

Answering Today's Need for High-Quality Anesthesia Care at a Lower Cost

Remaining states need to consider opting out of physician supervision for CRNAs

By Juan Quintana, DNP, MHS, CRNA, President of the [American Association of Nurse Anesthetists](#) (AANA)

© 2016, American Association of Nurse Anesthetists

Introduction

The United States has built an elaborate and expensive healthcare system. The Affordable Care Act (ACA) is reshaping the system, including health insurance coverage expansions, provider payments, quality and technology reforms and important changes to Medicare and Medicaid programs.

Debate over whether the ACA will improve the system will continue for many years. One thing is clear – given the addition of an [estimated 30 million](#) previously uninsured people to the healthcare system, hospital administrators, policymakers and healthcare providers must find ways to improve patient access to safe, quality care without further burdening the healthcare system.

Advanced practice registered nurses (APRNs) such as Certified Registered Nurse Anesthetists (CRNAs) are meeting this challenge. CRNAs align with the needs of today's healthcare system because they deliver the same safe, high-quality anesthesia care as other anesthesia professionals but at a lower cost, helping to control rising healthcare costs.

The role of CRNAs

Nurse anesthetists, the first healthcare providers dedicated to the specialty of anesthesia, have [roots in the 1800s](#), when nurses provided wounded soldiers with anesthesia on the battlefields of the Civil War. Today, CRNAs are master's-prepared APRNs who provide anesthetics to patients in every practice setting and for every procedure that requires anesthesia care.

Each year, the nation's 49,000+ nurse anesthetists deliver approximately [40 million anesthetics](#) to patients. The patient and patient care team count on CRNAs to fulfill many roles and responsibilities that contribute to excellent patient care outcomes.

CRNAs collaborate with all members of the patient care team to ensure patient safety and comfort. They are responsible for the patient's safety before, during and after anesthesia and stay with the patient for the entire procedure. CRNAs are uniquely prepared to care for patients suffering from acute and/or chronic pain and are educated, trained and experienced in managing emergency situations.

Supervision requirements

To date, [17 states](#) have opted out of the federal physician supervision requirement for CRNAs, taking advantage of a rule implemented in 2001 by the Centers for Medicare & Medicaid Services (CMS) that allows state governors to opt out of this requirement. The opt-out states allow CRNAs to practice to the full scope of their education and training without the supervision of a physician for practice or reimbursement.*

Even though many other states' laws do not require CRNAs to be supervised by physicians, the governors of those states have yet to opt out of the federal supervision requirement. Forty states and the District of Columbia have no supervision requirements concerning nurse anesthetists in nurse

practice acts, board of nursing rules/regulations, medical practice acts, board of medicine rules/regulations or their generic equivalents. Additionally, 33 of those states have no requirements concerning hospital licensing statutes, hospital licensing rules/regulations or their generic equivalents.

As a new healthcare environment takes shape under the ACA, now is a good time for governors and policymakers in those states to take another look at their positions on this matter.

Cost effectiveness and access

CRNAs are the most cost-effective anesthesia providers. A landmark [study](#) titled “Cost Effectiveness Analysis of Anesthesia Providers,” conducted by the Lewin Group and published in the May/June 2010 *Nursing Economic\$*, shows the most cost-effective anesthesia delivery model as a CRNA working as the sole anesthesia provider.

The mean annual salary for an anesthesiologist is approximately two-and-one-half times greater than a CRNA’s. Additionally, Medicare pays the same fee for an anesthesia service whether it is provided by a CRNA, an anesthesiologist or both working together. The higher anesthesiologist compensation is shouldered by the hospital, healthcare facility or the patient.

Cost effectiveness directly relates to access for patients. In addition to delivering essential healthcare in thousands of medically underserved communities, CRNAs are the [main providers](#) of anesthesia care for women in labor and for the men and women serving in the U.S. Armed Forces, especially on frontlines around the globe. They also serve as the backbone of anesthesia care in rural and other medically underserved areas of the United States. A recent [study](#) published in the September/October 2015 *Nursing Economic\$* found that CRNAs are providing the majority of anesthesia care in U.S. counties with lower-income populations and populations that are more likely to be uninsured or unemployed. They are also more likely found in states with less-restrictive practice regulations where more rural counties exist.

[Brian Bradley](#), CRNA of Bozeman, Mont., has been a practicing CRNA for 22 years and specializes in pain management. He provides pain relief for between 1,500 and 2,000 patients each year and is employed by two rural hospitals. Without him, his patients would have to travel 90 minutes to get to the nearest pain management services, rather than just a few minutes.

“Being able to practice to the full extent of my capabilities has allowed me to make an impact on the quality of my patients’ lives,” he said. “For example, there was a 10-year-old boy who was electrocuted and lost both of his arms. For his prosthetic arms to work correctly, he had to wear a wrap that went around his neck and rested where his arms would have normally been. After years of wearing the wrap, it caused a disc herniation in his neck. I treated him with cervical epidurals and eventually the condition of his neck reached a point where he was able to begin wearing the wrap again and using his prosthetic arms. If I did not work in this area of Montana, this young boy and his parents would have had to continuously travel two hours to receive these services instead of 10 minutes to the local hospital where I worked. Today, the boy is a man in his 30s with impeccable handwriting, married with children and employed.”

CRNA safety recognized and proven

The Institute of Medicine (IOM) [“Future of Nursing Report”](#) from 2010 strongly endorsed expanding the role of nurses in the U.S. healthcare system to meet the growing demand for medical services. The IOM

report urged policymakers to remove barriers that hinder nurses – particularly advanced practice registered nurses such as CRNAs – from practicing to the full extent of their education and training.

[Research](#) from “No Harm Found When Nurse Anesthetists Work without Supervision by Physicians,” conducted by the Research Triangle Institute (RTI) and published in the August 2010 issue of *Health Affairs*, the nation’s leading health policy journal, examined 500,000 individual cases in 14 states that had opted out of the Medicare physician supervision requirement for CRNAs. RTI found no difference in anesthesia safety when patients receive anesthesia care from a CRNA working alone, an anesthesiologist working alone or the two providers working together.

A CRNA-based anesthesia model is supported from a risk management perspective because, like physicians, CRNAs are responsible for securing their own liability coverage. The same legal principles that govern the liability of surgeons working with nurse anesthetists apply to surgeons working with anesthesiologists. Additionally, case law supports that surgeons are no more liable when working with a CRNA than with an anesthesiologist.

Today, CRNA professional liability premiums are [33 percent lower](#) than 25 years ago (62 percent lower when adjusted for inflation), proving that care delivered by CRNAs is extremely safe.

Education and safety

CRNAs have an average of [three-and-one-half years](#)’ critical care experience before entering a nurse anesthesia educational program. The requirements for acceptance to nurse anesthesia school are rigorous and the competition is tough. Although most applicants have much more experience than required when applying to nurse anesthesia school, the [minimum requirements](#) to submit an application include having a bachelor’s degree in nursing (or other appropriate baccalaureate degree), Registered Nurse licensure and a minimum of one year of critical care experience (surgical or medical intensive care units).

The length of nurse anesthesia educational programs varies from [24-36 months](#) and all APRNs who hold the CRNA credential graduate with a minimum of a master’s degree from an accredited nurse anesthesia educational program and pass the National Certification Examination following graduation.

To be recertified, CRNAs must obtain a [minimum of 40 hours of approved continuing education](#) every two years, document substantial anesthesia practice, maintain current state licensure and certify that they have not developed any conditions that could adversely affect their ability to practice anesthesia.

Nationally, the master’s requirement will change to [doctoral preparation](#) by 2025. Numerous nurse anesthesia programs have already transitioned to a doctorate curriculum, and others are in the process of converting.

Conclusion

The healthcare landscape in the United States is changing, and professionals whose services result in cost-effective, high-quality, safe outcomes will be needed more than ever. CRNAs play a critical role in meeting that challenge by providing safe, quality anesthesia care at a cost that ensures access to anesthesia for millions of Americans. Facility administrators need to look to CRNAs as a solution to their anesthesia staffing needs, and states that have not opted out of the CMS physician supervision requirement should reconsider their stance.

*CMS does not require CRNAs to be supervised by physician anesthesiologists, regardless of the opt-out rule.

About the author

Juan Quintana, CRNA, DNP, MHS, is President of the American Association of Nurse Anesthetists (AANA), the professional association representing more than 49,000 Certified Registered Nurse Anesthetists (CRNAs) and student registered nurse anesthetists nationwide. For more information, visit www.aana.com or www.future-of-anesthesia-care-today.com, or call the AANA at (847) 692-7050.

Published online by *Becker's Hospital Review* January 20, 2016