TESTIMONY OF MARK BLAZEY, PRESIDENT OF THE NEW YORK STATE ASSOCIATION OF NURSE ANESTHETISTS (NYSANA) BEFORE THE JOINT ASSEMBLY AND SENATE BUDGET HIGHER EDUCATION HEARING

February 25, 2025

Senate Finance Chair Krueger, Assembly Ways & Means Chair Pretlow, Senate Higher Education Committee Chair Stavisky, Assembly Higher Education Committee Chair Hyndman, and members of the Joint Higher Education Budget Committee, I would like to thank you for this opportunity to submit written testimony for your consideration as you review proposals with respect to the Governor's proposed 2025 – 2026 New York State Budget. My name is Mark Blazey, and I am the President of the New York State Association of Nurse Anesthetists (NYSANA).

NYSANA is the statewide professional association representing New York's nearly 2,200 Certified Registered Nurse Anesthetists (CRNAs) and Resident Registered Nurse Anesthetists (RRNAs). NYSANA has been advocating for state recognition for CRNAs as advanced practitioners commensurate with their national certification, advanced education, clinical training, and experience for over 30 years.

As you contemplate the Higher Education budget priorities for the 2025 – 2026 year, I strongly encourage you to consider including S357-A sponsored by Senator Cooney and Assemblymember Karines Reyes in the final budget. This legislation will create a title and scope of practice for Certified Registered Nurse Anesthetists in the State and is one of the best tools that can help address the health care workforce issues in New York. During the Health budget hearing two weeks ago, we heard repeated statements related to the challenges of ensuring a

strong and robust health care workforce in New York. While some view this as an issue that would be before the Health budget hearing, we know that this is in fact the Higher Education Committee's responsibility as this committee manages and implements scope of practice changes.

The continued shortage in the health care workforce is a problem that should concern all New Yorkers. Anesthesia is no exception. To help address this shortage in New York, we must allow providers in the State to practice to the full extent of their education and training. We must remove artificial and redundant practice barriers that limit their ability to maximally contribute to our health care system. I believe the legislation sponsored by Senator Cooney and Assemblymember Reyes will accomplish this for CRNAs and for New Yorkers.

To give context to this belief, I wanted to share a bit about myself. I earned a master's degree in Nurse Anesthesia in 2013 and a Doctor of Nursing Practice from Northeastern University in 2020. I have practiced as a CRNA for twelve years. In that time, I have practiced in two different states, at quaternary major academic medical centers with over 60 anesthetizing locations, small rural hospitals with as few as two operating rooms, stand-alone plastic surgery centers, eye clinics, endoscopy offices, dental offices, and mid-sized hospitals. I have taught nurse anesthetist residents both clinically in the operating room as well as in the classroom, in the United States and in other countries such as Liberia and Rwanda. I have delivered anesthesia in several developing countries with medical and nursing surgical missions. I have performed anesthesia for neonates less than an hour old and for patients over 100 years old. Given my training and clinical experience, there is not a surgical procedure or patient condition for which I would not be able to safely administer anesthesia. Yet in New York State, I am not considered an advanced practice nurse. In New York, I cannot carry a license that recognizes me as a Certified

Registered Nurse Anesthetist. When I moved to New York, I lost a license by virtue of NYS law. This waste of a valuable resource needs to change.

In New York, CRNA practice is not codified in law. Instead, CRNA practice is defined through Department of Health (DOH) regulations, NYCRR §405.13 and §755.4, and requirements from the New York State Education Department (NYSED). As a result, CRNAs do not have their own licensure in the state, as afforded every other advanced nursing specialty. While I am grateful that the DOH regulations exist, and therefore allow me to practice in New York State, they are no longer sufficient for recognizing CRNAs in New York State. The regulations do not define the scope of practice for a CRNA and do not define key duties of a CRNA in New York. As a result, decisions on how a CRNA practices in New York vary from facility to facility and therefore our ability to efficiently provide care likewise varies. Title VIII of the Education Law clearly defines the scope of practice for over 57 licensed professions, which creates a statewide standard of practice that does not vary from facility to facility. It is well-past time to do the same for CRNAs in the State.

From March 23, 2020 until June 23, 2023, one of the many provisions in the executive orders issued related to COVID and the skilled health care worker shortage in NY, was a waiver of NYCRR §405.13 and §755.4, allowing CRNAs to administer anesthesia without physician supervision. The waiver of the supervision requirements under the New York Health code was critical for the health care infrastructure and allowed CRNAs to finally practice to the full extent of their education and training during the pandemic and during the state of emergency. The waiver allowed CRNAs to practice independently and prove to New Yorkers they were able to provide dependable, high quality anesthesia services without expensive and redundant physician oversight. During the pandemic, when the call for help was issued, CRNAs answered.

To evaluate this professional and cultural shift, NYSANA created a taskforce to record the experiences of our members. We heard from many CRNAs on the frontlines of the pandemic: they led and organized COVID-19 airway teams, managed the conversion of operating rooms into ICUs, converted anesthesia machines to successfully ventilate multiple patients during a ventilator shortage, consulted on prone positioning on the most critical patients, assisted pulmonologists with mechanical ventilation parameters and management, oversaw sedation and prescribing, placed invasive lines, and performed intubations. With surgeries postponed, CRNAs worked as part of Rapid Response and Airway Management Teams. CRNAs demonstrated in real time the increased value they provided to the health care system when unnecessary practice barriers are removed, and CRNAs are allowed to practice to the full extent of their education and training.

The COVID experience brought into sharp focus the false narrative that if the redundant physician supervision was removed, there would be negative outcomes and impacts on patients throughout New York State. Yet, it is important to note, even with this data showing that the removal of all physician supervision led to no negative outcomes in the State, our bill does not remove physician involvement —though many do consider it unnecessary. Instead, our bill embraces a model similar to the one that has been used by Nurse Practitioners in the State. CRNAs with less than 3,600 hours of experience will practice under the supervision of a physician, dentist or podiatrist. Once a CRNA has 3,600 hours of experience, the CRNA will serve as a member of a patient-centered care team. CRNAs do not administer anesthesia in a vacuum. Anesthesia is only administered as part of a procedure for a patient. A procedure that has many health care providers involved depending on the type and complexity of the case. The

CRNA will work as a member of this team and will be charged with determining the anesthesia needs of the patient.

Passing a scope of practice bill for CRNAs is not only important to the CRNAs in the State but is critical to ensuring patient access to care. New York residents and patients should not have surgeries delayed while waiting for physicians to be available to supervise highly qualified CRNAs. To be clear, supervision in this context has nothing to do with patient outcomes as there are countless studies demonstrating patient outcomes are not improved in supervisory models. Hospitals at risk of closure and operating at a fraction of their surgical capacity due to a lack of appropriately employed anesthesia providers cannot afford to waste underutilized resources. New York needs CRNAs to do what they were trained to do—administer anesthesia. New York needs physician anesthesiologists to do what they were trained to do—administer anesthesia—not solely supervising others delivering it.

More than 30 years of scientific studies have repeatedly demonstrated CRNAs administer safe, quality care with patient outcomes equivalent to those of physician anesthesiologists. When anesthesia is provided by CRNAs, it is the practice of nursing. When anesthesia is provided by a physician it is the practice of medicine. Similar to other specialties, there is overlap among anesthesia specialists. While their approach to the way they interact with patients may vary, CRNAs and physician anesthesiologists administer anesthesia services in exactly the same way. Their techniques are the same, their equipment is the same, their protocols and emergency algorithms are the same, and the anesthetic techniques, agents, and medications used are the same. Most importantly, their patient outcomes are the same. There is no difference in morbidity, mortality, patient or surgeon satisfaction, pain, or hospital discharge rates, across the country, in repeated studies looking at tens of thousands of anesthetics over decades.

New York is the last State to recognize CRNAs. For New York to remain at the forefront of cutting-edge medical care, we must remove artificial barriers to practice. Removing these barriers is imperative to ensuring a functioning and quality health care system. In May 2021, the National Academy of Medicine issued a report: *The Future of Nursing 2020 - 2030: Charting a Path to Achieve Health Equity*. Key Message 1 from the report was that "Policymakers need to permanently lift artificial regulatory and practice barriers that keep nurses from practicing to the top of their education and training and that restrict people's access to high quality care." The report further found that, "Eliminating restrictions on the scope of practice of Advanced Practice Registered Nurses and Registered Nurses so they can practice to the full extent of their education and training will increase the types and amount of high-quality health care services that can be provided to those with complex health and social needs and improve both access to care and health equity."

Nurse anesthesia services are critical to rural health care services and access. According to the American Association of Nurse Anesthesiologists (AANA), CRNAs are the primary providers (over 80% nationally) of anesthesia care in rural America, enabling healthcare facilities in these medically underserved areas to offer obstetrical, surgical, pain management and trauma stabilization services. In some states, CRNAs are the sole providers in nearly 100 percent of the rural hospitals. Unlike metropolitan or urban areas that have access to a robust population and providers in all areas, rural health providers must deliver a broad array of services to a limited population with limited resources. A study published in the September/October 2015 Nursing Economic$ found that CRNAs are providing the majority of anesthesia care in U.S. counties with lower-income populations, higher unemployment and populations that are more likely to be uninsured, unemployed or on Medicaid. Important as it relates to New York, the

number of practicing CRNAs is higher in states with less-restrictive practice regulations where more rural counties exist. New York is seeing this firsthand–health systems and patients increasingly suffer with our continued and worsening staffing shortages.

Recent national surveys indicate the demand for anesthesia care and services will outpace the supply of providers over the next several years. New York State is the *only* state that does not have a scope of practice law which enables CRNAs to practice to the full extent of their training and education. This limitation has and will continue to impact patient access to care because the demand will outpace the supply. This will be compounded by data that indicates that the lack of an appropriate scope of practice recognition for CRNAs in New York is causing newly graduated CRNAs to leave the State upon graduation and, likewise, is pushing experienced CRNAs to move to other states where they can practice to the full extent of their education and training. States like New Jersey, Maine, Pennsylvania, Vermont, New Hampshire, Connecticut, and Massachusetts are directly benefiting from this phenomenon.

Per data from the AANA from the three CRNA programs in New York over the past five years of 456 graduates, 166 of them, or 29.7%, have left New York to practice in other states. This is a shockingly high number of new graduates leaving to practice in other states and far outpaces the data from other states. With New York now having four anesthesia programs—and three more on the horizon—those numbers are going to be magnified and compounded. Without a change in New York State law, this brain drain will worsen, our ability to attract CRNAs into our state will continue to be impaired, and our workforce shortages will continue to be exacerbated. Once the graduates leave and start their families and careers in other places, it is difficult to pull them back. The common reason listed by graduates on why they are leaving New

York for other states is that they don't want to practice in a state that has such strong practice restrictions on their profession.

Since 2000, New York has seen at least 34 hospital closures and hospital financial struggles are only worsening. In November 2024, Becker's hospital review cited 29 rural hospitals at risk of closure within five to seven years. That's 56% of the rural hospitals in New York. They add to that alarm a staggering 20 rural hospitals at risk of immediate closure within the next 2-3 years—38% of rural hospitals in New York. While reducing redundancies and the cost of anesthesia labor cannot prevent all closures, anesthesia services can be a major contributor. In 2024, Burdett Birth Center narrowly avoided closure due primarily to a New York State grant included in the 2024 budget. A primary contributor they listed to their financial struggles: the cost of their anesthesia services.

Over the past several years, NYSANA, in conjunction with Senator Cooney and Assemblymember Reyes, NYSANA's health care attorneys, and NYSED, have worked and reworked, negotiated and renegotiated, to craft bill S357-A specifically to fit the needs of New York. This bill has now received technical sign off from NYSED, and we believe that this follows New York State health regulations, and the intentions behind them, and would bring New York to the standard of the rest of the United States. In addition, the Senate version of the bill already has 22 co-sponsors. In the Assembly, we are just awaiting introduction but are anticipating broad co-sponsorship in that house as well. NYSANA believes that including S357-A in the budget is the best way to ensure the current anesthesia workforce shortages New Yorkers experience, and the subsequent risk and harm these shortages bring, do not continue.

As you put together the issues to be included in the 2025 – 2026 Fiscal Year budget, I hope that you will include S357-A to help address the healthcare workforce shortage in New

York and ensure that New York's patients have access to the health care services they need. It is time for New York to join the 49 other states in passing a title and scope of practice for CRNAs.