ALANA
NewsBulletin
advancing quality anesthesia care, serving our members, promoting the nurse anesthesia profession

VA Publishes Long-Awaited Rule Extending Full Practice Authority to CRNAs and Other APRNs

Amy P. Neimkin

In an effort to ensure access to timely, quality healthcare for our veterans, the Veterans Health Administration (VHA) published a proposed rule on May 25th in the Federal Register for public comment that would authorize advanced practice registered nurses (APRNs), including Certified Registered Nurse Anesthetists (CRNAs), Full Practice Authority. This effort supports the safe and effective care that CRNAs provide our nation's Veterans every day. The proposed rule will be open for public comment via www.regulations.gov for 60 days from the date of publication.

The proposal is supported by more than 60 organizations, including veterans' groups such as the Military Officers Association of America and the Air Force Sergeants Association. The policy is also supported by AARP (whose membership includes 3.7 million veteran households), numerous healthcare professional organizations including the American Association of Nurse Anesthetists (AANA) and other APRN associations, and 80 Democratic and Republican members of Congress. (AANA.com)

The policy change, which is consistent with recommendations from the National Academies of Medicine (formerly the Institute of Medicine), would define Full Practice Authority in VHA facilities for CRNAs, Nurse Practitioners, Clinical Nurse Specialists and Certified Nurse Midwives. Its definition of Full Practice Authority means that APRNs working within the scope of VA employment would be authorized to practice as described in the law in section 17.415(b) "without the clinical oversight of a physician, regardless of state or local law restrictions on that authority." (AANA.com)

The rule also makes the VHA consistent with the U.S. Military service branches, which allow CRNAs and other APRNs to practice to the full scope of their education and abilities. Nurse anesthetists, who first provided healthcare to wounded soldiers on the battlefields of the American Civil War, have been the main providers of anesthesia care on the front lines of every U.S. military conflict since World War I. (AANA.com)

However, the outcome of the proposed rule is far from certain, as the VHA's efforts face attack from physician specialty groups, especially the American Society of Anesthesiologists. As part of the process to move the proposal forward, it is critical for the VHA to hear from state associations, CRNAs, and other stakeholders in support of this change to Full Practice Provider status.

We need your help today!! Let's try to have 100% participation from Alabama CRNAs by going to www.crna-pac.com/takeaction or www.veteransaccesstocare.com and sending your letters of support for full practice authority to the VHA.

Amy P. Neimkin, CRNA, DNP, MBA
Federal Political Director

President's Message

Michael Humber, CRNA, DNP, MNA

We are approaching the mid point of 2016 and I want to ask each member to recall my previous challenge. How have you given back to the profession over the last several months? I would love to hear stories from our members. I know that all CRNAs provide high quality, cost effective care to the citizens we serve. However, I need your help in making sure others know who we are and what we do. Now that the legislative session has closed, find time to visit your representative or senator back in their hometown.

I invite each of you to join me and bring a friend that is a non-member over the coming months as I attempt to bring the ALANA close to your region. We will have a time to mix and mingle followed by dinner and an ALANA State and Federal Political Update. This is a great time for you to meet a board member from your area and voice your comments and concerns. The following dates have been set aside for these meetings:
June 16 Tuscaloosa (Java Room at 5)
June 21 Anniston (Classic on Noble)
July 14 Dothan (Old Mill Restaurant)
July 28 Huntsville (Rosies Mexican Cantina)
August 24 Mobile location TBD
August 30 Montgomery location TBD

Please contact the ALANA office ALANA@gmsal.com for details and be on the lookout for postings at your workplace.

YOUR BOARD AT WORK

I have to commend the board members of ALANA for a strong first half of the year. We had our annual Legislative Day in Montgomery on March 2nd with students from both UAB and Samford. The Secretary of State, John Merrill, spoke to the group along with Peggy Benson, Executive Director of the Alabama Board of Nursing, State Health Officer, Dr. Tom Miller, and other distinguished guests. Of course this was during the peak of the legislative session. I spoke in support of SB 227 sponsored by Senators Greg Reed and Tim Melson. This bill will establish a loan repayment program for advanced practice nurses through the Board of Nursing. This bill has now passed both the House and Senate and was sent to the Governor for signing.

As a follow-up on SB 104, this bill passed both the House and Senate with our amended language protecting the definition of CRNA and was sent to the Governor for signing. This was a productive and busy legislative session.

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President's Letter Continued

April 2-6, 2016, a group of representatives from Alabama went to Capitol Hill in Washington DC for the AANA Mid-Year Assembly. We had an opportunity to meet with health liaisons for the Alabama House Members and Senate Leaders. This year we were able to reinforce some of our previous discussions and answer questions. The major topic for discussion was the pending action on the Veterans Health Administration's publication of the APRN Full Practice Authority and HR 1247.

This proposed rule was published in the Federal Register May 25, 2016 and is open for public comment for 60 days. Please do your part and file your comment TODAY.

The ALANA Annual Spring Meeting was a HUGE success. We had national leaders from our profession on hand as speakers. The educational sessions along with the expanded time for social interaction were well received. Our business meeting was held on Saturday, April 23 over a hot breakfast. We had the honor of having Senator Greg Reed speak to the group prior to my address to the membership. I am excited to announce that we are in the final stages of the Go Live with our new and improved website. This new website will be highly interactive and will provide our members with more information even while you are on the go. We will be sending an Eblast to our membership when the last stage is complete. Also I announced that our BOD has proposed bylaws revisions. We will be sending information to all members so that we can vote on the revision at the ALANA Annual Fall Business Meeting at the Grand Bohemian, October 15, 2016.

What's Next?

File your comment for VHA Full Practice Authority. Join me for the regional meetings. Vote for your next ALANA Board of Directors and Executive Officers. Electronic voting will commence late summer. Attend the AANA Annual Congress in Washington DC, September 9-13, 2016. Attend the ALANA Annual Fall Meeting at the Grand Bohemian October 14-16, 2016.

I hope you all have a wonderful summer and on behalf of the ALANA Board of Directors I would like to thank each of you for providing such high quality services for the patients that we serve. Please contact me if I can be of service to you.

Respectfully,
Michael Humber, CRNA, DNP, MNA
President

Anesthesia Abstracts

Pharmacology
Perioperative dextromethorphan as an adjunct for postoperative pain
Anesthesiology 2016;124:696-705
King MR, Ladha KS, Gelineau AM, Anderson TA

Abstract

Purpose: The purpose of this study was to examine the effects of preoperative dextromethorphan on postoperative opioid use and pain scores.

Background: NMDA antagonists are useful adjuncts for prevention of postoperative pain. Ketamine is a potent and well-studied NMDA antagonist shown to result in "preemptive" analgesia when given preoperatively, intraoperatively, and postoperatively. Dextromethorphan is a weak NMDA receptor antagonist most commonly used as an over-the-counter cough medicine. Preemptive analgesia caused by NMDA receptor blockade is thought to change pain impulse transmission in the spinal cord and CNS. Doing so prevents a pain syndrome commonly referred to as "windup" which amplifies pain perception. In previous studies, dextromethorphan has been shown to decrease chronic pain from diabetic neuropathy, postherpetic neuralgia, and phantom limb pain. Nevertheless, dextromethorphan seems to be used infrequently to help reduce postoperative pain. Doses of dextromethorphan greater than 2 mg/Kg PO may produce dissociative effects.

Methodology: This was a meta-analysis of previously published studies. The following search terms were used to locate subject studies in multiple databases:

- dextromethorphan
- acute pain
- postoperative pain
- pain

Studies were only included in the meta-analysis if they were randomized, double blind, placebo controlled, and the dextromethorphan was administered preoperatively. Studies on patients less than 12 years old were excluded. After discovering when each study had tracked opioid use and pain scores, the meta-analysis organized opioid consumption into 24-h and 48-h time periods. Pain scores were grouped by 1 h, 4 h, 6 h, and 24 h post-op. All opioids were converted into IV morphine equivalents for comparison.

Result: The meta-analysis included 21 studies, but not all studies had the required data for each category. Each category, e.g. post-op pain scores, included 12 to 14 studies. Likewise, the number of patients represented by these different numbers of studies varied between 799 and 849. In some of the studies, dextromethorphan was administered more than once preoperatively. Some studies administered dextromethorphan PO while others used IM dosing. [Editor's Note: dextromethorphan is only available orally in the USA.] The dose of dextromethorphan ranged from 30 mg to 200 mg. Most doses were between 40 mg and 60 mg. The time of dosing ranged from the night before surgery to 30 min preoperatively. The surgical procedures involved ranged widely including orthopedic, major abdominal, and ENT.

Preoperative dextromethorphan reduced average 24-h or 48-h IV morphine use by over 10 mg (P=0.0006). In three studies IV morphine use was decreased by over 20 mg, while in three other studies IV morphine use was slightly increased (14 total studies). Morphine use was reduced by between 5 mg and 17 mg in 95% of patients.

(continued on next page)

Mean pain scores at 1 h postoperatively (1 lowest to 10 highest) were 1.6 lower in the dextromethorphan group (P=0.00001). Pain scores at 4 h, 6 h, and 24 h were statistically significantly lower but the actual difference was less than 1. None of the studies included in the meta-analysis showed a higher pain score in patients who had received dextromethorphan.

Side effects were tracked in 18 studies. Side effects were similar for both dextromethorphan and opioids:

- nausea
- vomiting
- dizziness
- lightheadedness

In 10 of the 18 studies, there were either no side effects reported or the incidence of side effects were similar between the dextromethorphan and control groups. Fewer side effects were reported in the dextromethorphan group in 5 studies.

Conclusion: Preoperative dextromethorphan significantly decreased postoperative pain and opioid use. The optimum dose and preoperative timing of dextromethorphan is not yet known.

Comment: You can choose to look at this study one of two ways. I'll try to present both of them.

Position 1: Preoperative dextromethorphan is cheap, easy, low risk, and may produce a significant reduction in postoperative pain. For clinical and scientific reasons, I believe investigators too often get over enthusiastic about differences in pain scores. In this study the differences in pain scores are small enough that they may not impress you either. But, an average reduction in IV morphine use in the early post-op period of over 10 mg is something I think we can agree is a good thing. So what dose of dextromethorphan do you use? This meta-analysis doesn't tell us. My guess is that most CRNAs are going to want to use a single dose. That dose should probably be within two hours of induction. Lest you are worried about administering a PO medication, remember that we are talking about a cough medicine, a teaspoon or two. As to the dose, my personal guess for the dose to start at is 1 mg/Kg. This is similar to most of the studies in the meta-analysis and well below the point where dysphoric reactions have been reported.

There are different genotypes that determine the hepatic elimination half-life of dextromethorphan. In some the half-life will be only 4 hours. But ketamine produces preemptive analgesia for longer than its half-life so dextromethorphan may too. In other patients the elimination half-life is 24 hours. This fact probably accounts for some of the wide differences seen in the studies. It may also mean that it works great for some of your patients and just so-so in others. Personally, this first position is the one I now hold.

Position 2: Preoperative dextromethorphan is just another thing to do that at best produces only modest reductions in postoperative pain. It is not worth the bother. I agree that the improvement in postoperative analgesia wasn't uniformly impressive. This may have been due to the wide range of doses that were used (some too small?), the difference in how quickly dextromethorphan was eliminated in different genotypes, or just not being a very effective intervention. But the reduction in opioid pain medication required was still fairly impressive. Nevertheless, if this is your position, you may want to learn more about a strong NMDA receptor blocker, ketamine, which is well documented to prevent windup type postoperative pain.

Postoperative pain highly influences patient satisfaction and is an area in which we still have lots of room for improvement. Let's learn everything we can about preventing acute pain and keep after it.

Michael A. Fiedler, PhD, CRNA

NMDA = N Methyl-D-Aspartate - ANESTHESIA ABSTRACTS IS A PUBLICATION OF LIFELONG LEARNING, LLC © ISSN Number: 1938-7172

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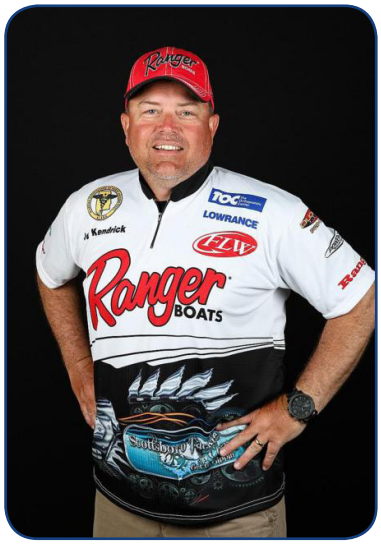
Michael A. Fiedler, PhD, CRNA, Editor

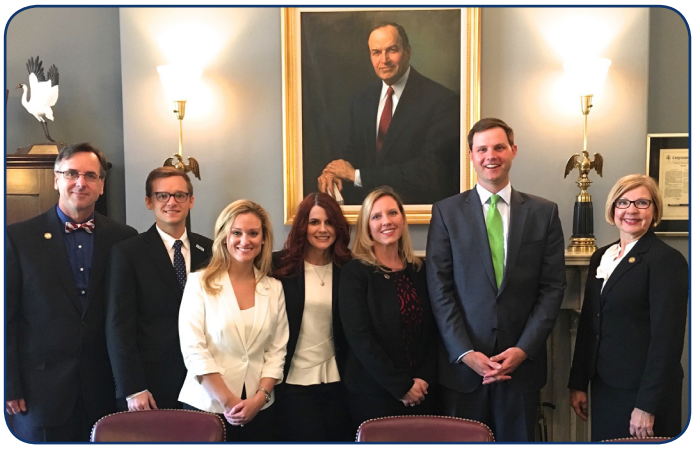
ALANA's Jay Kendrick Advocates for CRNAs

Jay Kendrick is a competitor. He is a CRNA practicing in North Alabama, and when he isn't working as a CRNA, he is working on his "other job." ALANA is pleased to help sponsor Jay's efforts on the Fishing League Worldwide (FLW) tour. You can follow Jay at www.flwfishing.com. He wears the ALANA logo and promotes the profession thoroughout his work on the tour. Go Jay!



CRNAs on the Hill

Willie Furr, Heather Rankin, Michael Humber and Wesley Cannerday on the Hill.



The ALANA team takes message to Senator Shelby's staff

The ALANA gang at AANA's Midyear Assembly.

Congresswoman Eleanor Homes Norton, District of Columbia, Amy Neimkin and Congresswoman Terri Sewell.

Gastroschisis: A New Concern for the Anesthesia Provider

Stephanie Price RN, BSN and Susan McMullan PhD, CRNA

Gastroschisis and omphalocele are rare abdominal wall defects found in the neonate (Bachiller, Chou, Romanelli & Roberts, 2013). The Centers for Disease Control and Prevention (CDC, 2016) reports a profound increase in the incidence of the birth defect gastroschisis, which increased 263% from 1995 to 2016. Risk factors for giving birth to a child with this defect include young maternal age, smoking, drug abuse, and infection (Bope & Kellerman, 2016). The population undergoing the largest increase is non-Hispanic black teenage mothers. It is crucial that every anesthesia provider be aware of the increased frequency of this defect in order to provide safe anesthesia care.

Omphalocele is a congenital defect involving the herniation of abdominal content, contained in a sac comprised of peritoneum and amnion, through the umbilicus. This defect occurs when the gut fails to migrate into the abdomen during gestation (Bachiller, Chou, Romanelli & Roberts, 2013), and is associated with many concurrent anomalies, including congenital heart disease and Beckwith-Wiedemann syndrome (Bernstein & Shelov, 2012). In contrast, gastroschisis occurs as a result of occlusion of the omphalomesenteric artery, and involves periumbilical herniation of visceral content not contained within a membranous sac. This leaves the herniated content exposed and vulnerable to massive heat and fluid losses. Unlike omphalocele, gastroschisis is not associated with other congenital anomalies, but is unfortunately associated with gut malrotation, necrotizing enterocolitis, and intestinal atresia. A gastroschisis may be small or large; it may be corrected easily at birth, or require extensive, staged procedures performed at a dedicated pediatric facility (Bope & Kellerman, 2016).

As the CDC (2016) has reported, gastroschisis rates in neonates born to teenage, non-Hispanic black mothers have skyrocketed in the past 18 years. Studies repeatedly show that teenage women are the least likely maternal population to seek out prenatal care. Many times, the first medical or prenatal care the teenage mother (particularly American Indian, Alaskan Native, and black) receives is when she presents to the hospital in labor (Child Trends, 2014). Because these patients are less likely to have prenatal care, this defect may not be diagnosed prenatally. As an anesthesia provider, you may see this unexpected neonatal condition at your facility, and be called on to provide anesthesia to the baby.

The anesthetic management of the patient with gastroschisis focuses on maintaining perfusion of the herniated contents and minimizing heat and fluid losses due to the exposed abdominal contents (Bachiller, Chou, Romanelli & Roberts, 2013; Bope & Kellerman, 2016).

Key points include:

- Immediate placement of a nasogastric tube to aspirate stomach contents
- Securing the airway via RSI or awake intubation
- Ensuring that any exposed abdominal content is promptly wrapped in sterile saline-soaked gauze
- Ensuring that the herniated contents and lower half of the infant are covered with a sterile bag (to aid in the attenuation of heat and fluid loss)
- Initiation of aggressive fluid replacement (20ml/kg isotonic fluid boluses)

Furthermore, while stabilizing this patient for surgery, the nurse anesthetist should be aware of the following concerns and complications:

- Abdominal content reduction and subsequent closure may lead to dangerous increases in intraabdominal pressure. This may result in:
  Compromised ventilatory reserve
- Constricted diaphragm
- Atelectasis-> respiratory failure
- Compromised organ perfusion
- Decreased organ function-> organ failure
- Changes in drug metabolism-> possible extended effects
- Bowel edema
- Decreased urine output
- Compromised lower extremity venous return
- Vast discrepancies in hemodynamic parameters between upper and lower extremities
- Due to these detrimental effects, staged closure of the gastroschisis may be necessary (Bachiller, Chou, Romanelli & Roberts, 2013).

In summary, gastroschisis is a rare neonatal condition that has suddenly increased in prevalence. Early stabilization and surgical repair are critical to successful patient survival. Approximately 2000 infants in the United States are born with gastroschisis every year (CDC, 2016). While still a

relatively rare condition, the sudden increase in incidence of this anomaly is of concern to the anesthesia provider, and warrants a review of the anesthesia concerns and requirements necessary for successful care of this fragile patient population.

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Philadelphia:Elsevier

Spring Meeting 2016

Army strong for CRNAs.

ALANA President Michael Humber and AANA Vice President Bruce Weiner

Farley Templeton is "The Voice" of the ALA-CRNA PAC raffle.

David Knight visits with Krista Niedermeier, Lisa Herbinger, Nita Morrissette and Heather Rankin.

ALANA Leadership poses with AANA President Juan Quintana.

Spring Meeting 2016

Senator Greg Reed addresses ALANA.

Senator Greg Reed visits with Kyle Vanderford, Susan Hansen and Shannon Scaturro in Exhibit Hall.

Salima Mulji urges audience members to get involved with ALA-CRNA PAC.

The Welcome Reception was sponsored by the Samford and UAB Nurse Anesthesia Programs.

Team Samford wins the prized Sandcastle trophy.

Nominating Committee Report

Krista Niedermeier

I am pleased to announce that the ALANA membership approved the slate of candidates for the upcoming election at the annual Spring Meeting in Sandestin.

As the Nominating Committee Chair, I would like to thank the members of the Nominating Committee and all of the Board members for their help in assembling the ballot. I would also like to express my appreciation to the candidates who have offered their time and experience to serve on the ALANA Board and work on behalf of the members and our great profession. This year's ballot consists of the following positions: President Elect, Treasurer, four Board of Directors positions and a Nominating Committee Chair.

Look for more information on the slate of candidates in the next ALANA NewsBulletin. Also, please keep in mind that we will be utilizing online voting for the upcoming election. Information regarding instructions for accessing the electronic ballot will be delivered via email. Please be sure you have a valid email address on file with the AANA and ALANA. Again, I am very pleased to offer this year's slate of candidates. I encourage each and every member to take the time to research and get to know the nominees and VOTE!

Krista Niedermeier, CRNA, DNP, MNA
Nominating Committee Chair

President-Elect
Matt Hemrick
Michael Humber

Treasurer
Todd Hicks
Bryan Wilbanks

Director (Vote for Four)
Wesley Cannerday
Justin Carroll
Rob Holt
Nita Morrissette
Salima Mulji
Kerry Varner

Nominating Committee Chair
Heather Joiner

Take Pride in Your Profession . . .
Farley Templeton, CRNA

How did you get interested in a career as a nurse anesthetist?
I can remember when I was in college and working at a local hospital as a blood collector. I had drawn blood from a patient that was to have an appendectomy and I asked the surgeon if he would mind if I observed since I had never seen surgery. He said yes and I went to the OR and stood by the nurse anesthetist. It didn't take me long to lose interest in the procedure because I was so consumed with what this CRNA was doing. The next day I changed my major and started on track to become a CRNA.

What is the most rewarding aspect of your career as a CRNA?
I think the most rewarding part of being a CRNA is doing something I truly love and being a part of making a difference.

How do you introduce yourself to your patients?
I usually introduce myself by saying, Hello I'm Farlie from Anesthesia and I will be your nurse anesthetist today.

When not practicing anesthesia, what do you enjoy the most?
My hobbies outside anesthesia are scuba diving, snow skiing and big game hunting.


Farley Templeton

What is the most rewarding aspect of your career as a CRNA?
The most rewarding experience as a CRNA is hard to pin down to just one. I think one of the best rewards is when you run into a patient or a family member and they go out of their way to thank you for taking care of them.

What is the most challenging aspect of your career as a CRNA?
One of the most challenging experiences for me had to be several years ago. We had a special needs adult male, physically fit but mentally challenged, that was very skeptical about going to the operating room for his hernia repair. Forget the possibility of holding him down for an IV much less taking any vital signs. So I convinced him to walk down the hall to the OR to take a look at all the cool stuff! Once he sat on the table I had someone grab him from behind and I quickly stuck a syringe into each thigh and injected some Ketamine. It sounds brutal, but was our only option at the time. He quickly fell asleep and we went straight to work. I don't think I'll ever forget that as long as I live.

Do you recommend this career to others?
And yes I would recommend our profession to others. I don't think this profession is for everyone, but that it takes a unique individual to do what we do.

What advise would you give those contemplating a career as a CRNA?
My advice to others about their interest in our profession would be to shadow an anesthesia provider for some time to see if this truly seems appealing or sparks your interest.

Why are you active in ALANA?
I have been a member of the ALANA since I graduated in 1984. There are several things I really like about the ALANA. I enjoy the friendships that come about by being a member, both personally and professionally. I like the ongoing effort our association makes to keep us out front both in the political forum and the public eye. I really enjoy the PAC and its efforts to raise money to help fund these efforts. I have enjoyed giving anesthesia for these 30+ years and hope to continue for several more. I've seen a lot of changes in that time that, for the most part, has improved our practice and patient care. Be proud of who you are, what you are and who you want to be.

Updates from the Board of Nursing

Dawn Daniel, MSN, RN

CRNAs: Please Check Your My Profile Page on the ABN Website

With the recent relaunch of www.abn.alabama.gov, our interface for nurses is more user-friendly than ever. As you know, CRNA recertification occurs at the end of July, and the My Profile page will allow you to verify the status of your approval with the Board. Please note that ABN's offices will be closed July 30 and 31, we must receive notification of your recertification from NBCRNA by 3:30 p.m., Friday, July 29, so that you may maintain your approval and continue to work. If your notification of recertification is not received by that time, your approval to practice as a CRNA in Alabama will expire and you must reinstate fully before returning to work.

Alabama Legislature Approves Loan Repayment Program for Advanced Practice

Prior to adjourning the 2016 Regular Session, the Alabama Legislature granted final passage to HB 228, which establishes a loan repayment program for CRNP, CNM, and CRNA students who agree to work in an area of critical need in the state for a period of time following completion of their programs. This legislation was proposed by Governor Bentley and sponsored by Representative April Weaver (R-Alabaster), the only nurse currently serving in the Legislature, and Senator Greg Reed (R-Jasper). Additionally, the Legislature has provided $450,000 to fund the program next Fiscal Year. Please stayed tuned as ABN moves forward in establishing the rules and processes necessary to implement this exciting new venture for Advanced Practice Nursing in Alabama.

Future Meetings

2016 – ALANA Annual Fall Meeting
October 14 – 16, 2016
The Grand Bohemian Hotel
Mountain Brook, Alabama

2017 – ALANA Spring Meeting
April 24 – 26, 2017
Hilton Sandestin Beach Golf Resort and Spa
Destin, Florida

2016 – AANA Annual Meeting
September 9 – 13, 2016
AANA Annual Meeting
Washington, DC

2016 – AANA Fall Leadership Academy
November 11 – 13, 2016
The Westin O'Hare
Rosemont, IL

2017 – AANA Mid-Year Assembly
April 7 – 11, 2017
Renaissance Hotel
Washington, D.C.