CRNA VS. AA

Certified Registered Nurse Anesthetists	Anesthesiologist **ASSISTANTS**
AUTONOMOUS, safe, cost-effective—ensure access to care	**DEPENDENT**, costly—do not improve access to care
CRNAs are educated to be an **AUTONOMOUS** anesthesia provider and are qualified to make **INDEPENDENT** judgements regarding all aspects of anesthesia care. CRNAs and anesthesiologists can work **INDEPENDENT** of one another or together.	AAs are trained to be an **ASSISTANT, DEPENDENT** practitioner and cannot work autonomously; they can only work under the direct supervision of an anesthesiologist[1].
The most cost-effective anesthesia delivery model is a CRNA working **AUTONOMOUSLY**. A CRNA working **AUTONOMOUSLY** can provide the care that requires two providers when the anesthesiologist-AA model is used.	AAs are **DEPENDENT** practitioners that must work with a supervising anesthesiologist; therefore, it takes two providers to provide anesthesia care to one patient, which is not a cost-effective model of care.
CRNAs work in urban and rural areas, and across all types of practice settings. CRNAs working without anesthesiologist involvement are the primary providers of anesthesia care in rural areas.	AAs are **DEPENDENT** practitioners who cannot expand access to care. AAs cannot help solve problems of inadequate access to anesthesia care in rural and underserved communities.
CRNAs are **AUTONOMOUS** within a patient care team regardless of the composition of that team. CRNAs provide high quality anesthesia care with or without physician oversight.	AAs are **DEPENDENT** practitioners who are not trained to make autonomous decisions when there are lapses in supervision[2].
CRNAs provide quality care with or without physician oversight. When working in the anesthesia care team, if there is no supervision, the facility simply bills exclusive of the anesthesiologist for the procedure (QZ vs. medical direction).	AAs are **DEPENDENT** practitioners that create an environment for Medicare fraud. AAs cannot provide care without direct supervision, leading to possible unauthorized independent practice.
CRNAs are educated and trained to work with or without physician involvement and are capable of high-level **AUTONOMOUS** function and judgement.	AAs are **DEPENDENT** providers who can only take delegated orders from an anesthesiologist.
Applicants for nurse anesthesia programs have acquired extensive clinical experience in a variety of areas such as coronary, respiratory, postanesthesia, and surgical intensive care units before they begin their nurse anesthesia programs.	AA programs do not require any nursing, medical, anesthesia or healthcare education, experience, licensure, or certification for admission into an AA program.
CRNAs receive 7-8 ½ years of formal education and preparation, from commencement of the professional education in nursing to graduation from nurse anesthesia school. During the course of their education, CRNAs will typically have acquired, on average, 8,636 hours of clinical patient care experience.	Clinical hours for AA programs include experiences such as learning to do physicals, taking patient histories, training and certification processes for life support training, and other learning experiences that a licensed professional RN has already mastered prior to nurse anesthesia program entry. During their AA program, AAs students average 2,600 hours of clinical anesthesia education.

1 As used in this document, "supervision" also refers to "medical direction" under TEFRA (Tax Equity and Fiscal Responsibility Act of 1982).

2 "Lapse in supervision" is the inability of a supervising anesthesiologist in an anesthesia care team to be physically present at "bedside" during required (most important) aspects of a case as specified under TEFRA.

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