Talking Points: Anesthesiologist Assistants and CRNAs

Summary: CRNAs are far better qualified to provide quality anesthesia services than AAs. CRNAs are better prepared, have a superior breadth of healthcare education and clinical experience, and can be utilized more flexibly. There is no comparison between CRNAs and AAs in terms of education, experience, history, ability to work without anesthesiologist direction, recognition by surgeons, and presence as the predominant anesthesia provider in the military.

	CRNA	AA
Quality of Care	Repeated peer-reviewed studies in prominent journals[1] have demonstrated the excellent, safe anesthesia care that CRNAs provide.	No peer-reviewed studies in scientific journals have been published regarding the quality of care of AA practice or AA anesthesia outcomes.[2] The quality of care that AAs provide is unproven.
Education	Currently MSN; in 2025 will require doctorate for entry into practice. Must have at least one year of acute care nursing experience as an RN 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.	MSN. GRE or MCAT for entry depending on school. No prior healthcare education or experience (e.g., nursing, medical, anesthesia or healthcare education, licensure, or certification)
Starting Salary	$130,000	$120,000+ except in VA Healthcare where they are GS-9 entry level. (2013)
Practice Scope	CRNAs are qualified to make independent judgments regarding all aspects of anesthesia care, based on their education, licensure, and certification. Nurse anesthesia educational programs graduate nurse anesthetists prepared for autonomous practice.	AA program curriculum is characterized by training that only allows them to assist anesthesiologists in technical functions.
Regional Anesthesia	Yes	No Ohio: AAs can do regional anesthesia since 2007.

[1] *See* http://www.aana.com/resources2/professionalpractice/Pages/Professional-Practice-Manual.aspx > Quality of Care in Anesthesia. *See also* the AANA White Paper titled, "Quality of Nurse Anesthesia Practice," at http://www.aana.com/aboutus/Pages/Resources,-About-AANA.aspx.

[2] A 2007 Kentucky legislative commission report stated: "No studies have been published in peer-reviewed journals assessing the impact of anesthesiologist assistants on patient safety … Overall, the lack of data limits the conclusions that can be made about patient safety outcomes for anesthesiologist assistants." Nothing has changed since 2007 to alter the Kentucky commission's conclusion. *See* http://www.lrc.ky.gov/lrcpubs/RR337.pdf. *A Study of Anesthesiologist Assistants*. Research Report No. 337, Kentucky Legislative Research Commission. February 2007. Pages 11-12.

Practice Location	CRNAs practice in every setting in which anesthesia is delivered: traditional hospital surgical suites and obstetrical delivery rooms; critical access hospitals; ambulatory surgical centers; the offices of dentists, podiatrists, plastic surgeons, ophthalmologists, and other medical professionals; and U.S. Military, Public Health Service, and Veterans Administration healthcare facilities. CRNAs can provide anesthesia care anywhere it is needed, whether urban, rural or suburban.	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.
Cost Effectiveness	More cost effective: do not need to practice with an anesthesiologist.	AA practice requires two providers to provide care to one patient.
National Authority to Practice	Recognized in all 50 states and District of Columbia	Explicitly recognized in state laws or regulations in only 15 states and the District of Columbia. Louisiana passed legislation limiting anesthesia practice to MDAs and CRNAs in the state.
CMS Conditions of Participation	CRNAs work under only *physician* supervision, and *without* physician supervision in states that have opted out of the CMS physician supervision requirement. (16 states)	Require AAs to work under *anesthesiologist* supervision.
Military Practice	CRNAs are the predominant anesthesia provider in the armed forces and the Veterans Affairs healthcare system.	AAs are not authorized to work as anesthesia providers in the armed forces, and reportedly no Veterans Affairs facilities have hired AAs.
Market	CRNAs directly compete with anesthesiologists, which controls costs and protects patient access to care, particularly in rural areas. There is no anesthesia provider shortage in Washington State. There are more than 7 applicants for every CRNA job opening.[3] Further, restrictive state law provisions can contribute to the shortage of anesthesia providers. It makes no sense to authorize AAs, a less qualified anesthesia provider that can only work with anesthesiologists and can't be used in any area where anesthesiologists don't practice, such as many rural locations.	Anesthesiologists control education, accreditation, certification, clinical practice, payment and employment of AAs. Their increased use sets the stage for anesthesiologist control of the marketplace.

[3] Personal communication with state CRNAs.

Licensure	Licensed in all 50 states. Board certified through the National Board of Certification and Recertification of Nurse Anesthetists (NBCRNA).	Licensure through the National Commission for Certification of Anesthesiologist Assistants (NCCAA). The certification is good for six years.
Recertification	Recertification required every 2 years. Beginning in 2016 recertification will be every 4 years. A certification exam will be required every 8 years (every other four year cycle). Recertification examination required every 8 years beginning in 2032.	Retesting required every 6 years.
Practice Numbers	44,000	700-1,000 (2011)

Information obtained from AANA website, AANA Executive Summary, http://www.aana.com/myaana/Advocacy/stategovtaffairs/stateassociationresources/Documents/SGA Documents/1 Overview Exec Summary AA Tool Kit.docx