

Will **NOT** Solve the Anesthesia Workforce Problem in Virginia

SB 882 and HB 1647 would direct the Board of Medicine to establish criteria for licensing a brand-new category of anesthesia provider called “anesthesia assistant,” also known as Certified Anesthesiologist Assistants (CAAs).

CAAs must be directly supervised by a physician anesthesiologist, making CAAs one of the costliest anesthesia providers with no scientific evidence of increased patient safety.

In a 2017 report, the Virginia Department of Health Professions found that CAAs reduce the number of clinical rotations available for anesthesia care providers and recommended against licensing CAAs in Virginia. Licensing CAAs will have an immediate negative impact, reducing the already limited training clinical rotation opportunities for Virginia's 400 CRNA students across the state.

In 2024, the Joint Commission on Health Care report recommended studying the impact of bringing CAAs to Virginia before considering immediately licensing them.

CAAs are one of the costliest anesthesia providers with no scientific evidence of increased patient safety.

With a CAA, the need exists to educate and use two providers – the supervising physician anesthesiologist and the CAA – to provide anesthesia care to a single patient. According to the American Academy of Anesthesiologist Assistants (AAAA), CAAs are limited by their training and licensure to provide clinical support to anesthesiologists and may not practice “apart from the supervision of an anesthesiologist.” **Because CAAs must be directly supervised by an anesthesiologist, the CAA/physician anesthesiologist team is one of the costliest anesthesia delivery models, and there is no scientific evidence of increased patient safety.**

CAAs will not address the workforce shortage for anesthesia services in Virginia.

CAAs have a limited ability to meet patient anesthesia needs. **There are approximately 3,500 CAAs in the U.S. versus over 65,000 Certified Registered Nurse Anesthetists (CRNAs).** The fact that CAAs have not proliferated despite being in existence for approximately 60 years is evidence of their limited value. An estimated 3,000 new CRNAs enter the workforce annually, compared with about 300 new CAA graduates. Virginia has three CRNA training programs at Mary Baldwin University, Old Dominion University, and Virginia Commonwealth University, while there are no CAA training programs in Virginia. The number of new CRNAs entering the workforce yearly is about the same as the number of CAAs practicing nationwide. **Given the cost-effectiveness of utilizing CRNAs on the anesthesia care team, expanding CRNA opportunities in Virginia makes more sense before licensing less experienced and more expensive CAAs.**

CAAs hinder opportunities for expanding anesthesia care services.

Given that CAAs can only practice under the supervision of a physician anesthesiologist due to their limited education and training, their geographical reach is restricted to facilities where physician anesthesiologists practice. The vast majority of Virginia's nearly 1,200 physician anesthesiologists practice in high population areas, leaving rural communities underserved. **ODU and VCU Nurse Anesthesia Program Directors state licensing CAAs will have an immediate negative impact affecting the clinical rotation spots available to train CRNAs.**

It is virtually impossible to assess the quality and safety of CAAs.

CAAs are limited by their training and licensure to provide clinical support to physician anesthesiologists and may not practice without direct physician anesthesiologist supervision. Because of this, it is nearly impossible to assess the quality and safety of CAAs because they cannot work apart from physician anesthesiologists. CAAs are not required to have any prior healthcare education or experience before they begin their CAA educational programs. Unlike CRNAs, CAAs have not learned to assess and treat a broad range of health problems before beginning anesthesia training. All these factors contribute to an anesthesia provider's safety, and **CAAs do not measure up against the proven safety of CRNAs.**



A 2024 Joint Commission on Health Care report found that CRNAs, like physician anesthesiologists, are capable of performing similar preoperative, intraoperative, and postoperative responsibilities. However, CAAs do not have these capabilities.



CAA VS. CRNA

Certified Anesthesiologist ASSISTANTS

DEPENDENT

costly—do not improve access to care

AAs are trained to be an **ASSISTANT, DEPENDENT** practitioner and cannot work autonomously; they can only work under the direct supervision of an anesthesiologist¹.

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.

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.

AAs are **DEPENDENT** practitioners who are not trained to make autonomous decisions when there are lapses in supervision².

AAs are **DEPENDENT** practitioners that create an environment for Medicare fraud. AAs cannot provide care without direct supervision, leading to possible unauthorized independent practice.

AAs are **DEPENDENT** providers who can only take delegated orders from an anesthesiologist.

AA programs do not require any nursing, medical, anesthesia or healthcare education, experience, licensure, or certification for admission into an AA program.

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 2,000 hours of clinical anesthesia education.

Certified Registered Nurse Anesthetists

AUTONOMOUS

safe, cost-effective—ensure 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.

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.

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.

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.

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).

CRNAs are educated and trained to work with or without physician involvement and are capable of high-level **AUTONOMOUS** function and judgement.

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.

CRNAs receive 7-8 1/2 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, 9,369 hours of clinical patient care experience.

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.

Learn more about Virginia's 2,300 CRNAs
at VirginiaCRNA.org.