Pennsylvania Association of Nurse Anesthetists

Proposed Anesthesiologist Assistants (AA) Legislation

April 5, 2022

Legislation (H.B. 1956) recently was introduced in the state General Assembly that would license anesthesiologist assistants (AAs) for the first time in Pennsylvania. This is bad public policy that will do nothing to enhance patient care or make health care more accessible, but instead will increase the cost of care and severely limit the practice of certified registered nurse anesthetists (CRNAs).

This is what we know about AA legislation and policies in other states:

- CRNAs are certified anesthesia experts independently licensed to practice in all 50 states and the District of Columbia. Because of their extensive education and training, CRNAs are permitted by federal and state legislation and regulations to provide every type of anesthesia service to patients without the involvement or presence of a physician anesthesiologist.

- CRNAs are the hands-on providers of anesthesia care, operating safely in every setting where anesthesia is administered, including: hospital operating and delivery rooms; ambulatory surgical centers; the offices of dentists, podiatrists, ophthalmologists, and plastic surgeons; pain management centers and more.

- In contrast, AAs are authorized to practice in only 14 states (Alabama, Colorado, Florida, Georgia, Indiana, Missouri, New Mexico, North Carolina, Ohio, Oklahoma, South Carolina, Utah, Vermont, and Wisconsin), plus the District of Columbia. They are limited by their training and licensure to providing clinical support to anesthesiologists and may not practice "apart from the supervision of an anesthesiologist," according to the American Academy of Anesthesiologist Assistants (AAAA). **In Louisiana, AAs actually are *prohibited* from practicing.**

- Because AAs are required to be directly supervised by an anesthesiologist, the provider redundancy of the AA/anesthesiologist team is one of the costliest anesthesia delivery models with no scientific evidence of increased patient safety.

- Furthermore, because AAs cannot practice without anesthesiologist supervision, AAs do not practice in rural areas where CRNAs working without anesthesiologist involvement are the primary providers of anesthesia care. AAs, in contrast, can only practice where anesthesiologists practice, which greatly limits their utilization. AAs, therefore, can't help solve problems of inadequate access to anesthesia care in rural and underserved communities.

- CRNAs remain the primary providers of anesthesia care in rural America, enabling health-care facilities in these medically underserved areas to offer obstetrical, surgical, pain management and trauma stabilization services. Without these advanced practice nurses, some 1,500 facilities would not be able to maintain these services, forcing many rural Americans to travel long distances for such services. In some states, CRNAs are the sole providers in nearly 100 percent of the rural hospitals. CRNAs are, in fact, far less costly for hospitals to employ, so rural hospitals are able to staff emergency services with

in-house CRNAs 24 hours a day, 7 days a week so that every Pennsylvania resident has access to these needed services.

- The quality of care that AAs provide is unproven, as there is no meaningful research data concerning AA anesthesia safety. In contrast, all peer-reviewed research studies on anesthesia safety and cost-effectiveness conducted in the last 20 years confirm that CRNAs provide the safest, most cost-effective anesthesia care to patients.

- AAs are not required to have any prior health-care education or experience (e.g., nursing, medical, anesthesia or health-care education, licensure, or certification) before they begin their AA educational programs. CRNAs, in contrast, must have a bachelor's degree, be a registered nurse, and have at least one year of acute care nursing experience prior to entering nurse anesthesia educational programs. CRNAs, unlike AAs, learn to assess and treat a broad range of health problems before even beginning anesthesia training.

- Proponents of the measure try to equate AAs to physician assistants as a way to expand care. That's simply untrue. AAs can only function one way as an assistant, and they are required to work under the direct supervision of an anesthesiologist. There is no expansion of care access, just a larger care team. Physician assistants can work without direct supervision.

- Proponents also claim there is a shortage of anesthesia providers in Pennsylvania. That's simply untrue as well --- and there are no data to support the claims. The reality is that CRNAs --- not physician anesthesiologists --- already fill critical roles in medically underserved areas across Pennsylvania to ensure access to care. If a shortage existed, the answer is more CRNAs, allowing these professionals to practice to the fullest extent of their education and training, and no AAs who are tied to anesthesiologists.

- Due to federal Centers for Medicare and Medicaid Services regulatory rules for payment with AAs, there is an incredibly high risk of fraud related to how medical direction is managed and billed, which puts facilities and anesthesia groups at risk. To remedy this, anesthesia groups are migrating toward models that allow CRNAs to practice more autonomously.

- With 13 nurse anesthetist programs, Pennsylvania ranks among the top draws nationally for CRNA students. Retention of these advanced professionals should be a priority. Moreover, because AAs cannot train where CRNAs do, this legislation puts at risk the state's national reputation for education and training in high-value, high-quality, advanced health-care sectors, ultimately limiting the practice of an anesthesia provider who can expand access to health care *and* drive down costs.

Anesthesiologist assistants DO NOT improve patient safety or enhance care. Anesthesiologist assistants DO NOT reduce health-care costs, but instead contribute to costlier care models. Anesthesiologist assistants DO NOT improve access to anesthesia services or address critical care shortages in underserved areas.