AANA | GET THE FACTS

Access to care.

CRNAs are critical to the provision of rural surgical and obstetric care and to the sustainability of rural hospitals.

- **County-level analysis** of the availability of CRNAs and Anesthesiologists demonstrate greater availability of CRNAs in counties with more vulnerable populations including uninsured, Medicaid eligible, and unemployed.[1]
- **CRNAs represent more than 80%** of the anesthesia providers in rural counties. There are also more CRNAs per population in less restrictive and opt-out states.[2]
- **50 percent of rural hospitals** use a CRNA-only model for obstetric care.[3]
- **CRNA delivery models** predominate in rural areas: 61% in ASCs, 55% in small hospitals, and 35% large hospitals.[4]
- **Surgical volume is directly associated** with the financial viability of rural hospitals.[5]
- **Rural hospitals are essential to the local economy** in many rural communities. Many of these are Critical Access Hospitals (CAH) which are often reliant on independently practicing CRNAs for anesthesia care.
- **Surgical outcomes** including mortality and serious complications in CAH are better than or similar to outcomes in non-CAHs and have lower costs.[6]
- **CRNAs can also safely deliver pain management care** in areas where there are no physician providers available saving patients long drives of 75 miles or more.[7]

Opt-out allows expanded options to hospitals, ambulatory surgical centers, and other providers in delivery of anesthesia.

- **According to the regulation,** the intent was to "provide hospitals, CAHs, and ASCs, with more flexibility in how they provide quality anesthesia services, and encourage implementation of the best practice protocols."[8]
- **Hospital administrators are often confused** about the complexities of anesthesia supervision and reimbursement policy and take great care to establish facility regulations that ensure compliance with these laws.[9]

CRNAs report less restrictive SOP in opt-out states and when practicing in rural areas.[10]

- **This is necessary due to the lack of anesthesiologists** available to supervise in many areas – 81% of counties have no anesthesiologist, 55% of counties have no surgeon, and only 58% have no CRNA.[4]
- **There is a weaker relationship between CRNA and anesthesiologist availability** in less restrictive and opt-out settings due to the potential for greater substitution.[2] The current shortage of anesthesia providers may be partially alleviated with less restrictive supervision policies that make more efficient use of the available anesthesia workforce.
- **Anesthesia services are not reported as a current limitation** to care delivery in rural areas because CRNAs have strong, diverse skills sets and many hospitals already allow a high level of CRNA autonomy.[11]

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Access to care.

ASA research on opt-out and access to care misses the point.

- **Despite the true intent of this regulation,** a series of studies funded by the ASA and largely published in ASA journals has attempted to demonstrate that this policy has no beneficial effect on patients' access to anesthesia or surgical services.
- **However, increased access** was not the intended goal of opt-out policy.
- **These studies found that a state's decision to 'opt-out'** of the Medicare supervision requirement has no measurable impact on access to services in that state as measured by utilization of surgical services and distance traveled by patients.[12–15]
- **Such outcomes are highly complex phenomena** unlikely to be causally linked to any single policy initiative, particularly one that was never intended to produce such effects.

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