Information Regarding Anesthesiologist Assistants (AAs)

- AAs administer anesthesia solely under the medical direction of physician anesthesiologists to assist anesthesiologists, which limits their scope of practice. In contrast, CRNAs are qualified to make independent judgments regarding all aspects of anesthesia care, based on their education, licensure, and certification. This allows delivery of autonomous anesthesia care regardless of whether anesthesiologists are involved.

- AAs utilization is greatly limited due to the inability to practice without direct anesthesiologist supervision. AAs cannot practice in rural and underserved areas where CRNAs working without anesthesiologist involvement are the sole providers of anesthesia care. Because of this limitation, AAs are not able to work in 75% of Iowa hospitals unless those facilities would hire an anesthesiologist in addition to the AA.

- There is **no** anesthesia provider shortage in this state. It makes no sense to authorize AAs who can only practice in 29 of Iowa's 117 hospitals and cannot be used in any area where anesthesiologists don't practice.

- AAs are not required to have any prior healthcare education or experience (e.g., nursing, medical, anesthesia or healthcare education, licensure, or certification) before they begin their AA educational programs. CRNAs, in contrast, must have a bachelor's degree, be a registered nurse, and have at least one year of acute care nursing experience prior to entering nurse anesthesia educational programs.

- AAs will increase healthcare costs because two anesthesia providers– the supervising anesthesiologist and the AA – are always necessary when an AA practices –CRNAs may practice independently anywhere in the state, and 1 provider is much more cost effective than 2 for the same quality care.

- There exists no regulating/licensing body for AAs in Iowa. It is believed that if an existing board within state government were to accept the responsibility of regulating AAs, the first year fiscal note would be over $100,000. This cost cannot be justified in view of the financial constraints already facing the overall state budget for a few interested AAs.

- The federal government, as reflected in Centers for Medicare & Medicaid Services (CMS) rules, understands that CRNAs and AAs are not equivalent, and recognizes critical differences between the two providers. Unlike CRNAs, AAs cannot bill as a sole provider as dictated by CMS.

- Increased use of AAs would set the stage for increased anesthesiologist control of the anesthesia marketplace – and hence, less competition with resultant displacement of CRNAs in those specific facilities. This is because anesthesiologists have exclusive control of AA practice, including education, accreditation, certification, clinical practice, payment, and employment. AAs cannot compete with anesthesiologists, because they cannot practice independent of anesthesiologist supervision. In contrast, because CRNAs are educated to practice independently, CRNAs directly compete with anesthesiologists.

- There are 45,000 CRNAs compared to approximately 1800 AAs in the United States. Every state authorizes CRNAs to provide anesthesia care. In contrast, AAs are licensed to practice in only 13 states and the District of Columbia.

- CRNAs are the predominant anesthesia provider in the armed forces and the Veterans Affairs healthcare system. AAs are not authorized to work as anesthesia providers in the armed forces, and reportedly no Veterans Affairs facilities have employed AAs.

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