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.

- **CRNAs have long been the dominant provider of anesthesia care in rural areas**, caring for patients in places where physician anesthesiologists are few and far between.[16]
- **Unsurprisingly, studies conducted on behalf of anesthesiologists suggest that opting-out of physician supervision has no impact on patient access**. This policy reflects long-standing patterns of anesthesia delivery and the recognition among policymakers that rural and other disadvantaged communities rely on CRNAs, supervised or not.[16]
- **This year, both Arizona and Oklahoma opted out** of the CMS requirement for physician supervision of CRNAs. Both cited the need to free up physicians to provide other needed services, noting that this policy would likely improve access to care specifically in rural communities. States continue to recognize that removing the burden of supervision from desperately needed rural physicians is good policy.
- **A shortage of rural anesthesiologists means other physicians must assume responsibility** for supervising CRNAs, despite their lack of expertise in anesthesia.
- **Opting out relieves hospitals of burdensome compliance concerns**. 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.

AANA GET THE FACTS

Access to care.

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 in many areas – 81% of counties have no anesthesiologist, 55% of counties have no surgeon, and only 58% have no CRNA.[4]
- **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. Less restrictive and opt-out settings have potential for greater substitution among physician anesthesiologists and CRNAs.[2]
- **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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