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Access to anesthesia care is not improved when states eliminate physician supervision

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Patient access to anesthesia care for seven common surgical procedures is not increased when states "opt-out" of the Medicare rule that requires anesthesia to be administered with physician supervision, reports a study published in the Online First edition of *Anesthesiology*, the peer-reviewed medical journal of the American Society of Anesthesiologists (ASA). The study showed that "opt-out" states did not experience a reduction in the distance patients were required to travel for their procedure—a common measure used to gauge access to care.

"The assertion is that by opting-out of the federal rule requiring physician supervision, the pool of potential anesthesia providers will be expanded, and patients will not have to travel as far for procedures, surgery or anesthesia care," said Eric Sun, M.D., Ph.D., study author and assistant professor of anesthesiology, Perioperative and Pain Medicine at Stanford University Medical Center, Stanford, California. "It would be advantageous to decrease the distance patients must travel for surgery and anesthesia care, especially older patients, but our research is showing that 'opting-out' may not be accomplishing this goal."

Since 2001, 17 state governors exercised the option to "opt-out" of the federal rule that physicians supervise the administration of anesthesia by nurse anesthetists, citing increased access to anesthesia care as the rationale for the decision. However, until the current study, and a previous paper published by the same researchers in February 2016 that found a lower growth in anesthesia cases in "opt-out" states versus non-opt-out states, no research had looked at whether opting-out of the

federal rule achieved improved access.

In the study, researchers used Medicare administrative claims data from more than 1.1 million cases to determine the distance Medicare patients traveled for five common elective procedures: total knee replacement, total hip replacement, cataract surgery, colonoscopy/ sigmoidoscopy, and esophagogastroduodenoscopy, as well as two common urgent procedures for which timely access to care is important: appendectomy and hip fracture repair. Procedures were performed between 1999 and 2011. Access to anesthesia care was measured by the percentage of patients who had to travel outside of their residential zip code for their procedure, and the average distance these patients traveled (variances in land area for each zip code were adjusted). Researchers examined distance traveled for these procedures before and after the decision to "opt-out" in "opt out" states. To rule out more general changes in travel distance (for example, due to trends in hospital closures occurring nationally), the researchers compared these changes to changes in the distances traveled for patients in non-opt-out states.

There was no reduction in the percentage of patients who traveled outside of their residential zip code for the seven procedures examined in "opt-out" states, except for total hip replacement (2 percentage point reduction). However, the authors note that since more than 80 percent of total hip replacement patients traveled outside their residential zip code, this effect is of little practical significance. For those who did travel outside of their zip code, "opt out" had no significant effect on the distance traveled.

"Patients in 'opt-out' states were no less likely to avoid traveling further distances to undergo these common procedures, than those in non-opt-out states," said Dr. Sun. "By looking at distance traveled as a measure of access, we're adding to the body of literature that increasingly shows 'opt-out' is unlikely to be a silver bullet when it comes to improving access to

care."

More information: "Opt Out and Access to Anesthesia Care for Elective and Urgent Surgeries Among U.S. Medicare Beneficiaries," *Anesthesiology*, 2017.

Provided by American Society of Anesthesiologists