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A Publication of the Illinois Association of Nurse Anesthetists





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Clinical Fun: Penny Auten ('22)

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Jennifer L. Banek, CRNA

PRESIDENT'S MESSAGE

Dear Illinois CRNAs,
Last September, I assumed the position of IANA President. Since then, myself and the IANA Board of Directors have been very busy, working on YOUR behalf.

After much consideration, we put out a request for proposal for a new lobbying service. In doing so, we also hired a consultant, Joe Hollabaugh, a lobbyist from the Ohio Association of Nurse Anesthetists. The lobbying industry is highly nuanced, and the Board wanted a subject matter expert to guide us through the process. Joe sat through the interview process, background checked our candidates, and guided us through internal discussions. After we identified the candidate we were interested in hiring, Joe helped on-board the new Team. I am pleased to announce that Michael Best Strategies and Sanborn Williams are our new lobbying firms! I look forward to the opportunity to introduce them to you at our next IANA meeting.

The legislative session began in January and will conclude in April. It commenced with IANA playing defense on two bills HB 1820 and SB 3214. HB 1820 would have added required “physical presence” to the Dental Practice Act. This is currently already in

the Nurse Practice Act, and we felt it was redundant and unnecessary for it to be duplicated in the Dental Practice Act. SB 3214 would have limited the use of the term “anesthesiologist” to physicians only. Thanks to the hard work of IANA Board Members and our lobbying team, neither bill made it out of committee. Conversely, we have successfully gotten HB 4922, sponsored by Representative Anna Moeller, through the Health Care Licenses Committee. HB 4922 grandfathers certification CRNAs to be able to continue to practice. There are approximately 100 Illinois CRNAs who continue to safely practice in this capacity, and it was important that we protect their ability to work until retirement. All Illinois CRNAs should consider reaching out to Representative Moeller to thank her. She has been a long-time supporter of our profession. She can be reached at: (847) 841-7130.

Our Illinois CRNA PAC is doing very well. Over the past four years, the balance has grown almost four-fold. The “secret sauce” to its success has been monthly, recurring investors. We are presently up to 229 individual CRNAs who contribute in this way. 2022 is an election year, and we anticipate supporting as many legislators

as possible, regardless of their political affiliation, who support the CRNA profession. A robust Illinois CRNA PAC will be critical to our success. There are approximately 1800 CRNA association members in Illinois. The math is easy; over 1500 CRNAs do not contribute to the Illinois CRNA PAC. Yet a “win” for our IANA is a “win” for all of us. If you are one of the 1500+ not investing, what are you waiting for? \$25/month is our ask. You can go here to sign-up: <https://www.ilcrna.com/IANA/Support/ILCRNA/SupportCRNAs.aspx?hkey=c1ff2008-590a-4724-91e7-116ca890a25f>. IANA is thankful for ANY amount invested, one-time or recurring. The benefit to recurring investments is that (1) the amount is usually small enough that the investor does not miss it, and (2) the IANA can continue to count on your investment.

IANA has bold initiatives on the horizon. Consider getting involved, either by serving in IANA leadership or investing in the Illinois CRNA PAC. Stay-tuned for advocacy alerts and additional information. In the meantime, please feel free to reach out with any questions or concerns.

Jennifer Banek, CRNA

Illinois Association of
Nurse Anesthetists, President ■

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Jennifer Greenwood, CRNA, PhD

LETTER FROM THE EDITOR

This spring edition of the Journal of the IANA kicks off a new endeavor by the editorial committee to bring the members two editions per year. There is so much going on in Illinois, that we want to make sure that your efforts toward scholarship, leadership, and practice are recognized in a timely way. To that end, we hope you will consider contributing to the content of the Journal.

Responding to the changes caused by the pandemic has produced a shift in how we work and definitely how we educate. You will see that reflected in the content here. Adaptability has always been a strength of CRNAs, and the last 2 years (has it been that long?) is a testament to that trait. Many of you have adapted your family and work routines, maybe even changed jobs during the pandemic. Hopefully there have been some positive adaptations in the way you prioritize self-care, wellness, and reflection. If resilience is the capacity to recover quickly from a difficult situation, we have collectively

shown that as a profession. This spring feels like a turning point, though. Having just returned from the in-person version of the Assembly of Didactic and Clinical Educators, in Colorado Springs, I can attest that people are ready to get back to normal! It was so nice to see friends and colleagues from all over the country and actually give them a hug and share stories. I definitely participated in that event with a new appreciation of community and proximity.

In this edition we are highlighting leadership among students and practitioners. Remember when you were a student and managed to do about 100 things every day! They really do... Their article highlights several students that have served on national organizations to learn about governance and participate in the process; all while being full time trainees and finishing up their doctoral work. We are also pleased to highlight the leadership contribution of Jennifer Banek, CRNA. She is not just the IANA president, but

she is also serving as an elected official in Lake County. Our interview with her tells an enlightening story about advocacy and access. Finally, we are proud to spotlight the DNP work of recent graduates from Rush and Rosalind Franklin University. Don't forget to send in your ideas about a CRNA to spotlight for the fall edition and the Student Vigilance stories. We would like to continue those types of articles as well.

Finally, I'd like to say it has been a fun and fulfilling seven years as the editor of the Journal of the IANA. The look and content has undergone a transformation since I took over in January 2015, and now it is time to hand over the responsibility to Jeff Matson, PhD, CRNA. Jeff is a faculty member at NorthShore University, and he has a lot of excitement and new ideas about the direction of the Journal. Please join me in welcoming him to this role! ■

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Jeff Matson, PhD, CRNA

IANA Fall 2021 Conference Review

The IANA board and staff were happy to welcome CRNAs and SRNAs to the first in-person IANA meeting since the beginning of the COVID-19 pandemic. The family-friendly Great Wolf Lodge proved to be a perfect location for the Fall Conference. The hotel housed a large indoor water park where children and their families could swim and slide down waterslides that were several stories tall. These waterslides were visible to attendees as they walked down a window-lined hallway to reach the conference meeting hall, and the children's excitement in the background mirrored the excitement of the CRNAs and SRNAs who joyously met colleagues and friends, many of whom had not seen each other in more than a year. Once everyone had a chance to catch-up and share their pandemic sagas, the conference began with a wonderful line-up of sponsors and speakers.

The conference had a broad range of topics pertinent to providing safe patient care. I opened the conference on Saturday with a presentation on gender-affirming care and was followed by Ginna Kim, DNP, CRNA, who discussed the use of cognitive aids in anesthesia practice to help during routine and emergency situations.

Regional anesthesia was a major focus of the Saturday talks; Mindy Ruan, DNP, CRNA, Noor Bader, SRNA, Avni Suresh, SRNA, Sara Hoffman, SRNA, and Eduardo Ornelas, SRNA, gave presentations on the best practices for specific nerve blocks and regional techniques. Michael Chelberg, SRNA, discussed orthopedic patient education in Honduras and Shane Garner, MSNA, CRNA, spoke on the pharmacology of local anesthetics and their adjuncts



Pictured above: Noor Bader, SRNA, speaking at Fall '21 IANA conference.



Pictured above: Pictured above: Hannah Loek ('23), Emily Tresley ('23), Laura Engel ('23), Jill Jesionowski ('23), Maiko Yamashita (PD)

► Continued on Pg. 24

Jeff Matson, PhD, CRNA

CRNA Spotlight on Current IANA President and Lake County Coroner Capt. Jennifer Banek

I had the pleasure of sitting down with Lake County Coroner and current IANA president Capt. Jennifer Banek to discuss her background and her thoughts on holding elected office as a nurse anesthesiologist. We spoke about her life, and all the adventures and obstacles she had to overcome to reach where she is today.

Jennifer's desire to serve is rooted in her Midwestern upbringing. As a child, she moved around Illinois, Indiana, and Michigan, and, no matter where she lived, she observed that there was always a need for people to serve their communities. This youthful observation grew into a desire to serve her country, which she pursued by enlisting in the Army as a young adult. She spent the next nine years as a combat medic; during which time, she fell in love and started a family. Despite enjoying her time in the military, she had a growing family and a desire to grow professionally.

Her path to becoming a nurse anesthesiologist began by obtaining a Bachelor's in Science in Biology from Illinois State University. From there, she took a position with Abbott Laboratories where she assisted with pharmaceutical research. While there an anesthesiologist friend, recognizing her talent, suggested that she pursue a nursing career and train in anesthesia. Always up for a challenge, she completed the nursing program at the College of Lake County and worked her way into the intensive care unit at Advocate Condell Medical Center. Once she was able, she applied for, and was accepted to, NorthShore University HealthSystem's School of Nurse Anesthesia, where she juggled school, children, and working in the ICU, all while her husband was deployed in Iraq. Despite these challenges, she enjoyed her anesthesia training. Her only regret was that she never got to go on a surgical brigade

to Honduras; she graduated before the school began participating in the brigades.

Once becoming a CRNA, she looked again to serve her country and took a direct commission in the Army as a nurse anesthesiologist. She was mobilized to Al Udeid Air Force base in Qatar and spent 90 days providing anesthesia care for military personnel overseas. She was proud to provide anesthesia care for our military personnel and encourages SRNAs who are interested in service to consider that route.

Although she was always knowledgeable about politics, it took an IANA lobby day to move her from political observer to politician. She noticed that it was difficult for nurse anesthesiologists to get the attention of politicians on issues that were important to the profession. Acting on that observation, she decided to run for political office so that she could have a greater voice on the issues that impact nurse anesthesiology. Working with her local Democratic party, she ran a grassroots effort to unseat the sitting Coroner, Dr. Howard Cooper, DDS. Despite the odds against her unseating an incumbent, she was able to win 53% of the vote (171,586 votes) and became Lake County's newest Coroner.

As Lake County Coroner, Jennifer uses her nursing background to lead a team of professionals to improve the public health of Lake County. With a staff of fifteen, including eight deputies and one forensic pathologist, her team establishes cause of death in a variety of cases. Increasingly, her office is finding itself on the frontlines of the opioid epidemic. It is their responsibility to determine cause of death and, more and more, she must inform families that loved ones have died from opioid overdose. To combat the epidemic, her office educates students on the consequences of drug use



and the benefit of pursuing scientific degrees. In her position she has shown the politicians of Illinois the benefit of involving nurse anesthesiologists decision making and government.

Despite her success, there is still a need for nurses, especially advanced practice nurses, in politics. The United States Congress has always had more physicians than nurses and decisions that impact our profession are made without us at the table. In recent memory there have been seventeen physician members of Congress compared to only two members who were nurses. To change this, Jennifer hopes that nurses will get involved in politics at the grassroots level to improve the care of our patients and move our profession forward. This doesn't necessarily mean running for office, although she strongly encourages running, it can be financial support to nurses running or organizations that support nurses who run. All readers are encouraged to reach out to the IANA or Jennifer for more information on how they can help. ■



Pictured Above: Team 23 receiving their White Coats before heading out to clinical, Nov 2021.

Lori Anderson, CRNA, DNP

Rosalind Franklin University Nurse Anesthesia Program

Rosalind Franklin University (RFU) is well-known as an institution that fosters a culture of diversity and inclusion. Under the guidance of the RFU President's Diversity and Inclusion Task Force (which includes Class of 2022 member Terrell Foster), our program has been working diligently to enhance our admissions/faculty hiring processes—with an overall key strategic goal of increased diversity and inclusion within our community. The RFU Department of Nurse Anesthesia welcomed 37 newly matriculated students in May 2021—the Class of 2024—our most diverse cohort to date with 57% underrepresented minority students as part of this team.

The CRNA profession welcomed 31 graduates from RFU in May of 2021. In mid-November of 2021, 35 students from the Class of 2023 successfully completed their didactic education, and headed out to their first clinical residency rotations—where they joined the 34 senior NA residents from the Class of 2022. It is hard to believe, but our program began

accepting applications for the Class of 2025 on August 12, 2021—with the cycle closing just four months later. At the close of this cycle, we had received a record number of 295 completed applications for the 37 available seats in the class. We have been very excited to meet and interview these diverse and talented critical care nurses, and anticipate that we will make our final offers of acceptance in early February 2022 for the class matriculating in May.

Over the past two years, the RFU portfolio of clinical sites has grown from 31 to 50 sites—with 33 sites in Illinois, 13 in Wisconsin, 2 in Indiana, and 2 new sites in Colorado. Since there are no nurse anesthesia educational programs based in Colorado, our new clinical partnerships there may provide further CRNA opportunities in that state. Affiliation agreements will soon be finalized with 7 additional clinical sites located in Illinois and Colorado. Recent clinical site additions for 2021 include: HealthONE Swedish Medical Center in Englewood, CO; Parkview Medical Center in Pueblo, CO; AMITA Health Mercy Medical Center in

Aurora, IL; Mt. Sinai Hospital in Chicago, IL; OSF Heart of Mary Medical Center in Urbana, IL; OSF St. Elizabeth Hospital in Ottawa, IL; OSF St. Paul Hospital in Mendota, IL; Ascension Columbia St. Mary's Hospital in Milwaukee, WI; Ascension Columbia St. Mary's Hospital in Ozaukee, WI.

With the growth in both cohort size and clinical sites, the Department has added two new full-time faculty members --Dr. Kristine Tierney DNP CRNA APRN and Dr. John Russell DNP ACNP APRN. We have also recently welcomed a new part-time CRNA faculty member Dr. Pamela Chambers DNP EJD CRNA APRN. Recently returning to our program faculty (after completing her doctorate) is Dr. Ginna Kim DNP CRNA APRN.

The Department of Nurse Anesthesia at RFU is expected to move into RFU's new College of Nursing (from the College of Health Professions) in the Fall of 2022. The new College will include two other new nursing programs—a master's Entry into Nursing Practice, and a Psychiatric Mental Health Nurse Practitioner DNP



program. As part of the scheduled 10-year reaccreditation of the Nurse Anesthesia DNP program, we will also receive the Council on Accreditation of Nurse Anesthesia Educational Programs (COA) for an on-site visit in April 2022.

I am very pleased to announce the recent appointment of Class of 2023 Jean Weigand as the Student Representative to the American Association of Nurse Anesthetists (AANA) 2021 Communications Committee. This committee is responsible for promoting the profession of nurse anesthesia and engaging AANA membership through all appropriate resources.

The doctoral project work of Class of 2022 members Amy Avila and Peter Olakowski (former student member of the COA Board of Directors) was chosen from among nearly 3,000 competitive scholarship applicants for an AANA Foundation Scholarship, as the recipient of the Dean and Fred Hayden Student Research Grant in the amount of \$3,000.00. Their doctoral project research initiative, led by Dr. Jennifer Greenwood, involved a nationwide survey regarding substance use disorder among CRNAs, including barriers to reporting and frequency/incidence of random drug testing.

Check out our recently updated and expanded website pages to learn more about activities within the RFU Department of Nurse Anesthesia—including information for those interested in serving as a clinical site for the program: <https://rfu.ms/dnpentry> ■

Pictured Above: Students from Team 21 working with the TA to learn ultrasound line placement



Pictured Below: Students from Team 21 performing advanced airway skills with the integrated FOB and Glidescope

Maiko Yamashita, DNP, CRNA

Rush University, Spring 2022 Program Update

Rush University's Nurse Anesthesia Program has continued to ride the wave of pandemic uncertainty with an enduring strength of optimism by both faculty and students. The students have been incredible by demonstrating the CRNA spirit of adaptability. Thus far, despite shutdowns and case cancellations, our students have all graduated as planned, and are actively caring for patients. This is a reflection of the dedication to education by students, faculty, and clinical coordinators from all of our clinical sites.

The 2022 cohort is in their 3rd year, gaining confidence through complex cases and autonomy. They're nearing the completion of their longitudinal efforts to produce excellent DNP projects. Such work ranges from establishing a handoff tool to be utilized during the transfer of care to anesthesia, to an interprofessional collaboration project with perfusion students during cardiopulmonary bypass. The 2023 cohort is in their 2nd year, balancing their clinical days with didactic anesthesia courses. This cohort has two students who have shown exemplary leadership in their role as student representatives to two AANA committees; Avni Suresh serves on the AANA Professional Development Committee, and Lauren Coggins serves on the AANA Communications Committee. The 2024 cohort is halfway through their 1st year, gaining the foundational knowledge needed in anesthesia practice. Although it's

Pictured: Clinical Fun: Penny Auten ('22)





Pictured Above: Locker room selfie! Kari Hermanson ('22), Megan Calabria ('22), Renie Sanders ('22), Kate Buchanan ('22).

Pictured Below: SRNAs Volunteering at a Rush Health Fair: Zach McCluskey ('23), Hannah Loek ('23), Maiko Yamashita (PD), Linda Yi ('21)

been a dynamic time, we were able to safely provide a cadaveric regional workshop as well as a sonoanatomy educational event on a live model in the simulation lab. Students and faculty were happy to attend the first in-person IANA conference since the pandemic, and support their classmate, Noor Bader ('22) as she presented on "Improving SRNA Skills in Ultrasound Guided Regional Anesthesia."

Rush has also conducted a transformational leadership change, with the division of the Assistant Program Director role into two distinct roles that focus on clinical and didactic education. Samantha Pratt, DNP, CRNA, APRN has been appointed the Assistant Program Director of Clinical Education, and Audrey Rosenblatt, PhD, CRNA, APRN has been appointed the Assistant Program Director of Didactic Education. Drs. Rosenblatt and Pratt come with years of commitment to the education of Rush students, and are compassionate, well respected CRNAs. Maiko Yamashita, DNP, CRNA, will continue her role as Program Director, and with Drs. Pratt and Rosenblatt, a strategic plan has been established for the program to further grow. This plan includes the four pillars of Preparation for Current Practice; Professional Development; Diversity Equity and Inclusion; Wellness. With this plan, and our incredible faculty team, we are eager to see what the future holds for our students, and our contributions to the CRNA profession. ■

Dana Flatley DNP, CRNA

Millikin University and Decatur Memorial Hospital Nurse Anesthesia Program Update

Greetings!

It has been another busy year for Millikin University and Decatur Memorial Hospital Nurse Anesthesia Program. We welcomed two new members to the Anesthesia School Administrative team. Dr. Aron Oakley accepted the position of Assistant Program Director in January 2021. Dr. Oakley is a 2016 graduate of Rush University and currently practices at Carle Foundation Hospital. Dr. Catherine Hymel accepted the position of Clinical Advisor in May 2021. Dr. Hymel is a 2016 graduate of University of Texas and practices at St. John's Hospital in Springfield Illinois.

We continue to grow our Crisis Management Simulation program utilizing Memorial Learning Center's state of the art simulated operating room. It is a true joy to watch the interns grow in their crisis management skills and leadership skills as they move through each of the scenarios. The fourth annual Robert F. Waldvogel MD Memorial Lecture and Regional Anesthesia Workshop was September 12-13, 2021. This workshop was led by Adam Schneider DNP, CRNA, NSPM-C and Joseph Grazaitis DNP, CRNA. The addition of this workshop in our curriculum has resulted in improved competency among our anesthesia interns. Importantly, we have seen an increase in the number of regional anesthetics



*Pictured: Jessica Addai 3rd Year Registered
Nurse Anesthesia Intern*



performed during clinical experiences. We offered the Daniel Evans Memorial Lecture and Vascular Access Workshop in November 2021. The students were mentored by CRNAs from St. John's Hospital, Tiffany Stork CRNA and Eric Allen and Decatur Memorial Hospital CRNA, Brian Jones. The students were given opportunity to practice central line, PICC line, and arterial line insertion. The simulation program and yearly workshops are supporting the needs of our student's success in clinical, and beyond.

The interns continue to thrive in this rigorous program, amidst the ongoing COVID pandemic. We celebrated the Class of 2021 and their successful completion of the Program on December 12, 2021, and wish them the best as they begin their careers in anesthesia. The third-year interns are in the final steps of DNP Project Completion, beginning their National Certification Exam Review, while tackling challenging clinical rotations. Our second-year interns are getting deep into their anesthesia course work and looking forward to starting clinical experiences in June. We welcomed our first-year students to the program on January 20, 2022, just in time to celebrate national CRNA Week! We are fortunate to have clinical sites that support clinical education of our students in these stressful times. Thank you to the CRNAs that volunteer to mentor our students! ■

Pictured Above: Lauren Horve 3rd Year Registered Nurse Anesthesia Intern and Claire LaTulip 3rd Year Registered Nurse Anesthesia Intern

Pictured Below: Dorothy Mbondo 3rd Year Registered Nurse Anesthesia Intern

Health Literacy: The Anesthesia Provider's Role in Patient Advocacy

Abstract

More than 10 million inpatients and 11 million outpatients undergo anesthesia and surgery each year. Of these patients, a record 19-22 percent of them rank as health illiterate. This means that patients going through surgery and anesthesia may not have sufficient understanding of their health and wellness for the most optimal experiences and outcomes of their procedures.

Anesthesia providers are often the last person a patient sees prior to surgery. Anesthesia providers must connect with patients in the most limited amount of time, gain a person's trust, keep them safe during surgery and anesthesia, and often usher them through the education required to ensure patients are as empowered as they can be to understand the impact their health has on their surgical and anesthesia outcomes before, during, and after their procedures.

In this article we address how health disparities and low health literacy are associated with poor outcomes, and what we, as patient advocates, can do to mitigate these risks and empower patients to be stewards of their health—involved in their own outcomes through simplified language and shared decision making as a team.

Keywords

health literacy, patient advocacy, CRNA, anesthesia, surgery, health care

Introduction

Imagine this—your car is making a funny little sound. You're no car expert, but you figure you ought to take it to a mechanic to get it checked out. The mechanic assesses your car, and it's clear that they have seen this sort of thing on a routine basis. In a "no big deal" approach, they speedily rattle

off the assessment and plan to fix your car. All you hear are words like, "transmission," "spark plug," and "alternator," but really, it's all a blur. You think you've heard these terms before, and hastily nod as if understanding, but really, you have no clue. Nonetheless, you trust that the mechanic is the expert, and agree to proceed with a plan you don't understand... Now, imagine this, but with your body, or your loved one.

Health Literacy Defined

There has been a recent movement towards emphasizing the fluid nature of health literacy, as evidenced by the change in the definition of "health literacy" in the United States' Healthy People 2030 goals. In August 2020, the U.S. Department of Health and Human Services (HHS) published the new definition, subdividing it into two categories: "Personal Health Literacy" and "Organizational Health Literacy." Personal health literacy is defined as "the degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others," while organizational health literacy is "the degree to which organizations equitably enable individuals to find, understand, and use information and services to inform health-related decisions and actions for themselves and others."¹ These definitions put focus on the importance of information utilization to make informed decisions and the responsibility of organizations to foster health literacy.²

Prevalence and Statistics: The State of Health Literacy in Populations

The National Assessment of Adult Literacy (NAAL)³, the most recent national survey on health literacy, used the definition of

health literacy established by Healthy People 2010 to develop a health literacy scale and health literacy tasks. Categories included "below basic," "basic," "intermediate," and "proficient."³ Defining abilities for each literacy category can be seen in Table 1. The NAAL showed that 12% of adults had proficient health literacy, 53% intermediate, 22 % basic, and 14 % below basic.³

Social Determinants of Health and Health Literacy

According to the 2003 National Assessment of Adult Literacy,³ women had higher average health literacy than men, with 12% of women who were below basic, as compared to 16% of men. Adults 65 and older had the lowest health literacy, while ages 25 to 39 had the highest. White and Asian/Pacific Islander adults had higher levels of health literacy, while Black, American Indian/Alaska Native, multiracial adults, and most significantly Hispanic adults had lower health literacy. While this survey was conducted in English and Spanish, it found that adults who spoke languages other than English before starting school or who spoke only a non-English language had a lower average health literacy level. Lastly, health literacy increased with each level of higher education earned, with those who did not complete high school rating the lowest, and those who have completed or have some graduate education being the highest. In summary, the populations at most risk of low health literacy are men, individuals aged 65 and older, Hispanic, Black, American Indian/Alaska Native, multiracial adults, and those with low education level.^{3,4} Figures 1 and 2 detail the percentage of adults at each health literacy level in 2003.³

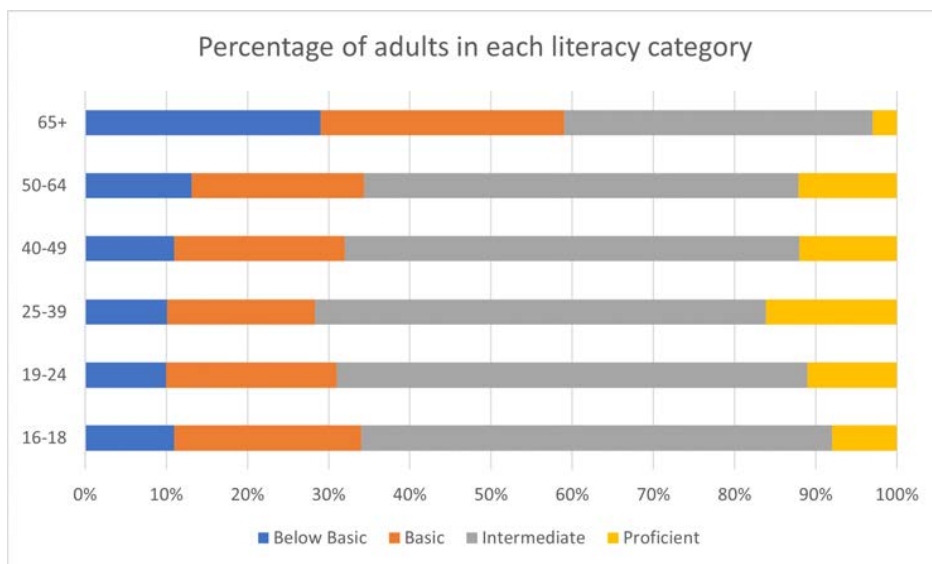


Figure 1: Health literacy categories organized by age. Adapted with permission from Kutner et al³

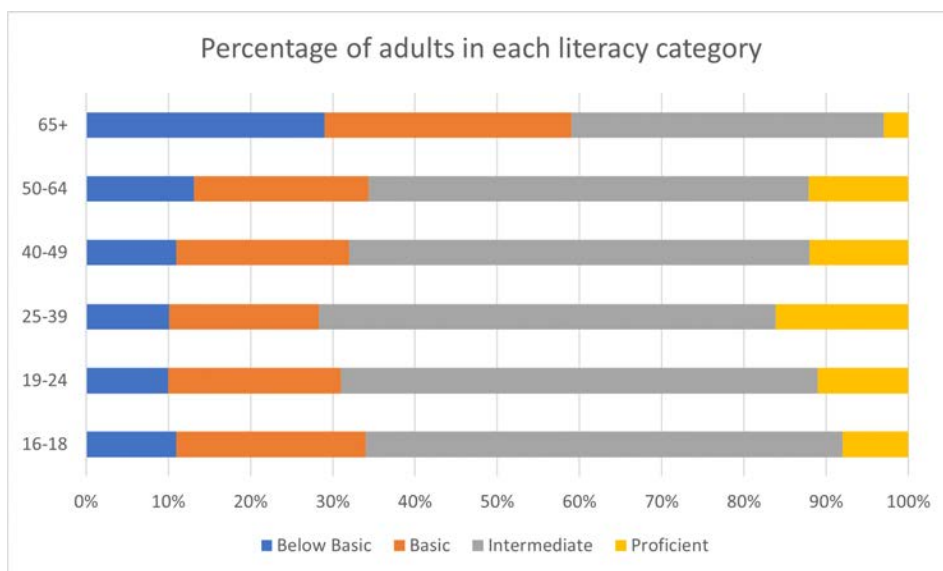


Figure 2: health literacy levels by race/ethnicity. Adapted with permission from Kutner et al³

Importance of Health Literacy

The importance of informed consent is to “make informed, autonomous choices about a proposed procedure while understanding its associated benefits, risks, and treatment alternatives.”⁵ It is a dynamic interaction that upholds the responsibility of the medical professional to disclose information so that the patient can comprehend, synthesize, and utilize the information to make the best decision for themselves. Many studies have concluded that patients with low literacy are less likely

to participate in their healthcare decision making.^{6–8} The patient’s role in decision making is a crucial component to health equity as it relates to patient-centered health care systems, and such systems should adapt to meeting the needs and capabilities of patients, particularly the underserved.⁹

Failure to adapt health information to meet the needs of patients with low health literacy can compromise health equity. In general, the informed consent process can be challenging for patients.¹⁰ In one study of 1034 patient surveys from 1343

preoperative patient visits, it was found that 13% of patients receiving a major surgery could not recall the procedure performed, its indications or alternatives, and 34% of patients exhibited at least one deficit in surgical decision making, half of which may not have met the standards of informed consent.¹⁰ While this study provided data on a general patient population, patients with low health literacy are an especially vulnerable population during the informed consent process.^{4,6} While patients may be able to understand information regarding other aspects of their lives effectively, health information may be difficult for them to obtain, understand, or use.¹¹ During a stressful time, such as receiving a serious diagnosis or in the preoperative area awaiting a procedure, low health literacy can compound stress, making it even more challenging for them to understand and use health information to make informed decisions.¹²

Current anesthesia practice in high-income countries predominantly take place in the outpatient setting. In the United States alone, the outpatient case percentage has increased from 34% in 1985 to 66% in 2014.^{13,14} This increase in outpatient surgery places greater reliance on patients and caregivers to understand health information for preoperative and postoperative care, and this greater reliance can be detrimental to outcomes.¹³ There is an association between vulnerable populations, such as patients with low health literacy, and poor surgical and anesthesia outcomes.^{15,16} Moreover, because surgical instructions can be complex, low health literacy can impact adherence to instructions.^{17,18} This inadequate adherence can then lead to increased hospitalization and mortality,^{9,16,17} which can be further exacerbated by undiagnosed or poorly managed comorbidities that are more prevalent among vulnerable, marginalized, and disenfranchised populations.¹⁵ With the increased trend to provide outpatient surgery, it is important, more now than ever,

to appropriately communicate with patients and align with The Healthy People 2030's goal for "Organizational Health Literacy."¹

The Provider's Role in Promoting Health Literacy

For surgical procedures, the anesthesia provider is often the last point of contact with the patient before surgery. During this preoperative time, it is critical that all parties understand not only the procedure to be done, but also the risks associated with anesthesia and surgery. Prior to surgery, patients may seek information about their procedures on the internet, from reputable health providers, or in materials provided by their own providers. Several studies have found that online health information materials are almost universally written at a comprehension level far beyond that of a general audience.^{17,19,20} The informed consent form is also frequently authored in a complex, unfriendly way that impairs readability.²¹ It is crucial for the informed consent materials to be written in simple language that is understandable to the general population.

As part of preoperative process, CRNAs explain the anesthetic implications of the patient's health and procedure as they relate to the patient's pre-existing conditions, the impact that their health will have on the surgery and outcomes, and what to expect intraoperatively and in the post-anesthesia care unit (PACU). Patients may understand what their procedure involves, but the volume of information about surgical and postoperative risks and the impact of their health on these risks (and vice-versa) may not be fully understood.²¹ Prior to surgery, the CRNA and patient engage in one-on-one discussion regarding these risks, what to expect, and patient preferences; the dialogue between the CRNA and the patient aims to confirm compliance with pre-surgical instructions and to generate an environment of trust and shared decision making with each individual patient.^{22,23}

Proficiency level score range	Examples
Proficient 310-500	382: Calculate an employee's share of health insurance costs for a year, using a table that shows how the employees monthly cost varies depending on income and family size. 366: Find the information required to define a medical term by searching through a complex document. 325: Evaluate information to determine which legal document is applicable to a specific health care situation.
Intermediate 226-309	290: Determine a healthy weight range for a person of a specified height, based on a graph that relates height and weight to body mass index (BMI). 266: Find the age range during which children should receive a particular vaccine, using a chart that shows all the childhood vaccines and the ages children should receive them. 253: Determine what time a person can take a prescription medication, based on information on the prescription drug label that relates the timing of medication to eating. 228: Identify three substances that may interact with an over-the-counter drug to cause a side effect, using information on the over-the-counter drug label.
Basic 185-225	202: Give two reasons a person with no symptoms of a specific disease should be tested for the disease, based on information in a clearly written pamphlet. 201: Explain why it is a difficult for people to know if they have a specific chronic medical condition, based on information in a one page article about the medical condition.
Below Basic 0-184	169: Identify how often a person should have a specified medical test, based on information and clearly written pamphlet. 145: Identify what is permissible to drink before medical tests, based on a set of short instructions. 101: Circle the date of a medical appointment on a hospital appointment slip.

Table 1: Health literacy scores evaluated by the NAAL, with examples. Adapted from Kutner et al³

Common Medical Phrases	Examples
"You will be intubated for the procedure."	"We will place a tube to help you breathe during your operation."
"We will place an arterial line during the procedure to monitor your blood pressure."	"We will insert a catheter, like your IV, into your wrist after you are off to sleep to monitor your blood pressure from beat to beat."
"Do you have any cardiac conditions?"	"Do you have any heart problems, such as a history of a high blood pressure or a heart attack?"
"Your consent states you're having a lap chole today."	"Tell me the procedure you're having in your own words."
"Would you be okay with receiving a transfusion if necessary?"	"Do you consent to receiving blood and blood products if necessary during the procedure?"
"We will monitor you throughout your procedure"	"We will be with you the entire time watching over your heart rate, blood pressure, and oxygen levels."
"There is risk of postoperative ventilation."	"If it's not safe to take the breathing tube out after the surgery, it will remain in, you will receive medicine to keep you sedated, and it will come out at a safer time in the ICU."

Table 2: Examples of common medical phrases and simplified, standardized, more comprehensible versions

How Providers Promote Health Literacy and Patient Understanding

The National Institutes of Health (NIH) and American Medical Association (AMA)

recommend all patient materials be written at a 6th grade level.^{20,24} Over one-third of Americans were ranked as having basic or below basic" health literacy in the 2003

NAAL study, with only 1 in 8 considered proficient.²⁵ Simple, non-polysyllabic language is an effective way to increase comprehension; this involves using smaller words, shorter sentences, and including only the most critical information in creating a dialogue with patients or when generating patient education materials.^{4,20,24}

Simplifying Language

To better communicate with our patients, we need to meet them where they are in terms of their level of literacy and education. Written and oral communications benefit from short words in short sentences for easier comprehension. It is ideal to use non-medical language whenever possible—the day-to-day language between health care providers and workers is often riddled with jargon and vernacular that is unintelligible to most patients.²⁴ See Table 2 for examples of common medical phrases and their simplified versions to promote patient understanding and adherence to their care guidelines.

A useful metric for readability of materials is the Flesch-Kincaid (FK) grade-level score.²⁶ This score evaluates the number of syllables per word and the number of words per sentence to determine a reading grade level. There are online resources for evaluating a document's FK grade level, as well as built-in functionality in modern word processing software, including Hemingway (www.hemingwayapp.com), Grammarly (www.grammarly.com), and Microsoft Word. Many useful platforms such as these exist to serve in the creation of materials that are easily understood by patients and family members according to their needs.

Shared Decision-making

Shared decision-making is a continuum that works to ensure that healthcare is as patient-centered as possible.^{9,10,27} A 2014 study showed that up to a third of patients reported that the decision to proceed with a surgery did not align with their values, preferences, or goals, showing a large deficit in this domain.¹⁰ Traditional medicine

relied on the physician unilaterally making care decisions, but that has changed²⁷; collaborative decisions between the physician and patient that align with the patient's values can promote clearer and more open communication between members of the healthcare team and the patient and family members. Shared decision-making has the potential to positively impact a patient's health outcomes with their involvement in decisions about their own care.^{9,27}

Teach-Back Method

The teach-back method is an effective tool to gauge patient understanding.²¹ In the teach-back or “repeat-back” method, patients are asked to describe their understanding of the procedure using their own words. This is not only useful in verbal communication, but has also been used to evaluate simplified informed consent materials.²¹ One study which tested two simplified informed consent documents at an ambulatory surgery center found increased patient success at teach-back, from 88% using the original form to 100% with the revised version.²¹

Follow-up care

Post-surgical follow-up with patients is critical for reinforcing their understanding of care after leaving the hospital. Post-operative rounding to reinforce anesthesia post-care guidelines and answer patient questions is important to supporting patient understanding and adherence to their plan of care. Before discharge, following up with patients improves outcomes²⁸; however there are concerns about information retention due to “grogginess” from anesthesia recovery.²⁹

Following up with patients anywhere from days to a few weeks after surgery improves their adherence to post-surgical guidelines regarding their care and medications.^{30–32} A meta-analysis of 18 studies showed that a text message or phone call reminder was associated with a 74% increase in patient

adherence to instructions.³² In a randomized study of patient follow-up after third molar surgery, a telephone call follow-up was associated with significantly higher scores for hygiene versus written instructions.³⁰ The timing of follow-up matters too: a retrospective analysis of patients discharged after acute myocardial infarction found higher rates of adherence to medication with a follow-up within 6 weeks compared to those with a later or absent follow-up.³¹

Conclusion

In healthcare, there is a large gap between what health care providers believe they are communicating to patients and what patients understand and use for decision making. This gulf in understanding applies not only to situations when speaking one-on-one with patients, but also in patient-facing materials published on websites or materials provided to by hospitals, healthcare providers, and drug-makers. Health literacy varies strongly by ethnicity, with Black, Hispanic, and Native people having a significantly lower health literacy score than white Americans.³ Contributing factors for low health literacy include disparities in access to education and healthcare, as well as income.³³

Healthcare organizations can help patients take ownership of their health decisions by making their written and oral materials more understandable. This can ensure patient and family understanding by engaging patients in their own care using simple language and other methods of ensuring patient understanding to empower patients and families to take further ownership of their health and health outcomes. Improving communication with patients, being cognizant of their needs and understanding, and employing methods to improve patient understanding, organizations can empower their patients and improve the quality of the healthcare they deliver.

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Legislative Update (as of February 9, 2022)

The Michael Best Strategies & Taylor UHE LLC Governmental Affairs team is currently advocating on behalf of the Illinois Association of Nurse Anesthetists on the following pieces of legislation.

HB4922 NURSE PRACTICE-CRNA LICENSURE

Amends the Nurse Practice Act. Provides that the Department of Financial and Professional Regulation may issue a certified registered nurse anesthetist license to an advanced practice registered nurse who does not have a graduate degree, applies for licensure before July 1, 2028 (instead of July 1, 2023), and submits the other required information to the Department.

BILL STATUS – IN HOUSE RULES COMMITTEE

IANA POSITION – SUPPORT

SB3214 DENTAL-COLLABORATIVE AGREEMENT

Amends the Illinois Dental Practice Act. Provides that a licensed dentist must hold an appropriate permit in order to perform dentistry while a nurse anesthetist administers conscious sedation, deep sedation, or general anesthesia (rather than conscious sedation). Provides that a certified registered nurse anesthetist who provides anesthesia services in a dental office shall enter into a written collaborative agreement with the operating dentist performing the procedure. Provides that the agreement shall describe the working relationship of the nurse anesthetist and the operating dentist and shall authorize the categories of care, treatment, or procedures to be performed by the nurse anesthetist. Provides that the operating dentist shall approve the anesthesia plan prepared by the

nurse anesthetist and shall remain physically present and be available on the premises during the delivery of anesthesia services for diagnosis, consultation, and treatment of emergency medical conditions. Provides that the nurse anesthetist may select, order, and administer medications, including controlled substances, and apply appropriate medical devices for delivery of anesthesia services under the anesthesia plan agreed with by the operating dentist. Provides that the holder of a faculty limited license may advertise his or her specialty degree as part of his or her ability to practice at a clinic or office affiliated with a dental school.

BILL STATUS – IN SENATE LICENSED ACTIVITIES COMMITTEE

IANA POSITION – OPPOSE

HB4574 DENTAL-COLLABORATIVE AGREEMENT

Amends the Illinois Dental Practice Act. Provides that a licensed dentist must hold an appropriate permit in order to perform dentistry while a nurse anesthetist administers conscious sedation, deep sedation, or general anesthesia (rather than conscious sedation). Provides that a certified registered nurse anesthetist who provides anesthesia services in a dental office shall enter into a written collaborative agreement with the operating dentist performing the procedure. Provides that the agreement shall describe the working relationship of the nurse anesthetist and the operating dentist and shall authorize the categories of care, treatment, or procedures to be performed by the nurse anesthetist. Provides that the operating dentist shall approve the anesthesia plan prepared by the nurse anesthetist and shall remain physically present and be available on the premises during the delivery of anesthesia services for diagnosis, consultation, and

treatment of emergency medical conditions. Provides that the nurse anesthetist may select, order, and administer medications, including controlled substances, and apply appropriate medical devices for delivery of anesthesia services under the anesthesia plan agreed with by the operating dentist. Provides that the holder of a faculty limited license may advertise his or her specialty degree as part of his or her ability to practice at a clinic or office affiliated with a dental school.

BILL STATUS – IN HOUSE RULES COMMITTEE

IANA POSITION – OPPOSE

SB3491 MED PRACTICE-TITLE & LICENSE

Amends the Medical Practice Act of 1987. Provides that a person who does not possess a valid license and uses the title Anesthesiologist or Dermatologist violates the Act.

BILL STATUS – IN SENATE LICENSED ACTIVITIES

IANA POSITION – OPPOSE

HB4269 NURSE LICENSURE COMPACT

Amends the Nurse Practice Act. Ratifies and approves the Nurse Licensure Compact, which allows for the issuance of multistate licenses that allow nurses to practice in their home state and other compact states. Provides that the Compact does not supersede existing State labor laws. Provides that the State may not share with or disclose to the Interstate Commission of Nurse Licensure Compact Administrators or any

► **Continued on Pg. 26**

Development of Evidence-Based Educational Videos: Best Practices for Airway Management

Abstract

Healthcare providers responsible for airway management must be proficient in skills and techniques to ensure ventilation and airway patency. Nurse anesthesia residents (NARs) and other airway specialists often use video-based learning to supplement their education efforts. Unfortunately, many instructional videos available through video-sharing networks, such as YouTube, are often of questionable quality. A survey conducted at Rosalind Franklin University of Medicine and Science (RFUMS) found that of three cohorts surveyed over 54% of NARs agreed that the accuracy of the content of existing videos was average to poor. Additionally, 21% of respondents would prefer to only use videos produced by RFUMS if they were available. A doctoral project was undertaken to develop evidence-based instructional videos, skills checklists for simulation assessment, and a comprehensive best practice guide on four airway management skills: direct laryngoscopy, video laryngoscopy, rapid sequence intubation, and the insertion of a supraglottic airway device to benefit NARs in airway management. Evaluation of the role of video based learning in simulation in an area of ongoing study.

Keywords: airway management, evidence-based videos, video-based learning, nurse anesthesia

Introduction

The airway management expertise demonstrated by anesthesia providers is critical to patient safety during routine procedures and medical emergencies. Although anesthesia is generally considered safe with a very low mortality rate, failures in airway management account for 2.3

to 16.6% of anesthetic deaths.¹ Airway management difficulties that are known to contribute to patient death include: inadequate ventilation, difficult intubation, and premature extubation. For providers to become efficient experts in airway management, various methods of instruction are often used to cater to different learning preferences. The four basic types of learning modalities most frequently used are visual, read/written, auditory, and kinesthetic sensory learning.² Learners can benefit from identifying which of these modalities works best for them, or using a variety of methods depending on the content.

Traditional classroom education and simulation training are often used to teach airway management. Despite these excellent learning modalities, students commonly search for videos to supplement in-person learning. With declining numbers of anesthesia educators, the amount of additional training that can be offered by professors is limited.³ Videos can be viewed an unlimited number of times to reinforce training, especially for those who need educational support. Additionally, research indicates that video-based learning (VBL) can strengthen content comprehension and may even be superior to traditional teaching methods when practical skills are being learned.⁴⁻⁶ Platforms such as YouTube are frequently used by both novice and experienced medical providers.⁷ Although highly accessible, concerns exist regarding the possibility of these videos' poor content quality.^{8,9}

A literature review was conducted to determine the applicability of video-based learning for NARs to improve their airway management skills and improve

confidence. There was minimal research specifically focusing on NARs' airway skills development. However, two studies in pediatric airway management found an improvement in performance and targeted skills when clips of live intubations were used, compared to still images.^{10, 11} The literature also revealed that VBL improved overall learning among anesthesia students performing machine checkouts versus traditional live instructor methods,¹² and improvement in dermatology residents' procedural skills and confidence.¹³ Although more studies specific to anesthesia education would be ideal, these initial findings indicate VBL to be at least as efficacious as traditional educational formats within other healthcare-related fields.

Given the lack of evidence-based airway management videos available to NARs and the importance of airway management to patient safety, a DNP project was undertaken to measure students' interest in using videos to enhance learning, followed by the creation of educational videos. Four evidence-based videos for the following airway techniques were developed: (1) direct laryngoscopy (DL) intubation, (2) video laryngoscopy (VL) intubation, (3) rapid sequence intubation (RSI), and (4) supraglottic airway (SGA) insertion. Each video covered essential concepts in a stepwise fashion, using the most current guidelines. The main objectives for the creation of these videos were to benefit NARs' understanding of the evidence-based application of airway management techniques, risks, and benefits, as well as facilitate educators' ability to incorporate these techniques into the curriculum for future RFUMS NARs. To ensure that the necessary skills were demonstrated

after using the VBL, comprehensive skills checklists were created as a guide for learners and as an assessment tool for faculty. These checklists were based on the most recent literature supporting best practices for airway management.

Theoretical Framework

The creation and implementation of airway management video learning was facilitated by employing the steps of the Ottawa Model for Research Use (OMRU). OMRU outlines the transfer of research into evidence-based guidelines and clinical practice in six steps.¹⁴ The steps include: (1) identify the project's team and key stakeholders; (2) clarify the innovation to be implemented; (3) assess the innovation, potential adopters, and the practice environment for barriers and support; (4) select and monitor the implementation interventions; (5) monitor the adoption; and (6) evaluate the outcomes.

This project focused on the first three steps, while a subsequent cohort of NARs have continued the work of measuring outcomes related to the use of the videos in simulation training, ensuring permanent adoption of the videos as part of routine simulation training at RFUMS, and evaluating the outcomes of the NARs that utilize them.

Methods

A literature search was performed to find evidence to inform the creation of the skills checklists and subsequently the steps portrayed in the educational videos. CINAHL Complete and Ovid MEDLINE databases were selected due to their focus on healthcare and allied health. Articles were included if they were peer-reviewed and written in English within the last 10 years. Keywords utilized included: airway management, airway, intubation, direct laryngoscopy, video laryngoscopy, GlideScope, rapid sequence intubation, RSI, cricoid pressure, laryngeal mask airway, LMA, supraglottic airway, SGA, and

RFUMS Department of Nurse Anesthesia
Direct Laryngoscopy and Endotracheal Intubation Fluency

Student Name: _____ Date: _____

Faculty Name: _____ Rating: Pass _____ Fail _____

Pre-procedure	Yes	No	N/A
Reviews H&P and pertinent diagnostic data.			
Introduces self to patient then conducts physical examination.			
Performs airway assessment.			
Confirms surgical procedure, including laterality, with the patient.			
Obtains informed consent for anesthesia from the patient.			
Orders appropriate preoperative medications.			
Determines both intubation and backup plans.			
Utilizes MSMAIDS mnemonic to ensure the readiness and availability of all necessary equipment and medications, including suction readily available and properly functioning.			
Procedure			
Observes universal precautions.			
Participates in the procedure timeout upon patient's arrival to the OR.			
Applies appropriate monitors after assisting patient to the OR table.			
Properly positions patient in sniffing position with black strap under the patient's head.			
Pre-oxygenates/de-nitrogenates the patient.			
Completes final pre-induction assessment of patient, including vitals.			
Administers appropriately selected induction medications and doses.			
Confirms induction of anesthesia by checking for apnea and loss of eyelash reflex, then tapes eyes closed.			
Demonstrates proper mask ventilation technique with adequate EtCO ₂ tracing.			
Obtains a baseline TOF prior to the administration of the selected NMB agent.			
Administers NMB agent and continues mask ventilation until appropriate NMB agent effect.			
Once jaw relaxation occurs, intubation readiness is confirmed with another TOF assessment.			
Correctly scissors the patient's mouth and demonstrates proper use of laryngoscope.			
Verbalizes anatomical landmarks			
Performs atraumatic introduction of ETT, advances to appropriate depth, removes stylet, and inflates pilot balloon.			
Verbalizes confirmation methods			
Recognizes the need to abort the intubation attempt. If intubation attempt is unsuccessful, performs mask ventilation. Initiates back up plan appropriately.			
Post-procedure			
Turns on selected potent inhalation agent, decreases fresh gas flows, selects proper ventilation mode and initiates mechanical ventilation.			
Secures ETT at appropriate depth with tape.			
Appropriately documents procedure.			

Figure 1. Direct Laryngoscopy Skills checklist

technique. MeSH terms related to the topic included intubation, airway management, laryngoscopy, rapid sequence intubation, and supraglottic airway.

The titles and abstracts of the resulting articles were assessed for relevance by the authors (CCR, NML). The most pertinent publications relevant to establishing best practices were appraised with the appropriate Joanna Briggs Institute (JBI) evaluation tool to determine the quality of the study.¹⁵ The primary research articles on relevant topics identified in Up-To-Date were assessed for relevance and were also included in the review.

A needs assessment survey was co-developed

by peers and faculty and then completed by former and current NAR cohorts at RFUMS using Qualtrics data capture. This survey gauged NAR's current use of videos to aid in their learning and the reported quality of the videos encountered online. The results of this survey served as a guide for content and breadth of this project.

After the best-practices guidelines were delineated from the extensive literature review, checklists for each of the four airway management techniques were created using a Delphi technique among simulation faculty and DNP students. Once unanimous agreement was attained, the checklists were published for student use. A sample of the DL skills checklist is

provided here (Figure 1), and additional skills checklists are provided on the Illinois Association of Nurse Anesthetists website as supplemental resources. Each skills checklist began with a review of pertinent patient information, conducting a patient interview and obtaining informed consent, formation of an anesthesia plan, and preparation of equipment and medications. Step-by-step guidelines were then provided for each skill from pre-procedure timeout through device placement confirmation, securement, initiation of ventilation and inhaled anesthetics (if applicable), and finally documentation.

Modeling these checklists, the airway management videos were published after critical review by senior NARs and faculty members to ensure accuracy, completeness, and quality of the product based on their expert opinion and existing literature. Lastly, the best practice guidelines were assembled into a doctoral manuscript to reflect the safest means for securing an airway and how to avoid common complications in that process. Only the most compelling and sometimes controversial steps in airway management encountered in the literature have been included here in consideration of the reader and to adhere to the length requirements of the journal.

Results

Out of 61 potential respondents, 59 participants completed the needs survey. Each respondent had used non-RFUMS online videos in the past and stated they assisted in their learning of procedural skills. 55.4% of respondents rated the production quality of the videos as average, 42.9% of respondents rated the teaching effectiveness as above average, and 48.2% rated the accuracy of the information contained within the videos as average (Figure 2). In a multiple response question, 53.8% of participants stated that if RFUMS-developed videos were available, they would be used in addition to already existing videos for the purpose of learning a new skill.

The needs survey indicated a variety of reasons that the NARs used VBL to support their learning. As depicted in Figure 3, the learners indicated that the ability to view videos repeatedly was of the most important learning advantages of the video-based learning. Second, the video could be stopped in a stepwise fashion to allow viewers to practice and follow along. The third most important trait was accessibility. The videos have an unlimited availability, which is not always the case with faculty or peer assistance.

Best Practice for Airway Management

This section delineates best practices in airway management for anesthesia trainees and practitioners, as described in the recent literature and depicted on the skills checklists used by RFU residents.

Traditional Direct Laryngoscopy Intubation

Tracheal intubation performed via DL is the traditional way to secure a patient's airway and maintain its patency.¹⁶ Two steps in the skills checklist that require further discussion are neuromuscular monitoring and administration. It is recommended that muscle response to peripheral nerve stimulation be assessed after induction of general anesthesia and again after administration of a neuromuscular blocking medication to ensure proper timing for tracheal intubation.¹⁷ Monitoring of the facial nerve activity is the most useful in the intubation setting since it most resembles the action of the laryngeal muscles.¹⁸ Regarding the timing of neuromuscular blocking agent administration, traditional anesthesia practice in non-emergent cases has been to confirm the ability to mask-ventilate prior to the administration of NMBA. However, there are newer studies that offer a possible alternative to this practice, proposing the administration of NMBA before confirming the ability to effectively mask ventilate. This change in

sequence may improve mask-ventilation in those who would be challenging to do so otherwise.^{19, 20} While infrequent, the unanticipated difficult mask ventilation and laryngoscopy despite thorough preoperative assessment does occur.²¹ As a result of the significant risks this situation poses, we continue to instruct mask ventilation prior to NMBA administration to avoid "cannot intubate, cannot ventilate" scenarios.

Video Laryngoscopy Intubation

The steps in accomplishing VL are similar to DL with one important caveat. VL use for securing the airway is associated with increased risk of damage to oropharyngeal tissue due to poor technique.²² DL enables the provider continuous direct visualization of the oropharynx and glottis, whereas VL requires the provider shift focus from the patient to the video monitor when inserting the video laryngoscope blade and ETT. Oropharyngeal tissue laceration and penetration can occur if attention is only focused on the VL monitor as the ETT is inserted into the patient's airway.²²

Rapid Sequence Intubation (RSI) with Cricoid Pressure Application.

Safely performing RSI has many steps in common with both DL and VL. The biggest point of debate with RSI surrounds the use of cricoid pressure. Due to ethical concerns, randomized controlled trials on the topic of cricoid application and its effectiveness are limited in the literature. Cricoid pressure is generally accepted and taught in many programs to prevent gastric reflux and potential aspiration by compression of the esophagus between the cricoid cartilage and cervical bodies. However, if applied incorrectly, patient injury can occur.²³ Research included in a systematic review in 2020 indicated no advantage of cricoid pressure for reducing the incidence of aspiration but it did suggest that it may increase the difficulty of intubation.²⁴ However, indirect evidence suggests the

benefits of cricoid application in certain patient populations.²⁵

Presently, insufficient evidence on this topic hinders practitioners from officially making new recommendations. Therefore, cricoid pressure continues to be incorporated into clinical training at RFUMS to ensure NARs are aware of the correct procedure. They are, however, also educated on its risks, so that informed judgment can be used to determine if cricoid pressure would be appropriate for the various patients they care for.

Airway Management with a Supraglottic Airway Device

Since its introduction into practice, SGAs have been designated for standard airway management during short surgical procedures. They are also used as emergency rescue devices for failed intubations and difficult or ineffective mask-ventilation scenarios. (ASA difficult airway). Relative contraindications for the use of an SGA device are related to situations that increase the patient's aspiration risk: full stomach, trauma, previous gastric surgery, gastroesophageal reflux, diabetic gastroparesis, pregnancy over 14 weeks, dementia, opiate use, hiatal hernia, and increased intestinal pressure.²⁶ Absolute contraindications are the presence of glottic or subglottic airway obstruction (e.g., tracheomalacia or external tracheal compression).

Like cricoid pressure, there are some controversies surrounding SGAs, especially regarding the use of neuromuscular blocking (NMB) agents. Some practitioners opt to paralyze their patients while others do not. A recent study explained that propofol administration alone had been traditionally used to blunt laryngeal reflexes to allow for the insertion of a [SGA].²⁷ However, their study also showed that a sub-intubating dose of succinylcholine (0.25 mg/kg) facilitated the insertion of the [SGA] by improving jaw relaxation. At that dose, succinylcholine did not significantly decrease the incidence of coughing or gagging. Additionally,

although mild, postoperative myalgia did occur with the addition of succinylcholine.²⁷ Thus, in patients where difficult placement is anticipated, the use of a low dose of succinylcholine to facilitate SGA insertion may be considered. Nevertheless, the use of propofol to blunt reflexes is sufficient for the majority of SGA insertions. Until there is sufficient evidence to demonstrate a clear benefit of NMBA use with SGAs, we cannot yet recommend this practice to our NARs. Thus, this step was not included in the SGA checklist.

Another point of controversy for SGAs is the degree of inflation of the mask prior to insertion. A recent randomized controlled, double-blind, clinical trial with the purpose of studying the incidence and severity of postoperative sore throat when using three different SGA insertion techniques concluded that there was no significant difference related to inflation.²⁸ The severity of sore throat between the three groups studied - LMA fully inflated, LMA semi-inflated, and LMA semi-inflated with added external laryngeal lift- were not statistically different. Given that there is not enough evidence to recommend one specific approach, the best instruction for use is to follow the manufacturer's recommendations for each SGA device.

Discussion

It is easy and somewhat expected for anesthesia providers to develop their own preferred way for managing the airway. However, as new data emerges and new devices come on the market, it is important for providers to stay up to date on best practices. One of the most efficient ways to stay current is using video-based learning. It is prevalent in the education of NARs and also in the ongoing education of licensed providers. The key is to find trusted and reliable sources of that information.

It was the purpose of this project to design and record evidence-based videos that

could be referenced by NARs and help shape their educational experience. These same learners will one day become teachers and have the opportunity to impact others with techniques that were reinforced by these videos.

Anesthesia providers are considered the experts in airway management in the medical community. The training for nurse anesthetists involves acquiring and mastering the skills to safely manage the patient's airway and respond to airway-related emergencies. The education received by these providers is key in determining their ability to effectively manage unpredictable airway-related complications that could be life-saving or detrimental to their patients' well-being. The goal of developing a series of evidence-based videos to model ideal airway management was to provide a bank of information that the learner could repeatedly come back to and review as much as needed during their learning experience. These videos have been made available to the public via YouTube, and the findings of this project were presented at the RFUMS Research Symposium in March 2021 and at the Assembly of Didactic and Clinical Educators in February of 2022. Finally, the videos created during this project have served as the basis for ongoing research related to learning in the simulated environment and how well they replace or augment the teaching by a faculty member.

Conclusion

Video based learning has been supported in the literature in other medical specialties⁴⁻⁸ and should be studied in the nurse anesthesia community. By offering additional methods of training, such as video demonstration, it is anticipated that students will show improvement in the

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video DNP*



safe performance of airway management skills. This will hopefully translate into safer practices in airway management and, therefore, enhanced patient safety.

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along with a protocol for total knee arthroplasty. And in what was the most technically astounding presentation, Emily Klinefelter, DNAP, CRNA, Meaghan O'Meara, MSN, CRNA, and Renee Pederson, DNP, CRNA, presented their work on anesthesia techniques for fetal surgery.

Sunday opened with Welsey Karcher, MSN, CRNA, discussing the usefulness of Ketamine in the treatment of depression and Shawn Collins, PhD, DNP, CRNA, FAANA, gave a wildly popular presentations on the importance of leading up and emotional intelligence in professional life.

David Clanton, MS, MBA, CRNA, presented a searing indictment of the inequalities in American healthcare system. Using historical evidence dating back to Jonestown to current data collected from the COVID-19 pandemic, he illustrated how past racial injustices impact healthcare to this day. His presentation was followed by Joseph Bogdan's, Pharm D., RPh, J.D., discussion of pharmaceutical law for the CRNA, which ended the session with a bit of, albeit dark at times, humor.

The fall conference provided CRNAs and SRNAs a much-needed opportunity to develop as professionals in an atmosphere of their peers. No one can know what SARS-CoV-2 will do in the future, but it was clear from the fall conference that a strength of our profession is our ability to come together during adversity. I look forward to seeing you all this year at IANA's Spring and Fall conferences. ■

Illinois Leadership Highlight

In this edition we would like to highlight the amazing leadership that is coming out of our nurse anesthesia programs in Illinois. Serving on any of these committees is a competitive process, and we applaud these students for throwing their hats in the ring and for having the qualifications and drive to be selected and serve. Thank you for sharing your stories. May this be the beginning of a lifetime of service to the profession.



**ALEX CORBITT,
RN, SRNA**
**Health and
Wellness
Committee,
Student
Representative
FY2021**

American Association of Nurse Anesthesiology

What inspired you to take on a role as a student leader?

To say the last few years have been challenging is undoubtedly an understatement. In the spring of 2020, the minds of so many SRNAs were focused on how to continue anesthesia training from home, how to participate in simulated learning activities, and how to be ready for clinical training. For others, as elective cases were canceled or clinical sites closed, their focus was how they were even going to graduate. The pandemic brought new challenges to students already at a stressful point in their lives. I desired to figure out how to improve the situation and promote the available resources. So, I applied and was selected along with two other SRNAs as student representatives to the Health and Wellness (H&W) Committee for the AANA.

What are some of your roles and responsibilities as a student member of an AANA committee?

I was tasked with providing a student

perspective to the committee, which creates and promotes programs on various wellness topics to serve CRNAs and SRNAs. I loved that the members of the H&W committee truly valued our input. Student representatives to AANA committees are active participants, serve as panelists at national meetings, and write for AANA publications. Last year we led and helped develop the SRNA Shared Experience, a virtual peer support session that aims to build camaraderie among SRNAs and helps us realize we are not alone. It was a great experience to serve our anesthesia colleagues, and I would absolutely recommend student involvement with the AANA!



**AVNI SURESH,
RN, SRNA**
**Professional
Development
Committee,
Student
Representative
FY2021**

American Association of Nurse Anesthesiology

Can you tell us about your experience as a student member on an AANA committee?

Serving as a student representative for the Professional Development (PD) Committee for the AANA has been a unique experience. From the first meeting, members of the PD committee genuinely valued my student perspective, and even though I am a novice to the profession, my input was considered. During my service, I have engaged in a wide range of activities, including designating the Annual Congress theme, ensuring high-quality continuing education experiences for CRNAs, providing input for SRNA-oriented conference sessions, and facilitating the smooth delivery of content at conferences.

What is the value you have found in serving as a student leader?

As a student, balancing school, clinical rotations, preparation for boards, and one's personal life is hard. Adding a leadership position to the mix can seem daunting; however, from my experience, I would say it is absolutely worth it. On a professional level, serving on the PD committee has provided me with a network of mentors, career development opportunities, a skillset for eliciting positive change, and a deeper understanding of our profession as a whole. On a personal level, the respect and value I was shown by my CRNA colleagues while serving as a student member has provided me with confidence for when I step into the role of CRNA and the insight that anyone can bring value in furthering our profession. For SRNAs with even the slightest interest, I highly recommend seeking out student leadership opportunities—whether locally in your program, regionally in your state's professional organizations, or on national committees—so you can experience these benefits for yourself.



**LAUREN G.
COGGINS,
RN, SRNA**
**Communications
Committee,
Student
Representative
FY2021**

American Association of Nurse Anesthesiology

Can you describe your journey leading to becoming a student leader?

My path has been anything but traditional, as I first worked in public relations, serving in various roles from reporter to corporate specialist. However, once I found my passion for nursing and, later, anesthesia, I desired the opportunity to bridge my experiences, an interest which arose after I learned about the rich history of nurse anesthesia practice. I particularly admired

the dedication and hard work of past CRNAs who advocated for the profession. Their commitment built the foundation for the profession that I am so grateful to join, and I wanted to contribute for future CRNAs. So, after reading more about the AANA, I applied for and was selected to serve as a student representative for the Communications Committee, which is responsible for promoting the profession and increasing membership engagement.

What is your role in the AANA Communications Committee?

Serving as a student representative has offered unique opportunities to network and learn from CRNA colleagues who have been incredibly welcoming and truly value student input, which has made my experience even more rewarding. As a student member, I've contributed to a variety of projects, from brainstorming and selecting the 2023 CRNA Week theme to tailoring content in the "Demystifying the Transition from SRNA to CRNA: An Interactive Q&A Session" for the Annual Congress. Unique to this year, the committee will be offering this favorite session in a virtual format beyond just the Annual Congress. In fact, the first session of the year will focus on wellness and take place on March 8, so I highly encourage all SRNAs to check out more details on the AANA website and join!



**PETER
OLAKOWSKI, RN,
SRNA**

**Board of
Directors,
Student
Representative
FY2021**

Council on Accreditation of Nurse Anesthesia Educational Programs

Can you tell us a bit about the Council on Accreditation?

The Council on Accreditation of Nurse Anesthesia Educational Programs (COA) is nationally recognized by the U.S. Department of Education (USDE) and the Council for Higher Education Accreditation (CHEA) as an accrediting agency for nurse anesthesia programs. The mission of the COA is to grant public recognition to nurse anesthesia programs that meet standards of academic quality. In addition, the COA assists programs to improve educational quality. The Board of Directors includes stakeholders of various areas interested in nurse anesthesia programs, including nurse anesthesia educators and practitioners, nurse anesthesia students, health care administrators, university representatives, and the public. Put more plainly, the COA creates standards and policies for nurse anesthesia programs, evaluates programs' ability to adhere to such standards, and subsequently awards accreditation to those programs. Accreditation represents a nurse anesthesia program's ability to maintain educational quality.

What have you gained from your experience as a student leader in your organization?

Serving on the Board of Directors made me feel like I was part of something bigger than myself, like I was doing something for the nurse anesthesia community and promoting its health. I had to understand my role amongst a diverse group. It was my job to represent the interests of SRNAs. This is the perspective I learned to have when interpreting information and providing feedback. I learned how to balance the interests of all stakeholders. Additionally, the connections and network I've built increased my reach within the nurse anesthesia community. ■

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other state any of the contents of a nationwide criminal history records check conducted for the purpose of multistate licensure under the Nurse Licensure Compact.

BILL STATUS – IN HOUSE HEALTH CARE LICENSES COMMITTEE

IANA POSITION – SUPPORT

SB3196 RADIATION-APRN-FLUOROSCOPY

Amends the Hospital Licensing Act. Provides that, notwithstanding any provision of the Act or the implementation of any rule of the Department of Public Health to the contrary, an advanced practice registered nurse licensed under the Nurse Practice Act practicing in a hospital, a hospital affiliate, or an ambulatory surgical treatment center may administer radiation to a human being through a fluoroscope pursuant to specified provisions of the Radiation Protection Act of 1990. Amends the Radiation Protection Act of 1990. Provides that an advanced practice registered nurse practicing in a hospital, a hospital affiliate, or an ambulatory surgical treatment center may intentionally administer radiation to a human being through a fluoroscope without acting under the supervision, prescription, or direction of specified licensed persons. Provides that provisions regarding accreditation of administrators of radiation do not apply to such advanced practiced registered nurses. Effective immediately.

BILL STATUS – IN SENATE LICENSED ACTIVITIES

IANA POSITION – SUPPORT ■

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Windy City Anesthesia is the Midwest leader in anesthesia services. We provide anesthesia coverage to physician's offices, surgery centers, and hospitals. Our dedication, hard work, and competitive rates allow us to excel in our service to you. Whether you are a patient, surgeon, a hospital/surgery center, administrator or a anesthesia provider, the employees of Windy City Anesthesia will work with you, for you.

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