AANA
American Association of
NURSE ANESTHESIOLOGY

August 26, 2022

Nebraska Department of Health and Human Services
Licensure Unit
Attn: Technical Review Committee
PO Box 95026
Lincoln NE 68509-5026

Attn: Technical Review Committee, Board of Health, and Dr. Anthone

The American Association of Nurse Anesthesiology (AANA), which represents more than 59,000 nurse anesthetists (including Certified Registered Nurse Anesthetists (CRNAs) and student nurse anesthetists) nationwide, submits the following comments **in opposition of the credentialing application to license anesthesiologist assistants (AAs) in Nebraska**. We respectfully request that the Department of Health and Human Services reject this application given that AAs are an unproven provider that will not improve access to anesthesia services for the citizens of Nebraska, and the AA-anesthesiologist model is the costliest model of anesthesia care.

CRNAs and anesthesiologists have a long-proven history of successful services to the healthcare community and efforts should be focused toward promoting these providers. CRNAs and anesthesiologists have both been providing anesthesia for more than 150 years. Both of these highly trained, educated and clinically experienced providers are proven and known entities

AAs are an Inflexible Provider Who Are Not Interchangeable with CRNAs

Unfortunately, the same cannot be said about AAs. These assistants have a limited history, and their numbers are too small to track safety or efficacy. AAs remain in unproven provider.

AAs are fond of suggesting that CRNAs and AA are interchangeable; **however, CRNAs and AAs are NOT interchangeable.**

CRNAs are educated to be independent providers, and multiple studies show they are safe providers of anesthesia care.[1] CRNAs are highly educated advanced practice registered nurses, receiving a minimum of 7 to 8 ½ years of education and training specific to nursing and anesthesiology before they are licensed to practice anesthesia.[2] CRNAs have strong healthcare backgrounds with critical care experience, taking care of the sickest and most critical patients. CRNAs are a flexible provider, available to work in all healthcare settings as the sole anesthesia provider. During the current COVID-19 pandemic, that flexibility has allowed CRNAs to lead COVID units and provide care to the most critically ill COVID patients.

[1] https://www.anesthesiafacts.com/the-research/
[2] https://www.anesthesiafacts.com/wp-content/uploads/2020/12/2020_SGA06_Ed_Training_Form1.pdf

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In contrast, AAs are not required to have any healthcare background prior starting their AA program, and AA programs are approximately 24-27 months total. [3] AA training and education is not equivalent to that of a CRNA; in fact, there is a program that allows AAs to transition into CRNAs during an additional 29-36 months of education.[4] The intent of this program is to provide an AA with the training and education needed for them to become a CRNA who can practice as an independent anesthesia provider.

The Centers for Medicare and Medicaid Services ("CMS") has long recognized that CRNAs and AAs are not interchangeable anesthesia providers.[5] CMS has clarified the distinctions between CRNAs, who may practice as the sole anesthesia provider, and AAs, whose must be medically directed by an anesthesiologist in order to bill Medicare.[6]

AAs must be supervised in all aspects of anesthesia. Assistants are trained, as their title would suggest, to assist the anesthesiologist. If for any reason an AA's supervising anesthesiologist is not available, off-site, on vacation, or simply home for the day, the AA may not provide anesthesia care.

AAs Do Not Create Access to Care

AAs simply do not have a broad foundation to fall back on when patient conditions become critical. When life and death decisions are required, the operating surgeon will be forced to step in until the anesthesiologist, who is caring for 3 other patients, becomes available. This situation very likely will not be good for the patient, the surgeon, or the facility.

The AA-anesthesiologist-driven model of practice, therefore, is inflexible and fails to adequately meet the needs of patients, hospitals, ambulatory surgical centers, or other healthcare settings. Further, it is the costliest anesthesia model. AAs are not the answer to any real or perceived anesthesia provider shortage. They cannot cure the serious health care access issues that exist in rural areas, whereas CRNAs, who do not require anesthesiologist supervision, can.

Difficult to Track AA Safety Data

AAs have not been proven to be safe. AAs must work under the direct supervision of an anesthesiologist, and it is not clear how complaints against AAs are tracked, particularly if the anesthesiologist is responsible for the AA's actions. For example, in the National Practitioner Data Bank (NPDB)[7], AAs do not have a dedicated licensure category. According to the NPDB, AAs may appear in "other" categories in which multiple unclassified practitioners are lumped together. This exemplifies the challenges of tracking AA adverse events and malpractice payments.

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[3] https://dhhs.ne.gov/licensure/Credentialing%20Review%20Docs/CRAALetterOfIntent.pdf

[4] https://harriscollege.tcu.edu/nurse-anesthesia/academics/aa-c-bridge-to-dnap/. Texas Christian University offers a "bridge" program which allows a certified AA to complete the didactic and clinical education to become a CRNA.

[5] CMS has clarified and confirmed that AAs are prohibited from billing Medicare for non-medically directed services (billing code QZ). This is in contrast to CRNAs, who are authorized to bill Medicare directly for non-medically directed services. This action confirms what we already know: CRNA and AA educational preparation and services are not the same, and Medicare recognizes them differently.

[6] See CMS Policy Transmittal #2716 dated May 30, 2013, available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2716CP.pdf.

[7] https://www.npdb.hrsa.gov/topNavigation/aboutUs.jsp. The NPDB is a repository of information on medical malpractice payments and adverse actions related to health care practitioners. This database prevents practitioners from moving state to state without disclosure or discovery of previous damaging performance.

Safety of AAs is Unproven

AAs are an unproven provider because they do not have a track-record of safety. In contrast, there is overwhelming evidence that CRNAs provide extremely safe, cost-effective anesthesia care. [8]The cost-effectiveness directly relates to access to anesthesia care for patients. CRNAs have been, since their inception, professionals who are acknowledged by the surgeons with whom they practice as being experts regarding anesthesia.

AAs have a limited history as a provider, and their numbers are too small to track safety or efficacy. AA proponents cite a 2018 study to conclude that AAs are safe ("Sun Study"); however, the population studied was highly restricted (older adults in non-opt-out states in higher volume hospitals and procedure types) limiting the study's generalizability. Also, the sample size fell short of the sample size needed to measure differences in quality by provider type, especially for AA cases (representing only 5% of the sample cases).[9] Further, the outcomes analyzed in the Sun Study were not anesthesia specific, and the mortality rate for AA cases was based on overall inpatient surgical cases and not necessarily related to anesthesia-related complications.

Relying on the Sun Study to support the safety of AAs is faulty. The Sun Study reviewed cases between 2004 and 2011, and only in non-opt out states. The number of AAs practicing during this period was significantly lower than it is today because there were fewer states that recognized AAs and fewer AA programs. In addition, any AAs practicing in opt-out states were excluded.

AAs are limited by their training and licensure to providing clinical support to anesthesiologists and may not practice without direct anesthesiologist supervision. It is virtually impossible to assess the quality and safety of AAs because they cannot work apart from anesthesiologists. AAs are not required to have any prior healthcare education or experience before they begin their AA educational programs, and unlike CRNAs, AAs have not learned to assess and treat a broad range of health problems before beginning anesthesia training. All of these factors contribute to the safety of a provider, and AAs do not measure up against the proven safety of CRNAs.

Conclusion

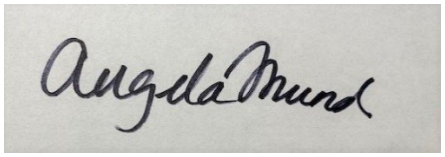
Nebraska should focus on growing the anesthesia providers already providing safe, high-quality anesthesia care in the state rather than introducing an unproven provider. Without evidence that AAs are safe and can provide access to care for Nebraska patients, AA licensure should be rejected.

Please do not hesitate to contact Sarah Chacko, JD, Director of State Government Affairs at schacko@aana.com if you have any questions or require further information.

[8] https://www.anesthesiafacts.com/the-research/

[9] Eric C. Sun et. al, "Anesthesia Care Team Composition and Surgical Outcomes." Anesthesiology 2018. "Non-opt out" states refer to the states that have not "opted-out" of the Medicare Part A supervision requirements for CRNAs.

Sincerely,



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