to the Committee for their consideration. They will vote on the minutes at the August 10, 2017 meeting and amend as they decide.

The transcript was received this morning and will be disseminated Monday once it is posted to the boards website and Townhall.

Thank you,
Laura

From: Satterlund, Michele [mailto:msatterlund@mcguirewoods.com]
Sent: Friday, July 21, 2017 12:44 PM
To: Carter, Elizabeth A. (DHP) <Elizabeth.Carter@DHP.VIRGINIA.GOV>
Cc: Peter Deforest (PeterDeforest@phscorporate.com) <PeterDeforest@phscorporate.com>
Subject: Correction

Dear Dr. Carter,

I just took a moment to review the draft minutes of the June 27, 2017 BHP meeting and wish to note that the minutes are inaccurate and do not reflect what VANA actually said. See https://www.dhp.virginia.gov/bhp/minutes/2017/RRC_draft_06272017.pdf

While VANA (Dr. DeForest and myself) indicated "VANA is not opposed to AAs per se," we went on to note that licensure could negatively impact CRNAs and that we had significant concerns and that we did not think the Board should recommend licensure.

BHP's draft comments are not reflective of what was actually said and we would ask that these be corrected to reflect the true context of our statements.

When will the transcription of the comments be available?

Thanks for your help in correcting this matter.

Michele Satterlund
SVP Government Relations - State
McGuireWoods Consulting LLC
Partner, McGuireWoods LLP
Gateway Plaza
800 East Canal Street
Richmond, VA 23219-3916

don't see myself as a physician extender. I don't see myself as a care extender. I see myself as a care giver. And I think that's a fundamental difference in the mentality of the two professions. I'm a care giver. I'm not extending anyone's services. I'm a licensed credential provider who is well educated in the art and science of anesthesiology.

Thank you for your time and I'm open to any questions. Thank you.

MR. WELLS: Ms. Satterlund.

MS. SATTERLUND: Good morning. Thank you for your time. I'm Michelle Satterlund. I'm with McGuire Woods Consulting and I represent the Virginia Association of Nurse Anesthetists. And I apologize I think I may have signed up on the wrong sheet. I'll provide the summary to VANA and I apologize for that.

I thank you all for giving us this opportunity to speak. I want to highlight what VANA's president, Dr. Peter DeForest mentioned. We are not opposed to AAs. We understand that in the world of health care there are many roles that are served.

But as you look at AAs in Virginia and as

you go through your criteria, it is critical that you look at the services that are already provided in Virginia. As you heard from Dr. Fallacaro and Dr. Apato, we have CRNAs who would love to practice in Virginia. We have a pipeline of ready people and you have to ask does it make economic sense to deviate from that pathway to start a licensure process of an entirely new group that will require the immediate and direct supervision of anesthesiologists.

If Virginia has access to care programs -- problems specific to anesthesia care, how will providing another provider with an additional provider in any way impact that access to care issue.

And I know in the report that you provided some workplace data information and we have some concerns with the data. I'll just be very candid about that. And we are going to be submitting written comments on it before the July deadline with some of our own data that we find that Virginia does not have a shortage of anesthesia providers. And that is backed up by the Herser (phonetically) report that you provide in your draft document, as well as the Veteran Administration and the

National Association of Anesthesiologists, that when they were looking at the issue of shortages, determined that there was no anesthesia provider shortage nationally.

So it's critical that if you think there is a shortage, can we address that shortage by what I would say by taking care of the low-hanging fruit, opening the hospital clinical trainings, allowing those other students who want to be practicing in Virginia as CRNA students, allowing them to do that, looking at the scope of practice issues that are impeding CRNA practice.

I know that there are misconceptions in many hospitals that anesthesiologists has to practice with a CRNA. That is simply inaccurate. The law in Virginia says that a CRNA practices under the supervision of a MD, dentist or podiatrist, does not require an anesthesiologist and it does not require that that supervision that that MD be on site.

Now because CRNAs practice in a surgical team model, there is always going to be a surgeon there. There always is a physician. But that individual may have no anesthesia training.

So that particular facility often,

particularly in the rural areas, relies on the knowledge, the anesthesia knowledge and training of the CRNA. So to say it's equal, I think, is inaccurate, to say that CRNAs and AAs are equal in training. CRNAs practice independently in a substantial number of the rural facilities in Virginia. And I don't see that if you plan to license these individuals that it will have any impact whatsoever on the access of care in the rural and small facilities.

We stand here ready to serve as a resource. I know you have a big job in finalizing the report. But I urge you to look comprehensively at this issue and not just at the very small criteria, is it feasible. Just about anything is feasible. But what will be the impact of licensing a third provider.

I thank you and if you have any questions, I'll be happy to answer them.

[redacted]

list. Is there anyone who would like to speak that has not spoken or anyone who would like to return to the microphone?

MR. BALL: Mr. Chair, we have a few [redacted]

significant increase in cost in running four anesthesiologists -- there's also a supply issue for a number of anesthesiologists versus providers.

MR. WELLS: Thank you.

MR. WELLS: Peter DeForest.

MR. DEFOREST: Good morning. As you heard, my name is Peter DeForest. I'm a CRNA with a master's in nursing anesthesiology, a doctorate in nursing anesthesia practice.

I'm the current president of the Virginia Association of Nurse Anesthetists. I am also a practicing CRNA and the director of services for a critical access hospital.

In my former life I was the director of anesthesia for a large southwest Virginia healthcare system, which I oversaw the staffing and professional aspects of seven rural facilities.

So, to that end, I can speak to a lot of your concerns about the smaller facilities and the actual real world cost of providing anesthesia in rural Virginia in mid to small size facilities.

I would like to take a second to let you know that in principle I am not opposed to anesthesiologist assistants and VANA has not taken a

position against anesthesiologist assistants. We do have some issues, which my colleagues to follow me will point out. But the arguments that have been presented for their utility in Virginia -- but I think my time would be best spent in addressing what I am most familiar with, which is trying to provide safe, cost-effective care in rural in smaller facilities.

I want to point out that you have heard several times that there is no difference between CRNAs and anesthesiologist assistants and that they are held to a very high standard for admission requirements and so forth. And with all of them were aiding in the admission to provide good, safe anesthesia care to the residents of the states and communities that they serve. But there are differences. And the physician anesthetist that said they treat their CRNAs and anesthesiologist assistants the same are probably speaking very truthfully. But that is because they are setting their own perimeters. I mean, I can treat my daughter and my son exactly the same, but that doesn't erase the fundamental difference between them.

The other difference is admission

standards. By all of the admission standards I have found for their programs, if you just look strictly at their criteria, none of those candidates would get accepted into a nurse anesthesiology program.

I personally got -- I was licensed as a registered nurse in 1985. I went back and got a graduate degree in nursing anesthesiology in 1990. And in that interim, my primary nursing education and my nurse anesthesiology education I spent five years working in post surgical settings, orthopedic post surgical settings, in coronary care units and in what we called at the time, cardiothoracic intensive care unit, which we would receive open heart surgery patients and back in the day when things were -- by today's standards pretty barbaric, and we would sit with those patients over night while they would emerge from their anesthetic and all of the various problems that came up during the course of the night with just a fellow on call three floors away.

And there were times when you had trouble with a patient, critical trouble with a patient, and you would be there for five minutes or however long you needed to be until the fellow could make his way down. The fellow staff people on the floor were

busy with their one-to-one patients and you were left with your judgement and professional skills and years of experience to manage that patient until help arrived.

So that is how I came to enter my graduate program in anesthesia with all those years of experience, those weekend nights being alone, having to manage patients with very critical circumstances, with backup, but backup at a distance. And that, I feel, prepared me to begin my study of anesthesiology.

And I admire these kids because it's going to take a lot of backbone to come into patient care as a new patient care provider and anesthesia at the same time. It terrified me and I had five years of critical care nursing experience. So they have a lot of guts. Either they have a lot of guts or being naive, probably a mix of both because we all have that.

You know, it's just in my basic nursing training I had rotations and semester long courses in pediatric care, mental health, public health, critical care, things that these kids, these young people, coming into the program won't necessarily have. So there is a difference.

There is also a difference in how CRNAs and anesthesiologist assistants are reimbursed. Now we heard several times that there is no difference in how insurance sees non-physician anesthetists, but that is not entirely accurate. It's only accurate if you look at a very narrow segment, which is the care team model.

So they have a four to one ratio and that's all fine and good. They can get reimbursed as medically directed anesthetists. If they go to a five to one, then suddenly all bets are off. If you have CRNAs in that practice, those CNRAs now become supervised.

There is a difference between supervision and medical direction in the eyes of CMS. And CMS is the agency to which other agencies refer, and defer in many instances, regulation and payment situations.

So the difference is that a CRNA can bill and perform anesthesia without the medical direction of a physician anesthetist whereas the CAA cannot. That is why I can be the sole anesthesia provider in Patrick County, Virginia day in and day out, year after year. There is not a physician anesthetist within 30 miles of me. And our hospital is able to

get reimbursed for my services and have safe, cost-effective patient care provided.

Another clinical situation in which I work is a surgery center in a small city and they came to my partner and I because they had a physician anesthetist that they had to pay a fairly high salary because a large fraction of their patients are CMS patients, so, Medicare, Medicaid, they were not charging enough. They were not getting reimbursed enough to pay the physician anesthetist's salary. They could only recoup two-thirds of the salary.

So they turned to us as known in the community and said can you guys help us out. And we are now providing their anesthetic care. They are at less than their reimbursement cost from their insurance billing. So not only do they get safe cost-effective anesthesia care, but they get to keep a little bit of money on top of that. So there are differences.

And I want to note that the anesthesia safety today is absolutely phenomenal, and as nurse anesthetists we owe a lot of that advancement in anesthesia safety to colleagues that have preceded us, physician anesthetists, nurse anesthetists, all

developing safety standards, quality management.

They have advanced anesthesia safety to the point where for a healthy individual undergoing routine surgery, they are extremely safe, very low risk of complications. And studies have shown that CRNAs providing care is equally safe and comparable to other types of physicians, or other types of providers.

To speak to the cost, the downward pressure in salaries that they mentioned, it is interestingly enough that only the physician extender salaries that increase. So I wanted to point that out. The physician anesthetists salaries maintain the same. There may be advantages to the department in certain facilities, but overall it's the extenders that are having the downward salary pressure. And that's part of the reason why my membership has prompted me to come here to address some of the questions that you might have because they are concerned about competition and downward pressure on salaries.

And we all have concerns about the financial stability going into what could be a period of extended healthcare reform or pressure downward. Cost pressures are going to be placed on everybody. We don't want to be put in a uniquely

weak position.

So there's an interest in our prior membership to see that we have a fair playing field. A level playing field is good for all. I would like to see all providers being able to provide care at their level scope of practice.

And to that end we would like that to be a consideration. When we look at the criteria for this study, one of them is are there alternative regulations, which would adequately protect the public, but might also meet the needs that are being proposed or being fit for the anesthesiologist assistants.

And one of those alternatives that I think I would strongly urge you to consider would be seeing about the feasibility of having all anesthesia providers that are licensed and board certified be able to practice to their full scope of practice and take down barriers to that level playing field that currently exists for CRNAs. I would be happy to take your questions.

MR. WELLS: Thank you.

[redacted]

MS. [redacted] morning. Thank you for [redacted]

COMMENTS OPPOSING AA LICENSURE		
1	Allysa Gilman, BSN, SRNA (CAA Student) Virginia Beach	Cites concern over AAs lack of clinical experience prior to training and competition for anesthesia clinical slots.
2	Bradley R. Prestidge, MD, MS Oncologist Norfolk	Notes successful use of CRNAs in practice and that their supervision does not require the supervisor to have anesthesia training or be on site in the facility. Indicates that paying another anesthesia provider such as an AA (who may only work under and anesthesiologist) would add additional costs to a surgical procedure. Those costs would be passed on to the patient and could result in decreased access to care.
3	C. H. Moore, CRNA, PhD Chief CRNA VCU Health System	Notes growing surgical case load. Has not experienced CRNA shortage, hired 15 in the past year and expects continued recruitment success. If more are needed, suggests class size enlargement rather than new infrastructure. Indicates CAA supervision requirement restricts their potential work settings. In areas where there are no anesthesiologists, such as in many rural hospitals, they cannot work while CRNAs can.
4	Carl M. Block, DDS/ Virginia Family Dentistry & Adjunct Clinical Professor at VCU School of Dentistry	Reports periodontal practice for 26 years, using CRNAs for IV conscious sedation for 25 years. Indicates they are an invaluable asset and provide an affordable level of comfort and safety for patients. Posits that many patients would not have sought potentially life-saving treatment had it not been for them. Notes the CAA supervision need would entail hiring two anesthesia providers to perform a single procedure. States that AA licensing would not impact access in office-based oral and dental settings.
5	Cary Braun, CRNA Clinical Coordinator Sentara Norfolk General and Sentara Leigh Hospitals in Norfolk	Notes concerns about AA licensure's adverse impact on CRNA students, as there are limited anesthesia clinical training sites now. Notes CRNAs are not permitted to participate in the clinical education of AA students, without risking professional standing in ANA and potentially incurring medico legal liability. With only anesthesiologists permitted to train AAs, staffing model changes would be needed with increase costs to patients and hospitals. Expresses concern over AAs lack of clinical experience prior to training and opines it would necessitate anesthesiologists' physical presence in the OR during training. States their current staffing models are inconsistent with this critical level of supervision. Notes the competition for training slots problem and because many CRNA students obtain employment in the state they are trained, posits it could create a shortage of future CRNAs in Virginia.
6	Cathy A. Harrison, DNAP, MSN, CRNA President/Owner of LCH Anesthesia Services, LLC Midlothian	MCV (1969) graduate. Has administered anesthesia in dental and cosmetic surgeons' offices for 17 years. Notes supervision for CRNA indicated earlier. She is the sole anesthesia provider in facilities where she practices. Notes that AAs must have direct supervision from an anesthesiologist (only) necessitating two providers to deliver anesthesia, increasing surgical costs and making access to anesthesia care more difficult. Notes CRNA education, training, and licensure requirements that include prior hands-on care in critical care settings

		prepares for independent judgments and performing life-saving actions that must be made in seconds. There may not always be time for the AA to consult an anesthesiologist, thereby creating further risk to the patient.
7	Danny Sandefur, CRNA Clinical Coordinator Hampton	Notes concern over adverse impact to CRNA students due to AA competition for clinical slots. Reports 99% of ORs are staffed by CRNAs. Cites anesthesiologists supervision requirement and CRNA's not being permitted to clinically train AAs. Has concerns over professional standing and medico legal liabilities. Indicates same concerns above as Cary Braun about physician staffing model and the need to provide an anesthesiologist in the OR where the AA student is training. Their current staffing models are inconsistent with this critical level of supervision. Reiterates the competition for training slots issue. Also indicates that because many CRNA students obtain employment in the state they are trained, it could create a shortage of future CRNAs in Virginia.
8	Donna Ells, CRNA	Expresses concerns over preservation of CRNA professional territory and practice. Notes safe, reliable CRNA have cared for generations, in US, abroad, and especially in underserved areas she posits are deemed unattractive by physicians. Is disturbed and insulted that physicians she works with daily are behind the initiative to replace CRNA practice with AAs. States that if the issue is more physician control, warns that PAs are seeking independent practice. States that anesthesiologists assuming AAs would present less autonomy and economic issues may be dealing with these issues soon. Posits that AAs have less clinical experience, only have a basic non-clinical science degree and 2-year "mini-med school" leading to a master's degree with no patient care experience. States it pales in comparison to CRNA preparation and rigor and that their practice standards are moving toward doctoral level for entry to practice. Concerned over the adverse actions to CRNAs.
9	Eric Stettler, DNAP	As Virginia resident, opposed to AAs practicing here. Believes it would be a disservice to healthcare providers and patients. States he has voiced his concerns with several PACs. Indicates that, based on his studies and experiences, he thinks it would be imprudent to warrant AAs in Commonwealth. Has also made note of this to elected officials.
10	Erin Smoak, CRNA, DNAP, NREMPT-P Richmond	Indicates she cannot speak personally to AA safety, wants to highlight the importance of CRNAs in rural Virginia communities. Notes that rural areas and many dental and outpatient surgical centers lack anesthesiologists and need independent providers. States CRNAs often fill these roles and AAs could not help in this capacity
11	Heather Beus, CAA No address indicated	ODU grad. Same letter as Alysa Gilman
12	Janet L. Setnor, Colonel (Ret), USAFR, NC Chief of Anesthesia/Compliance	Recently retired from Air Force after26 years as Aeromedical Evacuation Flight Nurse and CRNA. States that while in service she independently provided anesthesia in stateside medical treatment facilities and in Afghanistan where she was the sole anesthesia

	Officer, Austin-Weston Center Springfield	provider – closest anesthesia support was hundreds of miles away. States that CRNAs practice independently in all branches with no supervision by anesthesiologist or other physician to administer anesthesia. CRNAs have been main providers of anesthesia care in the military since the Civil War. States is it not unusual for CRNAs to be the sole provider on the front lines. CRNAs provide independent anesthesia care in all four military hospitals in Virginia. Notes the license of AA will NOT have a positive impact on access to care in Virginia's military treatment facilities because AAs cannot work as independent providers. Opines that for every 2-4 hired, one less anesthesiologist would be available to provide care because the anesthesiologist would fall to a supervisory role. States that all anesthesia providers must be independent providers and maintain readiness to individually deploy at a moment's notice. States that the frequency of deployments demands the ability to practice independently to save lives. Counters a comment made at the June 27, 2017 public hearing – that CRNAs were given independence because the military population tends to be younger and healthier. VANA vehemently opposes. States that although recruits are young and free of major medical conditions, soldiers do have limbs blown off, life threatening chest wounds, traumatic brain injuries and complications due to infections encountered in remote locales around the world, and have no exemption from infirmities of the general population. States that civilian anesthesia providers restrict their practices to small geographic areas and during normal hours, military providers practice around the globe and clock. They also care of indigenous populations who live in primitive and unhealthy circumstances where health care is almost non-existent and lifespans short. Stateside, they also care for warrior's families and aged veterans, some of whom served prior to World War II. Their population of patients is not all young or healthy. Considers scope of practice restrictions at the state and facility level as arbitrary and preventing CRNAs from practicing to the full extent of education and training. Concludes the addition of AAs, who must have a supervising anesthesiologist, will inevitably lead to increases in costs to the patient, the facility, and the Commonwealth and not improve access to care.
13	Jeannette Filpi, PT, MHA Pioneer Community Hospital of Patrick Stuart	Notes hers is a Critical Access Hospital in SW Va. Anesthesia coverage is solely provided by CRNAs. Notes other rural jurisdictions also have CRNAs as sole providers. Opines that because AAs must practice under an anesthesiologists direct supervision, it seems unlikely that AA licensure would benefit. Expects that surgical costs would increase in settings with AAs given two, rather than one, provider would be seeking reimbursement and the additional cost would be passed on to patients and payers and leaving the hospital hoping that payments would be made and costs covered. Indicates that additional costs would result in increased uncompensated care, increased bad debt, and likely decreased access to care.

14	Jeffrey R. Leidy, DMD, FAGD Virginia Beach	General dentist with moderate sedation certification. Notes practice for 32 years. Performs a variety of dental procedures in an in-office setting, and CRNAs and anesthesiologists provide sedation services. States it does not make financial sense for his practice to hire two anesthesia providers for a single procedure. So, licensing of AAs would have no impact on access to office-based dental settings. Notes proponents espousing a benefit of improving dental access to care are mistaken.
15	Jenny S. Finck, BSN, RN, CCRN Chesapeake	ODU grad. Details own educational background and experience in cardiac surgery step-down and CCU, then electrophysiology and sedation nurse. Worked with CRNAs decided to pursue CRNA – resumed education to get bachelors and worked 2+ years before entering ODU's program. She is a Student Registered Nurse Anesthetist currently. Concerned about AAs lack of clinical experience before entering their education program. Cites importance of proactive and preventive care as well as reactive. Notes finite clinical slots and competition AAs would add. States that anesthesiologists and other medical residents needing intubation training are given priority over SRNAs.
16	Jim Hale Constituent	State he is strongly opposed to AAs as they are "undertrained and dangerous."
17	John L. Clements, DPM Moneta	Podiatrist at Critical Access Hospital in Stuart. Been in practice in rural Va. for 40 years. Has experience with anesthesiologists and CRNAs and has seen no difference in performance or outcomes. However, he finds patients are more satisfied with CNRA's "patient and personable" approach. Because of AA supervision need, states it does not make financial sense for his practice to hire two anesthesia providers to perform a single procedure. Indicates cost of anesthesia care would increase dramatically while doing nothing to promote access to care. Further states it may limit access to care because it would make surgical services too expensive for rural hospitals to maintain. Concludes licensing AAs would have no positive impact and may have a detrimental one to his hospital-based podiatry settings.
18	Joseph L. Koen, MD, FAANS Neurological Specialists, Inc. Norfolk	Notes distinction between CRNA and AA supervision as above and that CRNAs are often sole anesthesia provider, especially in rural areas. Indicates that CRNA programs prepare for autonomous practice, but AA program prepare to assist only. States the AA/anesthesiologist model is inflexible and fails to adequately meet the needs of patients, hospitals, ambulatory surgery centers, or other healthcare settings because practice is contingent on the anesthesiologist's availability. Notes CRNAs practice in every setting in which anesthesia is delivered and is recognized in all states and DC. Reports that only 13 states and DC authorize AA practice and that KY requires PA-AA. Indicates that AA quality is unproven with no research on AA anesthesia safety. States CRNAs safety has been repeatedly demonstrated in peer-reviewed studies and publications in prominent journals. States unlike for CRNAs, CMS prohibits AAs from billing for non-medically directed services (billing code QZ).

		Reimbursement requires medical direction. Opines that this confirms what CMS knows about educational preparation and service and AAs and CRNAs are not the same. Notes paying for two anesthesia providers would add costs to the surgical procedure, that would be passed on to the patients and could decrease access to care. States that as a neurosurgeon, he performs surgeries that range from small outpatient to complex intracranial and spinal operations and relies upon the critical care in nursing CRNAs have. He does not what that care to be compromised.
19	Joshua Rieke, MSN, CRNA Southampton Memorial Hospital Franklin, resident of Chesapeake	Notes concern over competition for training slots and that all his hospital's ORs are staffed by CRNAs without anesthesiologists. States that many rural hospitals like his fully utilize CRNAs due to the economic advantage of hiring one provider per operating area. Notes the prohibition against CRNAs participating in AA clinical training. Opines that the anesthesiologist/AA model would dramatically increase costs to patients and hospitals. Expresses concern that many AAs have no prior healthcare or clinical experience suggesting the anesthesiologist would need to be present in the OR where the student is training. Same statement made by other commenters about students becoming employed in state in which they train and competing for slots feasibly creating shortage of future CRNAs in Va.
20	Judith Ricketts, CRNA, MSN Clinical Coordinator Childrens Hospitals of the Kings Daughters Norfolk	States issues indicated earlier, limited slots, CRNAs not being able participate in clinical education of AAs, AA/anesthesiologist two provider costs, same statement about students becoming employed where they train and completing slots affecting future CRNAs in Va., potentially creating a shortage.
21	Karen J. Spencer CEO Virginia Surgery Center Norfolk	Her ambulatory ophthalmology-only center serves a large geographic region, with over 8000 patients per year. Worked successfully with CRNAs. Indicates the costs of two anesthesia providers due to AA anesthesiologist supervision requirement would be prohibitive.
22	Keith Berger, MD (Gastroenterologist/ Internist) Ctr. Health & Cancer Prevention Va. Beach	Notes his endoscopy center and that Propofol and CRNAs have dramatically improved safety, quality, and patient compliance. States his center performs screening and diagnostic colonoscopies and endoscopies for 1500 patients per year. Indicates the requirement for two providers due to the requirement for anesthesiologist supervision would not improve availability or cost, especially not for GI office-based procedures.
23	Lauren K. Murphy, BSN, RN, SRNA	ODU student. As in previous comments, she expressed concern over AA lack of clinical experience and competition for training slots
24	Lawrence B. Cohen, MD Norfolk Plastic Surgery on behalf of Care Cajares, CRNA	States confidence in CRNAs and expresses concern over paying for two anesthesia providers to accommodate supervision which would add costs to surgical procedures that would be passed on to patients and could decrease access to care.
25	Linda E. Ferro, CRNA Va. Beach	States she is an independent contractor in endoscopy in Va. Beach and in ophthalmology in Norfolk. Noted concern over paying for two

		anesthesia providers, with costs passed on to patients and potential decreased access to care.
26	Macon McClease CRNA Student	Cites concern over AA's lack of clinical experience, competition for slots and its potential for creating a CRNA shortage.
27	Maria Hirsch, BSN, MS, DNAP, CRNA Director, Carillion Professional Services Carilion Clinic Roanoke	Reports her facility employs approximately 50 CRNAs. They staff two Critical Access Hospitals (CAHs)and a third rural hospital with CRNAs who are the sole providers. They also have two larger hospitals with anesthesiologists practicing alone or in collaboration with CRNAs. Notes that staffing models are determined by efficiencies or independent physician group contracts. States that CRNAs are sole providers at their difficult-to-staff CAHs due to rural location and high call assignment. Notes vacancies at these facilities are hard to fill and can take up to a year to recruit with a CRNA. Notes these facilities cannot afford to pay an anesthesiologist salary and opines that licensing AAs would not help fill the need for staff at rural facilities where there are no anesthesiologists to "medically direct." She states that when emergencies arise, CRNAs can be supervised by surgeons and other doctors, but AAs could not. She expressed concern over introducing AAs into a complex staffing model because it would generate the need to discriminate between the type of anesthesia provider being utilized at any one time in order to comply with regulatory and billing requirements. Contends that the AA's inability to practice independently could put patients at risk when chaotic staffing exists during emergencies and resources are scarce. Indicates licensing AAs would not help with staffing or improve access to care within Carilion Clinic. States CRNA safety is proven, while AA safety is not. Reports that Introducing a third type of provider would be a potential detriment to patients when it is not needed.
28	Mark S. Sorin, DDS Va. Beach	States he is writing on behalf of the dental profession. Notes he has practiced 40+ years, over 30 in pediatrics. Experienced in OR with anesthesiologists, CRNAs and dental anesthesiologists. Notes the additional cost of anesthesiologist to supervise an AA would add costs to a surgical procedure that would be passed on to patients and could decrease access.
29	Michael D. Fallacaro, DNS, CRNA, FAAN Professor/Chair Dept. of Nurse Anesthesia - VC	Notes school's history (1969) (see also Public Hearing comments). Reports that majority of graduates take employment in the region from which they are recruited and educated. Cites statistics on 50 clinical sites over five states and describes affiliate sites in Abingdon, Roanoke, Alexandria, and Richmond. Speaks to the need for adequate volume and types of cases for certification and that AAs taking slots would adversely affect SRNAs. Notes that CAAs cannot educate SRNAs in the clinical areas and that CAAs employed clinical affiliates would reduce the number of training cases available for SRNAs. Notes expansion of the VCU doctoral program with 44-48 students expected for Jan. 2018. Contends that introduction of a third anesthesia provider is not needed, would harm other state university supported anesthesia training programs, reduce the availability of finite clinical resources, reduce the number of clinical instructors, and potentially

		impact the Commonwealth's ability to support the training of qualified anesthesia providers who support medically underserved regions, including the coalfields of Appalachia. Offers that existing CRNAs may view this as threatening their livelihood which could result in unrest, political disharmony, and unintended consequences that may impact quality patient care access. Reports, that if workforce shortages arise, VCU's CRNA program is prepared address the issue by working with clinical partners across the state.
30	Michael W. Jackson, MSNA, CRNA Southampton Memorial Hospital Franklin, resident of Suffolk	See #19, Joshua Rieke's comments.
31	Nancy Harrison, MSNA, CRNA	States there is no need for additional anesthesia provider as scopes would be indistinguishable from CRNAs, with no patient benefits, but additional economic costs.
32	Nathaniel M. Aprov, MHS, MSN, PhD, CRNA Director, Nurse Anesthesia Program ODU School of Nursing	Reports ODU been educating CRNAs for >20 years and have provided nearly all practitioners for Hampton Roads area. Indicated ODU historically has accepted 10-15 students yearly and would accept more but are limited by available training slots, not qualified students. States they have increased slots recently to 17 this year and are approved for 19 in the future. Contends that licensing AA makes little fiscal sense. Cites lack of track record and inability to work independently and their competition for training slots adversely affecting SRNAs. Expressed concern that AAs are a heterogeneous group of learners with most having no experience caring for the ill. He reiterates the potential negative impact on nurse anesthesia training in Virginia.
33	Paul E. Pellini, MSNA, CRNA Southampton Memorial Hospital Franklin	Same comments in #19 and #30.
34	Raymond Lindsay, CRNA	States that with 900 anesthesiologists and 1900 CRNAs in Virginia, the proposal appears to be solution in search of a problem. References existing regulatory restrictions on CRNA practice and the Institute of Medicine's recommendations for nurses to be permitted to work to their level of education and training. Notes the proposed class of provider would have even further authority restrictions than CRNAs.
35	Richard Hartle, MD Gastroenterologist Tidewater Physician Multispecialty Group Williamsburg	States his practice chooses a CRNA-only model. They perform endoscopies and colonoscopies from Williamsburg to Va. Beach. Practice also does bronchoscopies, and urological and gynecological procedures. Notes it is not uncommon for the CRNA to be the sole anesthesia provider in a facility such as his and facilities in rural jurisdictions in Tidewater and Richmond. Cites concerns with

		increased cost of anesthesiologist supervision for AAs, passed on patient costs and potential decreased access to care.
36	Robert H. Schnarrs, MD, FACS Hague Center for Cosmetic and Plastic Surgery	Reports his practice has contracted with independent CRNAs since inception in 1999. Happy with CRNAs. They also provide services with anesthesiologists and CRNAs at a number of local hospitals and surgical centers. Notes it is not uncommon for CRNAs to be the only anesthesia provider in rural and other areas. Indicates that licensure would not improve or alter the current level of care provided patients.
37	Samuel Smith, CRNA	CRNAs can practice independently. AAs education program would have a severe impact on our ability to train CRNAs. AAs cannot practice in the military. The "need" projected for AA's by ASA and VSA is merely a 'money grab" slyly disguised as a "patient access" issue. Cannot compare AA and CRNA care, but licensing AA's to practice in Va. will place Virginians at risk from substandard anesthesia care.
38	Sara A. Rolfes SRNA ODU Portsmouth	Cites personal background in healthcare prior to RNA program. Concerned about training slot competition
39	Theodore W. Uroskie, Jr., MD of behalf of Caren Cajares, CRNA Norfolk Plastic Surgery	See same letter from Lawrence Cohen (#24) supporting CRNAs and the issue of cost for two providers with CAAs due to anesthesiologist supervision requirement.
40	Thomas Corey Davis, PhD, CRNA	Expresses concerned over CRNAs currently employed within the Commonwealth. Responsible for 50 clinical sites. Posits CAA licensure would jeopardize VCU's program, may cause them to have to reduce enrollment. Also, responds as follows to points raised by supporters of CAA licensure during the June 27 Public Hearing: • States there are differences between CRNAs and AAs (education, training, examinations, etc.) • Speaker from Williamsburg said it was difficult to hire CRNAs., but went on to hire 25 in 12 months. The practice had been an MD-only practice and moved to Anesthesia Team. Noted that they may have only needed 7 anesthesiologists not 25. If the group retained all of their anesthesiologists, he states he sees why the cost is high, but the problem isn't CRNA salaries. • Notes in general that one group of employers may have a significant need, while another none. States that it appears that differences in salary and benefits, coupled with the "unit culture" of a particular group has more to do with availability of employment than availability of applicants. • Reiterates that CRNAs are often sole providers, cannot be supervised by AA, and that 86% of graduates remain in the region in which they were educated. • Contends that the problem is not a lack of qualified SRNA applicants, but lack of clinical sites. Reports there being 30

		student applying from Northern Va. with seven placements but only one clinical site in Fairfax. • Indicates that AAs would be damaging by competing for training slots and unlikely service in underserved areas.
41	Thomas J. Joly, MD, PhD Ophthalmic Plastic Surgery Virginia Eye Consultants, Eastern Va. Medical School	Notes working successfully with CRNAs under his and other doctor's supervisions including an anesthesiologist, or independently. Concerned about the cost of two anesthesia providers due to the requirement for CAAs to be supervised only by anesthesiologists.
42	Virginia Association of Nurse Anesthetists	Reports representing over1900 CRNAs, many of whom serve as the primary providers in rural surgical facilities, including hospitals and dental offices. Describes numerous costs and negative impacts of licensing a third anesthesia provider, especially on existing providers and patients. Opines that CAA licensure will not increase access or reduce costs. Indicates further that there is no evidence of a shortage of anesthesia providers. Express concern over impact on existing CRNA provider jobs and limitation on competition by having the anesthesiologist in control of AA education, accreditation, payment, and employment of anesthesia delivery. Cites concerns over training slot competition and the CAA's relative lack of patient care experience.
43	McGuire Woods Packet	Original packet available prior to Public Hearing.

COMMENTS SUPPORTING AA LICENSURE		
1	Addison Cain 1st year student Case Western Reserve	Excited about the field. Would like to work in Virginia
2	Akash Sinha 1st year student Case Western Reserve	Same – notes students can rotate in state but not practice
3	Aldijana Mekic, CAA Alexandria	CWR graduate would like to work in Virginia
4	Alex Jucisin 1st year student CWR	Sister is a CAA at Medstar Washington Hospital Center in D.C. Wants to work in Virginia
5	Alex Steed, CAA Maryland Academy of Anesthesiologist Assistants Resident of Maryland	Practices at Children's National Medical Center in D.C.. Explains educational content, # of jurisdictions. Anesthesiologists are the only physician specialty in the state to have only one physician extender.
6	Amarender Parkash, MD Anesthesiologist at MedStar Health Washington Hospital Center	Supervises both CAAs and CRNAs. Counters argument that CAAs displace CRNAs, cites NPI data that indicates when CAAs enter the marketplace, there is CRNA growth. BLS data shows the costs of CRNAs drops in states with the highest # of CAAs. Concludes this will increase access ??
7	Ayman Abdel, MD., et al. (10 others) American Anesthesiology of Virginia Leesburg	Anesthesiologists practicing in Loudoun Hospital. Unable to recruit full-time CRNAs, no interest in night and weekend regardless of salary. Would hire CAAs in a minute if they could practice in Va.
8	Amy Cababe, MD, CAA Resident of Missouri	Both CAA and MD - speaks to CAA education. Refers to shortage without further proof. Notes cost of CRNAs drops 15.2% with introduction of CAA. Want more than one choice of midlevel provider,
9	Andrew Le Student CWR Resident of Arizona	Excited about the filed. Would like to work in Virginia.
	Annie O. Wilhite, MD	Speaks to ACT and adding members to the team. Speaks to anesthesiologist education and training. Thinks anesthesiologists needed to be present. Only one physician extender choice. Wants "competitive market" for extenders to help drive costs down. Rotation through Va. but not practice.
11	April Basham, RN Salem	Nurse for 11 years, supports ACT and reiterates anesthesiologists having one physician extender instead of 6.5 for other specialties.
12	Arthur Gower, III MD, FAAP Manassas	UVA 1958, Navy and pediatric residency in SC. Practiced in Manassas 1963 to 2010 son is CAA

13	Arthur Ke, CAA Providence Hospital DC	Provides personal education and training. Would like to work in VA, Notes a dozen colleagues would like the same
14	Ashish Patel, CAA Practicing in DC Director of Simulation CWR	CAA 19 years. Family and business in Harrisonburg but cannot live there because he can 't work in Va. Cites growth of the profession.
15	Ashleigh Dechow, CAA, MSA	Notes profession's growth in last 10 years, licensure in surrounding states, Bureau of Labor Statistics' "recognizing CAAs as reducing costs of CRNAs in states with largest concentration of CAAs. Contends CAAs do not displace CRNA's.
16	Babak Roboubi, MD Sr. Attending Anesthesiologist Georgetown U.M.C. MedStar Health	Worked alongside CAAs for 15 years. Immediate Past-President of DC SOA
17	Brian A. McConnell, MD Past President VSA Asst. Professor, VCU Northern Campus	States Va. law requires physician-led team-based model of care with nurses supervised. Describes differences in physician education and training with that for CRNAs, reiterates CAAs only work under the direction of an anesthesiologist. Cites a 2000 study published in *Anesthesiology* that concludes anesthesia care is improved with involvement of an anesthesiologist. Notes acute nature of anesthesiology requires moment-to-moment intraoperative anesthesiologist availability to address emergencies. States patient and family expectation of this availability in the operating room context. Notes anesthesiology is the only specialty in Va. without choice of physician extender/mid-level practitioner. Notes with CAAs in proportion to CRNAs in the employment market lower costs. Opines competition would lower healthcare costs. Notes AA students may do clinical rotations in Va. but practice as CAAs. Several Va. residents must travel to other states to work.
18	Bridgetee Coates, RN, C-EFM Roanoke	Nurse practicing for 34 years and has worked with anesthesiologists in the OR and labor and delivery. Believes the ACT approach is best. Notes CAAs are permitted to practice in surrounding states. References Bureau of Labor and Statistics and NPI data indicates decreased anesthesia cost with introduction of CAAs. Supports CAA licensure as addition to anesthesia care providers to help provide best care possible in most cost-effective way.
19	Caitlin Burley, CAA President DC Academy of Anesthesiologist Assistants, Treasurer Virginia Academy of Anesthesiologist Assistants Virginia resident	Adheres to ACT as best model. Notes requirement to travel to work while students can rotate in Va. Works at MedStar Washington Hospital Center in D.C. Notes there are 72 staff anesthetists with 40 CAAs which practice interchangeably as a team rotating through every specialty surgical care area offered by the hospital.

20	Caitlin Burley, CAA DCAAA President	On behalf of the DC organization supports Va. licensure. Notes CAAs have been practicing in D.C. for 15 years, in 17 jurisdictions and in the Veterans Administration System. They practice in all major hospitals in the city. They are recognized by CMS, TRICARE and major commercial payers. There are over 2000 CAAs nationwide. There are over a dozen CAA members who are Va. residents seeking to work here.
21	Camille Jansen, CAA Washington, DC	Expresses desire to work in Virginia.
22	Carina N. Rosslee, MD Anesthesiologist Winchester	See comments from Brian M. McConnell, MD (#17).
23	Catherine Olumba Junior AA Student CSW DC	Native DC resident. Expresses desire to work in Virginia and holds mutual benefit for respective communities.
24	Cathy Jo Swanson, MD Anesthesiologist Roanoke	See #17.
25	Chad Toujague, CAA, MBA CEO Halo Health, LLC Seffner, FL	Speaks to CAA educational and training background and considers difference with CRNAs only due to anesthesiologist supervision for CAAs. States his company staff anesthesia providers across the U.S. Notes the two professions are interchangeable where CAAs are permitted to practice. States CAAs are qualified to perform entire variety of anesthetic procedures, including procedures related to pediatric cardiac patients, labor and delivery, and full range of surgeries. Posits CAAs could contribute addressing a healthcare deficit in Virginia.
26	Chris Dejelo, CAA MedStar Washington Hospital DC	Previously lived in Va. but moved to DC because of commute. Wishes to return. Explains CAA education and training requirements, 17 jurisdictions regulate CAAs, and CAAs work in many specialties. Indicates CAAs work in the ACT model and are reliable practitioners with proven safety record.
27	Christopher Eric Cordero, MD Anesthesiologist and Partner, Valley Anesthesia Roanoke	Cites 25 years' ACT practice model experience. Considers existing Virginia statutes requiring physician supervised anesthesia care as the "gold standard" for patient care in Va. and U.S. It ensures physician access in an emergency. Refers to the 2000 published study in *Anesthesiology* indicating improved care with anesthesiologist involvement. Notes acute nature of anesthesiology requires moment-to-moment intraoperative anesthesiologist availability to address emergencies. States patient and family expectation of this availability in the operating room context. Notes anesthesiology is the only specialty in Va. without choice of physician extender/mid-level practitioner. Reports lower anesthesia care costs may be expected with CAAs participation in the employment market in proportion to CRNAs.

28	Christopher Cromwell, MD Chairman and Medical Director, Dept. of Emergency Medicine at Stone Springs Hospital Center Loudoun	Appreciates the value of team work in in clinical settings. Indicates the option to choose from a variety of qualified employees is essential to building a tem for staffing a facility.
29	Christopher C. Rigsby, MD Anesthesiologist Roanoke	Cites current shortage of both anesthesiologists and CRNAs in the area. See #17.
30	Connie S. Jones, MD Anesthesiologist August Health in Fishersville and UVA Health Systems in Charlottesville	Notes practices as MD-only and with supervision of CRNAs. Reports differences in pre-med curriculum for CAA vs. nursing curriculum for CRNAs. Holds the former is more advantageous to obtain advanced degrees required in the practice of anesthesia. Reports daily practice with rotating AA students. States if changed from an all-MD practice, would hire a CAA over a CRNA. Reports there are 14 CAAs and 8 CAA students who live in Virginia but must leave to work. Notes CAAs are recognized by CMS, Tricare and all major commercial payers. Cites Bureau of Labor Statistics reporting of decreased anesthesia care cost in states with CAAs.
31	Craig Stopa, MD Anesthesiologist Hampton Roads	Reports moving to Va. after Emory University residency where he worked with CAAs. Notes anesthesiologists have only one physician extender/mid-level practitioner to choose from, driving up costs. Notes the BLS described decreased anesthetist employment costs where CAA and CRNA are in proportionate numbers in the labor market.
32	Daniel Mesaros, CAA DC Fairfax resident	Notes serving as a board member for the American Academy of Anesthesiologist Assistants, having safely practiced since 2008 and believes he deserves to be permitted to practice in Va. Speaks to lowering health costs and promoting diversity in the team model.
33	Daniel Perlin, MD Senior Physician Anesthesiologist Washington Hospital Center MedStar Health DC	States working at a level one trauma center and at the hospital for 20 years, 15 of which with CAAs. Notes requisite premedical background and intensive anesthesia training though specialty-specific training rotations. Indicates high level CAAs have a high level of critical thinking and decision-making capabilities along with the specialized skill set that allows for safe, efficient, and quality patient care.
34	Daphne Tolentino, CAA	Describes education and training from Case Western Reserve University in Ohio, becoming a CAA in 2007, a Virginia resident since 2009 and working at the Washington Hospital Center level one trauma center since 2007. Seeks work opportunity options to expand to Virginia.

35	David Fields, MD Anesthesiologist Washington Hospital Center MedStar Health DC Resident Potomac, MD	Cites 30 years' experience as individual practitioner and ACT member. Indicates CAAs provide value and dedication.
36	Debbie Altizer, RNC-EFM Roanoke	States ACT approach is best for patients. Advocates for Va. residents being permitted CAA care. Indicates they provide anesthesiologists with an additional choice of mid-level anesthesia providers where other specialties have an average of six and a half. Expresses view that CAs will add to quality, availability, and affordability of healthcare and other aspects of Virginia communities.
37	Dia Copeland, MD Gastroenterologist MidAtlantic Permanente Medical Group DC and Maryland locations Alexandria resident	States gastroenterologists rely on anesthesia providers for endoscopic and other procedures. Approves of the ACT model as patients present with chronic conditions. Reports having worked with CAAs at Washington Hospital Center for six years. Notes high quality, compassionate care and emphasis on safety.
38	E. Alexandra Zubowicz, MD, FACS Surgeon Washington Hospital Center MedStar Health DC	Reports having worked with CAAs for a decade in the DC area. Performs surgery daily and supports ACT model. Indicates patients with high acuity levels. References a national shortage of anesthesia providers, growing number of procedures requiring anesthesia services, and aging complex patient population. Posits that licensing CAAs will minimize strain on CRNAs and anesthesiologists.
39	Eileen Begin, MD Interim Chair, Dept. of Anesthesiology Washington Hospital Center MedStar Health DC	Cites department employing CAAs for 15 years, use of ACT approach, and employing CRNAs side-by-side with CAAs. They are paid the same. Notes appreciation of the option of providers. Report no issues with employment of CAAs or CRNAS. Reports high acuity patient population and CAAs assisting with all subspecialties.
40	Eleanor Kathryn Lowry, MD Anesthesiologist Lynchburg	Reports embracing ACT approach and has 15 MDs and 8 CRNAs in current practice. Notes having difficulty recruiting CRNA for several months despite competitive salary, work schedule and benefits. Notes nearly 200 positions on www.gasworks.com. Indicates they have hired locum tenens to provide temporary staffing. Cites other physician specialties have multiple care extenders and CAAs are licensed in surrounding states. Cites CAA education and training backgrounds, safety, and anesthesiologist supervision for physician intervention if needed. Would hire CAAs if licensed.
41	Ella Branch, RNC-OB Buchanan	Virginia resident for 32 year and nurse for 10. Reports working with anesthesiologists in labor and delivery. Approves the ACT approach.

		Notes Va. is surrounded by states that license CAAs. Beliefs CAAs licensure will provide for best possible care and cost effectiveness.
42	Emil Engels, MD, MBA President, Virginia Society of Anesthesiologists Practicing Anesthesiologist in Fairfax and resident of Oakton	Reports several years' personal knowledge of CAAs and knows anesthesiologists who work with CAAs in NC, GA, and DC. Speaks to safety records, supervision and doing every type of cases. Cites his company has 40 open positions for CRNAs that they cannot fill now. References www.gaswork.com with almost 200 unfilled positions in Va. Indicates having to pay overtime and hiring locum tenens. Notes one care extender type. Reports a dozen CAAs living in Va. but not able to work here.
43	Emilia Morales Student CWR DC Californian with family in Stafford	Cites personal history and desire to work, notes 17 states that license CAAs. Seeks to work in Va. with CAA.
44	Emily Wilson Sister to CAA Aldie	Seeks licensure for CAAs and approves of the ACT approach.
45	Erin Felger, MD, FACS Assoc. Program Director of Surgery Washington Hospital Center MedStar Health DC Great Falls resident	Notes their endocrine surgery department attracts patients requiring specialized surgical and anesthesia care. Approves of the ACT approach. Worked with CAAs for 8 years and is highly favorable of their contributions to the team. Attests to their high level of safety and focus.
46	Eugenie Heitmiller, MD, FAAP Chief of Anesthesiology, Pain, and Perioperative Medicine at Children's National Health System	Also representing anesthesiologists from Pediatric Specialists of Virginia Ambulatory Surgery Center in Fairfax See #17. Additionally, notes p participating in AA training reports NPI data that show when CAAs enter the marketplace in a particular state, they do not displace any CRNAs. Indicates that there is a higher percentage of CNRA growth in states with CAAs vs. states without them.
47	Fay Horng, MD Dept. of Anesthesiology Washington Hospital Center MedStar Health DC	Reports working a major level one trauma center and working with CAAs and CRNAs within the ACT model. Indicates being able to work four rooms at once. States it provides for efficiency and safety, especially in faster-paced settings such as gastroenterology and electrophysiology suites. Equates CRNA and CAAs.
48	G. Bryon Work, MD Anesthesiologist Past-President of Atlantic Anesthesia and Past-President of the American Society of Anesthesiologists Va. Beach	Indicates CAA education and training. Their potentially service as an additional choice as physician extender. Counters that demand for all care team extenders continues to increase when CAAs are licensed in states and does not result in CRNA job loss. Seeks for CAAs living in Va. to be able to practice here.

49	Gail Simon Wappingers Fall, NY	Writes in support of CAA licensure and in support of Stefan Guzewicz, AA student.
50	George O. Woodrum, MD Staunton	Reports helping to train AAs at Augusta Health in Fishersville. Notes having worked with CRNAs in training and 25 years of private practice. Opines concern over insisting on own way rather than following directions and expense. Seeks CAA licensure to increase options for anesthesia providers.
51	George Landon Smith, MD Anesthesiologist SW Va.	No personal experience working with AA but colleagues in surrounding jurisdictions speak highly of them. Notes his practice serves an ever-expanding healthcare organization in rural Va. and that they have not been able to hire enough physicians or CRNAs. They pay overtime and hire locum tenens. Notes the dozen CAAs who are Va. residents.
52	Greg Mastropolo, CAA Clinical Professor Quinnipac University School of Medicine Washington Hospital Center MedStar Health DC	Reports being in practice 20 years. Notes CAAs have practice in ACT model for 15 years. Speaks to his practice in caring for trauma and emergency and other high acuity patients and the CAA's role in the perioperative team.
53	Harika Nagavelli Resident of Iowa (?)	Cites Rand Corporation study and projects a nationwide shortage of anesthesia providers by 2020 and need for 200-300 providers within the next three years, alone. Speaks to anesthesia as being an overlooked area and AA profession as new and evolving. Indicates AAs could help with costs and care.
54	Hassan Adeniji-Adele, MD Anesthesiologist Director of OB Anesthesiology School of Medicine Washington Hospital Center MedStar Health DC	Notes CAAs used successfully in his department for 15 years. Hospital cares for women with serious or potentially life-threatening comorbidities. Notes the hospital's Anesthesiology Department relies heavily on the ACT model and has benefitted from CAA availability.
55	Ikenna Uzomah, CAA, MSA MedStar Washington Hospital and Providence Hospital Maryland resident	Reports working in ACT model. Cites BLS data on cost decrease for CRNAs with CAAs and NPI data on growth of CRNAs in states with CAAs. Notes 17 jurisdictions.
56	Iman Mush Student Emory Born in Virginia	Expresses desire to work in Va. once certified.

	Resident of Georgia	
57	Jacquelyn Burley, RN Parent Resident of Georgia	Wishes for daughter who is a CAA to be able to practice in Va.
58	James & Elizabeth Eun Parents Reston	Wish for son who is a student at CWR to be able to practice in Va.
59	James F. Hammill, MD Anesthesiologist Virginia Anesthesia & Perioperative Care Specialists Newport News	See #17
60	Janet E. Ha Student CWR	Desires to be able to practice in Va. upon certification
61	Jared B. Fitzgerald Student – Senior Bedford	Desires to be able to practice in Va. upon certification
62	Jason Hansen Patient Alexandria	Reports having received CAA care and supports their licensure.
63	Jason Maas, MD Anesthesiologist Anesthesiologist Virginia Anesthesia & Perioperative Care Specialists Newport News	See #17
64	Jeff Kessel, MD Anesthesiologist ACV, Inc. Roanoke	Reports having trained and worked with CAAs in West Virginia. Notes that other specialists are hiring nurse practitioners and physician assistants while anesthesiologists have no other choice except CRNAs. Considers CAAs and equivalent with PAs. Notes they add diversity and that many areas of the state are in need of anesthesia providers. Notes they rotate through Va. as students but cannot practice here.
65	Jeffrey Gander, MD Pediatric Surgeon UVA Children's Hospital	Reported practicing in New York and working with CAAs. Seeks anesthesiologists to have the additional option of CAAs as anesthesia providers. Notes he does not understand the rationale behind permitting student rotations in Va. but not practice.
66	Jeffery S. Plagenhoef, MD President American Society of Anesthesiologists	Cites ASA Policy on ACT. Notes CAAs are key members of the ACT and anesthesiologists should have the choice of anesthesia providers. Describes CAA education and training and indicates they believe CAAs and CRNAs are interchangeable.

67	Jeffrey Weiss, DO President, Tem Health Anesthesia Palm Beach, FL	Head of a national anesthesia services management firm. Views Va. as having a significant shortage of anesthesia providers. Points to anesthesiologists having only one choice of provider as a problem.
68	Jennifer Hanna, MD Senior Anesthesiologist Washington Hospital Center MedStar Health DC	Reports having worked with CAAs for 15 years. Supports ACT model.
69	Jennifer Kunzelman, CRNA Washington Hospital Center MedStar Health DC Alexandria resident	Is married to an CAA. Opines CAAs are equally qualified to CRNAs. Reports that they are interchangeable with identical job responsibilities. Contends CAAs will not shrink CRNA job markets and will improve the shortage of anesthesia providers and reduce workload. Reports hoping to raise her family in Va.
70	Jermane Leclerc, MHSc. MHSA, CAA Program Director/Asst. Professor, Nova Southeastern University Ft. Lauderdale, FL	Generally supports CAA licensure in Va.
71	Jessica Roman, MD Anesthesiologist DC Va. resident	Reports having worked with CAAs for eight years. Thinks anesthesiologists should have choice of additional providers. Supports ACT model.
72	Jill Nagel, MD Anesthesiologist Anesthesiologist Virginia Anesthesia & Perioperative Care Specialists Williamsburg	#17
73	John F. Butterworth, IV, MD Anesthesiologist Richmond	Reports working in other states with CAAs. Notes they are employed by the Veterans Administration. Discusses CA educational backgrounds, they're not displacing CRNAs, and there are no changes in reimbursement rates in practices that utilize them.
74	John Gower, CAA Toledo, OH	Notes being born and raised in Va. and seeks CAAs practice here.
75	John E. Joyner, MD Senior Attending Anesthesiologist Washington Hospital Center MedStar Health DC	Reports working with CAAs for 15 years and has trained them. Uses CRNAs and CAA interchangeably and appreciates having provider options.

76	John Q. Schisler, II, MD Anesthesiologist American Anesthesiology of Virginia, P Loudoun	Reports working with CRNAs at Loudoun Hospital and the Air Force and was trained by and worked with CAAs during his residency. Notes no difference in CRNAs and CAAs.
77	Jonah Lopatin, MD Anesthesiologist Washington Hospital Center MedStar Health DC	Notes since starting in 2016 at this hospital has been working closely with CRNAs and CAAs and rotating students; comments on high quality.
78	Judy Stillway Aunt of student Annandale	Wishes for nephew who is a student at Quinnipiac to be able to practice in Va.
79	Kerlly Castellano Student CWR DC	Anticipates graduation in 2019 and would like to live and work in Va.
80	Kerrie Walton, RN White Stone	Reports living in Va. for 33 years and being a nurse for 12 years. Supports ACT approach. Notes surrounding states license CAAs. References reduction in anesthesia costs without displacing CRNAs based upon Bureau of Labor Statistics and NPI data.
81	Kevin Handy, MD Attending Physician Surgical Critical Care and Anesthesiology Washington Hospital Center MedStar Health DC	Notes the quality of CAAs at the hospital and the rotating students. Cites specific instance of CAA recognizing a pulmonary embolus on a chronically ill patient and secured airway and resources needed. Speaks to need for rapid and flawless teamwork in dealing with ICU and trauma and burn cases.
82	Kevin Sistani Student – 1st year CWR DC	Notes personal background and seeks ability to work in Va.
83	Khaled Salem, MD Fairfax	Reports working with CAAs for 12 years and notes trust with any patient. Supports ACT approach. Indicates he supervises CAAs and CRNAs and trains students in both professions. Notes that DC anesthesiologists can choose from among CRNAs and CAAs.
84	Kim Vuong, CAA Student Clinical Coordinator Washington Hospital Center MedStar Health, Adjunct Professor CWR DC	Prior Va. resident for six years but had to move due to commute. Seeks to return. Teaches students, CAAs, CRNAs, anesthesiologists and other physicians in life support courses. Also serves as the DC Academy of Anesthesiologist Assistants Treasurer. Notes 17 jurisdictions license CAAs.

85	Krishnan Venkatesan, MD Director of Urologic Reconstruction, Washington Hospital Center MedStar Health DC & Assistant Professor Urology, Georgetown University School of Medicine	Reports working closely with CAAS in the operating room. Supports ACT approach. Notes he finds no difference in care his patients receive due to type of mid-level provider. Indicates he feels safe due to the collaborative team approach.
86	Layne K. DiLoreto, MMSC, CAA	Reports practice over 7.5 years and living in Va. for 6. Notes CAAs have provided safe care in many other states and in federally mandated healthcare settings for over 50 years. Notes ACT model camaraderie and safe reliable practice. Cites supervisory and certification requirements, 17 jurisdictions, practice in VA system, and CMS reimbursement. Seeks practice authority in Va.
87	Lindsay Frey, CAA	Cites certification requirements. Affirms ACT model
88	Linh Duong	Cites personal background, growth of the CAA field, and student rotation but not later work in Va. Notes anesthesiologists' support for CAA licensure, reduction in cost of CRNAs, but not displacement. States 14 CAAs live in Va. and posits a student increase with licensure in Va.
89	Lisa Grubb, RN Vinton	Reports living in Va. 35 years and practicing nursing for 11. See #80.
90	Lynda Wells, MD Anesthesiologist Keswick	Reports working full-time in OR supervising CRNAs and teaching and supervising anesthesiology residents. Supports ACT model with presence of physician essential. States it is expected by patients and insurers. Considers CAA practice equivalent to CRNAs. Indicates they have an excellent safety record that is not inferior to CRNAs. Posits ACT benefits from flexibility of CAA's practice style differing from nursing. Opines CAAs complement CRNA role and improves care without diminishing or replacing the role of others. Indicates it makes no sense to permit rotation as AA students but not practice in Va.
91	Magdalena Tomecka, MD	Reports working with CAAs for several years. Indicates her practice has many open positions and cites 200 unfilled positions in Va. Posits a shortage that has to be addressed through overtime and locum tenens because anesthesiologists have only one anesthesia provider choice. Notes a dozen or so CAAs living in Va. but having to work outside of the state. Holds CAAs are safe and anesthesiologists enjoy working with them.
92	Mandy Irby, RN-OB, C-EFM Roanoke	Reports living in Va. for 16 years and 10 years as a nurse in labor and delivery. Notes sister is a CAA who lives in northern Va. and works in DC. Notes surrounding state license CAAs and indicates CAA licensure would provide more anesthesia staffing options to help alleviate shortages in many parts of the state.

93	Ma-Paz Giorla, MD Senior Attending Anesthesiologist Washington Hospital Center MedStar Health DC	Reports practicing 46 years and working with CAAs for 15. Cites CAA education and training. Notes trust with daughter's surgery.
94	Marc Camacho, MD Vascular Surgeon	Recommends ACT model. Notes other specialties have multiple mid-level extenders while anesthesiologists, only one. Reports seeing shortages. Opines that licensing CAAs will ease scheduling and reduce patient wait times. Views CRNA and CAA training and safety as similar.
95	Maria C. Forner, Student- 1st year CWR Resident of Ohio	Cites CAA education and training. Notes there are 17 licensing jurisdictions. Indicates CAA licensure would contribute to affordable care.
96	Marilyn L. Archambeault Student CWR	Supports ACT model. Notes rotation but not practice in Va. Knows students who would return to Va. Notes CAA education and training for certification, continuing education and recertification requirements every 6 years. Notes endorsement by ASA, CMS, Tricare, and major commercial insurer reimbursement. Indicates CAAs result in cost-reductions for patients and potentially reduce production pressures in the OR.
97	Marilyn Williams Senior Administrative Assistant Anesthesiology Department Washington Hospital Center MedStar Health DC	Reports hospital views CAAs and CRNAs as interchangeable and has reduced a shortage of anesthesia providers without jeopardizing care. Posits that more anesthesia providers are needed to keep pace with a growing, aging population. Cites trust with own surgery.
98	Mary Kay Grady, MD Anesthesiologist Washington Hospital Center MedStar Health DC Virginia resident	Reports practice for 20 years, and employing CAAs. Group teaches and supervises AA students at CWR-DC. Notes student quality and that they are in high demand once certified.
99	Matthew Kattapuram, MD President, DC Society of Anesthesiologists	Cites CAA education and training and their practice in several DC hospitals and ambulatory surgery facilities. Supports ACT model. Cites anesthesiologist education and training and that all patients should have access to this expertise. His society has 50 CAAs. Notes they participate alongside anesthesiologists in CE, legislative conferences, and social events with shared goal of promoting safe practice.

100	Matthew Fulton, DO Anesthesiologist Valley Anesthesia, PC Salem	Reports training at CWR-Ohio and University Hospitals of Cleveland which employs CRNAs and CAAs. See #17
101	Maxine Lee, MD, MBA Anesthesiologist Anesthesiology Consultants of Virginia, Inc. Roanoke	Notes periodic difficulty in hiring enough CRNAs to staff ORs, indicates CAAs could help alleviate the shortage. Cites CAA education and training, their recognition by CMS, Tricare and commercial. insurers, their licensure in 17 jurisdictions, and student rotating in Va. but unable to work here. Also notes anesthesiologists only have one physician extender currently.
102	Michael Burley Parent	Wishes daughter could practice in Va.
103	Michael Diskin Student – 1st year CWR DC Resident of Michigan	Reports having begun rotations at Washington Hospital Center MedStar in DC. Describes personal education and experiences prior to the program. Notes Michigan's delegation authority rather than licensure, favors licensure for the benefit of patients and cost-savings. Notes 17 jurisdictions and 14 CAAs living in Va. and students who would wish to practice here.
104	Michael F. Murphy, MD Chief Medical Officer MEDNAX Health Solutions Partner Sunrise, FL	Company manages professional anesthesiology services nationwide. Reports employing over 1,300 CRNAs and over 300 CAAs. Holds both professions are appropriately trained and proficient. Notes that anesthesia practices in Va. experience shortages on a continuing basis. Anticipates the problem will worsen. Supports VSA's efforts to gain licensure for CAAs.
105	Michael Wilson Parent Ashburn	CAA daughter a Va. resident for 16 year; wishes she could practice in Va. As a patient, prefers ACT model
106	Michel & Gezail Habib Parents Annandale	Supports daughter's ability to work in Va. Notes her work ethic, education and training. Reports on history of CAAs. Cites family history of healthcare practitioners. Notes CAAs and CRNAs perform similar work. Supports ACT model. References NPI data conclusion that CAAs do not replace CRNAs.
107	Mijin Kim, CAA Virginia resident	Reports practice in DC, having established an S-Corporation in Virginia and seeking practice here.
108	Millard Hawkins, MD Senior Anesthesiologist Washington Hospital Center MedStar Health DC	Reports working at the hospital and with CAAs for 15 years. Notes his department serve's DC's largest Level I trauma center's OR, cardiac electrophysiology lab, gastroenterology suite, interventional radiology, and cardiac catheterization lab. Their ACT model allows CAAs and CRNAs to staff all of these locations and have an anesthesiologist involved in care. Discusses high acuity of patients and interchangeability of and comfort with CAAs and CRNAs. Notes Va. facilities are more vulnerable to provider shortages because they cannot utilize CAAs.
109	Mirsada & Nusret Mekic Parents Roanoke	Wishes daughter could practice in Va. Cites 17 states, CAAs as additional mid-level provider and lowering costs, and supports ACT model.

110	Mohammed Pradhan Student – 1st year CWR DC	Reports personal background. Wishes to practice in Va. Notes southeastern region as favorable
111	Mukesh, Nigam, MD Anesthesiologist Danville Regional Health System	Reports practicing 15 years, neighboring licensing states, and need for second mid-level provider. Currently supervises CRNAs and would have no objection to also supervising CAAs.
112	Nagwa Moustafa, MD Senior Attending Anesthesiologist Washington Hospital Center MedStar Health DC Virginia resident	Reports working with CAAs for 15 years. Supports the ACT model. Notes addition of CAAs enabled increase of the department's reach without compromising care. Notes high level of trust.
113	Nancy Long Student – 1st year CWR DC Alexandria	Note 2000 CAAs nationwide, rotation but not practice in Va. Indicates there is a shortage of anesthesia providers in Va. States CAAs practicing in surrounding states could help offset it.
114	Oluwatoyosi Shitta-Bey, CAA Georgia	Would like to return to the area. Notes ACT model is the safest. Cites BLS information on reduction in anesthesia employment costs with CAA introduction. States he would be willing to move to and practice in Va.
115	Parth Kalola Student – 1st year CWR DC Alexandria	Notes personal background. Wishes to practice in Va.
116	Paul Rein, DO Anesthesiologist	Notes practice in Va. since 1982 and teaching residents and CRNA students, supervising CRNAs, and supervising AA students. Notes independent practice of CRNAs is not allowed in several countries. Supports the ACT model, seeks an additional mid-level provider choice. Notes that CAA practice in many states and often in the same practices as CRNAs. States there is no reason not to allow CAAs to practice in Va.
117	Paul Sugarbaker, MD Medical Director for Center for Gastrointestinal Malignancies Washington Hospital Center MedStar Health DC	Reports working with CAAs for 15 years. His performs surgeries with intra-operative chemotherapy several times per week. It is a long procedure and requires immense support from the ACT. Patient often require blood pressure support, transfusions, and electrolyte corrections, and CAAs are highly skilled in evaluating patient needs and appropriately intervening. Trusts CAAs.

118	Phillippe Phung, MD Washington Hospital Center MedStar Health DC Senior Anesthesiologist Clarkesville, MD	Reports practicing with CAAs for 15 years. Notes hospital is Level I trauma center. Indicates the training, expectations, and responsibilities for CAAs and CRNAs is the same. There is a 1:1 ratio.
119	Praful Ramineni, MD Plastic and Reconstructive Surgeon West End Plastic Surgery DC Virginia resident	Reports practicing 10 years. Has worked with CAAs and CRNAs and finds them equivalent. Notes the more specialized skill set for CAAs and opines this would benefit hospital environments by allowing greater ability to fill open positions and address shortages.
120	Rhett Irby Vinton	Sister-in-law is CAA. Would like CAAs to practice in Va. in support of their communities
121	Rhiannon Hainds Student -1st year CWR DC	Cites personal background. Reports working with many CAAs and classmates who live in Va. and would want to work here.
122	Richard Davies Student – 1st year CWR DC	Cites personal background. Reports working with many CAAs and classmates who live in Va. and would want to work here.
123	Richard P. Wyeth, MD, PhD Associate Professor of Medical Physiology and Human Anatomy Edward Via College of Osteopathic Medicine	Supports additional physician extender for anesthesiologists. Notes CAAs are recognized by CMS, Tricare, and commercial insurers. Reports having substantive discussions with CAAs and is confident in their education and training.
124	Rita Basanti Aunt Annandale	States she understands what it takes in the medical field and believes CAAs are fully equipped and well-trained to share the same goals as CRNAs. Cites need for second anesthesia provider for anesthesiologist support. Notes the BLS and NPI conclusions that there are lower costs in state with CAA licensure but no displacement of CRNA jobs.
125	Robert Jacobson, MD Senior Anesthesiologist Washington Hospital Center MedStar Health DC	Reports working with CAAs for 8 years. Indicates he practices exclusively in the cardiac electrophysiology lab and that patients are often the sickest and most fragile in the hospital. Supports ACT model. Trusts CAAs. Notes department has been able to expand services because they employ both CAAs and CRNAs. Noted previous employment issue in North Carolina also addressed with CAA licensure
126	Robert P. Shafer, MD Anesthesiologist	Reports practicing in a large private practice 12 years. Served 20 years as active duty Naval officer. Notes CAA education and training,

	Anesthesiology Consultants of Virginia Roanoke	their numbers nationwide, and 17 jurisdictions, including those surrounding Va. Fully endorses their practice and indicates costs are reasonable.
127	Robert Woo, MD Virginia Anesthesia & Perioperative Care Specialists, LLC Newport News	#17
128	Rose Wilson, CAA Alexandria	Reports working as CAA for five years in DC, working for a large Level I trauma center. Wishes to practice in Va. due to proximity to home and family. Cited CAA education and training and ACT model.
129	Roshan Martin Bashir, MD Gastroenterologist Anesthesiologist Washington Hospital Center MedStar Health DC	Reports over 40 years of practice and work with CAAs for over 15. Trusts CAAs. Notes a national shortage of anesthesia providers and growing number of procedures requiring anesthesia services. Posits CAAs could allow for expansion of surgical facilities without further adding to the strain on anesthesiologists and CRNAs.
130	Rudy Hamad, CAA Chief Anesthestist	1996 graduate. Seeks to practice in Va.
131	Samir Gupta, MD Senior Anesthesiologist Washington Hospital Center MedStar Health DC	Reports having worked with CAAs for 15 years. As Anesthesiologist-in-Charge, runs OR flow, assignments, and coverage several times a week. States he assigns staff to attend to traumas or other emergencies that arise at any time. Trusts CAAs. States he never distinguishes between CAAs and CRNAs. Notes the hospital trains AAs and RNAs and he ensures all students have an equal opportunity to rotate through every surgical specialty to ensure a well-rounded anesthesia education.
132	Sarah R. James, MD Anesthesiologist Chesapeake	Reports practice in Virginia for over 17 years. See #17
133	Scott R. Frank, MD Hospital Administrator Washington Hospital Center MedStar Health DC Virginia resident	Points offered in follow-up to testimony at the Public Hearing. States that no hospital or medical system is being required to hire CAAs. Posits that CAAs will be an equivalent alternative to CRNAs, both in salary and skills, to address anesthesia staffing shortages currently, and ensure more reliable availability of anesthesia services when needed. States There will not be an increase in costs. Indicates there is a national nursing shortage; at his institution, specifically recovery room and ICU nurses. Cites the use of "agency" nurses to fill the gap which is expensive and costs his hospital in the millions of dollars last fiscal year. Acknowledges the right of any nurse to pursue a career as a CRNA, he does not recommend nurse anesthetists training attempt to increase graduates to fill the

		anesthesia shortages. States the CAAs are equivalent and do not take away from the pool of sorely needed ICU and PACU nurses. Reports having worked with CAAs for 13 years. States CAAs and CRNAs are excellent and safe anesthetist, with no difference in skills, knowledge, and quality of care both provide at his facility. States allowing licensure of CAAs will assure health care needs are better supported with no increase in costs.
134	Scott Vasquez Student – 1st year	Wishes to practice in Va.
135	Shane Angus, CAA, MSA Program Director CWR DC	Cites CAA history, the ACT model, and 17 jurisdictions. Notes that since 2014 and the first graduating class from his institution, the number of licensed CAAs has grown to over 90. Reports they add about 20 additional CAAs yearly and nationally over 250 graduates. Notes that many have ties to Va. Describes education and training requirements for certification and recertification. Notes CAAs are regulated through state boards of medicine. Indicates that there is a shortage of anesthesia providers working in the ACT model in Va. Opines that with the aging population there will be increasing need for anesthesia services to address complex procedures with a strained workforce. Notes that Va. is increasingly becoming a state with AA students.
136	Sharad Agrawal, MD Anesthesiologist Director of Anesthesiology Washington Hospital Center MedStar Health D	Reports living in Va. for 22 years and 15 year's experience working with CAAs. Notes the department does not distinguish between CAAs and CRNAs. They use the ACT model and supervise both interchangeably Trusts CAAs. Welcomes the availability of two mid-level providers Notes CAAs are proven and cost-effective.
137	Steven Johnson, MD Anesthesiologist Norfolk	Reports being provider since 1985 and having corresponded with colleagues who work with CAAs in other states. They indicated that CAAs provide excellent care. Notes that other physicians in Va. utilize PAs and NPs, and anesthesiologists should have such an opportunity with CAAs becoming licensed.
138	Steven Price, MD Attending Anesthesiologist Washington Hospital Center MedStar Health DC	Reports living and working in Va. and DC for six years and working directly with CAAs for three. Supports ACT model. Notes challenging work in Level I trauma center. Trusts CAAs under the guidance of anesthesiologists, like himself. Notes the training and expectations placed upon CAA and CRNAs are the same.
139	Swen E. Laser, MD Anesthesiologist Staunton	Reports being a former nurse interested in becoming a CRNA, but changed course to become an anesthesiologist. Notes that the pre-medical and CRNA nursing curricula were vastly different, with the former more advantageous for advanced degrees in anesthesiology.

		Notes her current practice is an all-MD model, but if they need a change, she would prefer CAAs over CRNAs. States CAA students are rotated through Va. hospitals but not permitted to practice. Reports there are 14 CAAs who live in Va. but work out of state. Indicates reimbursement by CMS, Tricare, and commercial insurers, and notes anesthesia service cost decreases in states with CAA according to BLS data.
140	Tahir Manzoor, MD Anesthesiologist McLean	Reports licensure in Va. MD, and DC. Indicates he has spent much time supervising CAAs. Supports the ACT model and trusts CAAs working within it.
141	Terry Hurt, MD Anesthesiologist Lynchburg	See #17
142	Tim J. Nitzsche, MD Anesthesiologist Augusta Health Fishersville	Reports practicing in Va. 10 years. Discusses that anesthesiologists have only one choice of mid-level provider. Prefers CAA's medical rather than nursing background. Also favors CAAs because they do not seek independent practice, unlike CRNAs. Notes that his practice is currently MD-only. But if they need a model change, they would like the option of incorporating CAAs in addition to, and possibly in lieu of, CRNAs. Cites ASA Statement on the Anesthesia Care Team, Committee of Origin: Anesthesia Care Team. Points out reduced costs in CAA states as noted by BLS. Reports he spearheaded his group's involvement in AA student preceptorship at his hospital. They have been working with these students for three years. Would like CAAs as an mid-level provider option in Va. Notes they are well-trained and accepted in the anesthesiology community as equivalent to CRNAs when supervised by an anesthesiologist.
143	Todd Lasher, MD Anesthesiologist/Faculty Member Virginia Tech Carilion School of Medicine Blacksburg	Reports having worked with many CAAs in his career. Found them well-trained, well-educated, and safety minded. His initial residency training was, in part, under the direction of a CAA. Reports his practice has shortage of CRNAs and would welcome the ability to hire CAAs.
144	Todd B. Tescher, MD Urologist Fairfax	Reports operating several facilities in northern Va. and strongly supports physician-lead care overall and the ACT model particularly. Supports availability of second mid-level provider for anesthesiologists. States he has seen shortages in anesthesia departments, and posits that having more providers would allow greater access and scheduling cases easier. Does not have personal experience with CAAs, but he has heard from colleagues in DC that they provide superior care. He states he understands their training is similar to CRNAs, as is their safety record and would allow CAAs to work in his operating room under anesthesiologist supervision.
145	Trena Pilegaard Student—1st year CWR DC	Reports personal history. Desires to work in DC in the future; prefers to live and work in Va.

	Arlington	
146	Vanessa Gluck, MD Anesthesiologist Washington Hospital Center MedStar Health DC	Reports they hire the best and brightest of both CAAs and CRNAs. Also opines that having the choice of mid-level provider means they have decreased their shortage of providers. Holds that CAAs are excellent members of ACTs.
147	Virginia Academy of Anesthesiologist Assistants	Reports they represent 14 CAAs living in Va. Describe CAA education and training. Notes 17 jurisdictions, and cites BLS and NPI data concerning reduction in CRNA costs with CAA presence but no displacement of CRNAs, rather growth. Supports ACT model.
148	Xiqing Cathy Cao Senior Anesthesiologist Washington Hospital Center MedStar Health DC/ Secretary DC Society of Anesthesiologists	Reports having worked with CAAs for 15 years. Notes hospital is a Level I trauma center. She reports specializing in Regional Anesthesia and supporting the ACT model. She works with CAAs and CRNAs on all shifts and reports seeing no difference in the level of care provided by each. States that CRNAs wish to obstruct CAA practice for economic reasons. States further that CAAs will enhance the relationship between anesthesiologists and mid-level providers, indirectly facilitate CRNAs to comply with the ACT model, and ultimately benefit the quality of care in Va.
149	Zain Asif Student – 1st year Virginia resident	Provides personal background and speaks to rotation in all surgical areas. Seeks to practice in Va.
150	Williams Mullen Packet	Packet contains: • AA Talking Points (AAAA) • AA Training and Education Fact Sheet (AAAA) • AAAA Practice Map (AAAA) • Comparison of AA and CRNA Training Practice (AAAA) • AAAA FAQs (AAAA) • Statement Comparing CAA and NA Education and Practice (ASA) • CAAs – The Other Anesthetist (Advance Education Solutions) • Provider Salary Comparison – NA vs. AA (Advance Education Solutions) • CAA Talking Point (VSA)