



Pennsylvania Association of Nurse Anesthetists

Proposed Certified Anesthesiologist Assistants (CAA) Legislation

Last session, bills were introduced in the House and Senate to license certified anesthesiologist assistants (CAAs) for the first time in Pennsylvania. Neither passed, but legislation is being considered again this session, although nothing has been introduced to date. Let's be clear: 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 CAA 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, CAAs 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, CAAs actually are *prohibited from practicing*.**
- Because CAAs are required to be directly supervised by an anesthesiologist, the provider redundancy of the CAA/anesthesiologist team is one of the costliest anesthesia delivery models with no scientific evidence of increased patient safety.
- Furthermore, because CAAs cannot practice without anesthesiologist supervision, CAAs do not practice in rural areas where CRNAs working without anesthesiologist involvement are the primary providers of anesthesia care. CAAs, in contrast, can only practice where anesthesiologists practice, which greatly limits their utilization. CAAs, therefore, can't help to 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 rural hospitals. CRNAs are, in fact, far less costly for hospitals to employ, so rural hospitals can 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. What's more, there are 646 rural hospitals at risk of closure due to financial issues, comprising around 30 percent of all rural hospitals in the U.S., [according to the Center for Healthcare Quality & Payment Reform](#).
- The quality of care that CAAs provide is unproven, as there is no meaningful research data concerning CAA 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.
- CAAs 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 CAA 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 CAAs, learn to assess and treat a broad range of health problems before even beginning anesthesia training.
- Proponents of the measure try to equate CAAs to physician assistants as a way to expand care. That's simply untrue. CAAs 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.
- While there is a health-care provider crisis in Pennsylvania and nationally, what is happening here with respect to anesthesia providers is artificial because of unnecessary restrictions that limit how CRNAs can practice. The reality is that CRNAs --- not physician anesthesiologists --- already fill critical roles in medically underserved areas across Pennsylvania to ensure access to care. We don't need CAAs. We simply need to remove barriers to that limit the practice of CRNAs already in the field in Pennsylvania.
- Due to federal Centers for Medicare and Medicaid Services regulatory rules for payment with CAAs, 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 14 nurse anesthetist programs, Pennsylvania ranks among the top draws nationally for nurse anesthesia residents (NARs). **In fact, 2,400 NARs graduate each year nationwide, and roughly 340 of them, or about 15%, graduate from one of Pennsylvania's 14 nurse anesthesia programs.** Retention of these advanced professionals should be a priority. Moreover, because CAAs 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.