In our Fall 2024 edition of Accreditation News, Steven Hirsch & Associates published an article "Use of CRNAs in Hospitals and Surgical Care Settings." With the distribution by the California Department of Public Health (CDPH) on September 6, 2024, of "All Facilities Letter AFL-24-22", we have updated our original article to reflect clarification contained within the CDPH guidance.

Use of CRNAs in Hospitals and Surgical Care Settings

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For many healthcare facilities, the use of Certified Registered Nurse Anesthetists (CRNAs) has morphed into the chosen model for providing anesthesia care. In fact, the use of CRNAs in both rural and under-insured geographic areas has become essential in providing this care (www.anesthesiafacts.com 2022/11). The American Association of Nurse Anesthetists (AANA) claims that "CRNAs/nurse anesthesiologists are the sole anesthesia provider in approximately one-third of all U.S. hospitals, and more than two-thirds of rural hospitals" (Scope of Practice for CRNAs: A Complete Guide, obtained 8/16/22 at malpracticeinsurance.aana.com). However, hospitals have still been receiving citations, sometimes at the "Immediate Jeopardy" (IJ) level, for allowing CRNAs to practice outside of their scope, leaving organizations to wonder whether this model can continue.

For example, an acute care hospital in the Central Valley of California was recently issued an Immediate Jeopardy (IJ) because a CRNA changed the anesthesia type that was originally ordered by the anesthesiologist. A second, near-by short-stay hospital also was issued an IJ due to a CRNA claiming to oversee the entire anesthesia group (Scope of Practice Concerns Lead to Hospital's Temp Ban on CRNAs, A. Audit, 6/26/24, obtained 8/16/24 at Medscape.com). In California, there is no requirement for direct physician supervision. In fact, more than half of all U.S. states have no physician supervision requirement for CRNAs (malpracticeinsurance.aana.com). So, what exactly does a CRNA/nurse anesthetist have the autonomy to do independently?

It is first important to define what a Certified Registered Nurse Anesthetist is. CRNAs are highly educated, advanced practice nurse specialists who must complete several years of education, hundreds of hours of clinical work, and administer a minimum number of anesthetics before they qualify to sit for their national certification examination. Once the education and certification have been completed, the actual scope of practice for CRNAs/nurse anesthetists is determined by state regulation. Thus, what is allowed in one state may be quite different than what is permitted in another. For example, in California and Minnesota, CRNAs are permitted to work without direct physician supervision. In Maryland, CRNAs are not allowed to work independently. **In California, a CRNA may only administer anesthesia and anesthesia related medications ordered by a physician, dentist, podiatrist, or clinical psychologist as summarized in a recent All Facilities Letter (AFL 24-22 dated September 6, 2024) issued by the California Department of Public Health.**

Just as the state allows or prohibits the autonomy of nurse anesthetists, so, too, does the practice model used at the facility. The "CRNA Only Model" is often used in physicians' offices and outpatient care settings as well as in rural hospitals for obstetric care and pain management. In the "CRNA Only Model," the CRNAs are responsible for planning and providing all anesthesia care.

Under the "Collaborative Care Model," CRNAs may consult with, ask advice, and ask questions of the physician anesthesiologists on the care team. And with the "Anesthesia Care Model," an anesthesiologist

medically directs 2-4 CRNAs at a time (CRNA Supervision Requirements by State, obtained 8/16/24 at nursejournal.org).

In addition to the care model, the practice setting itself may determine the independence of the nurse anesthetists. Examples might range from a large, educational healthcare system to a short-stay surgery center to a dental office.

Lastly, just because a state has "opted out" of the CMS requirement for CRNA supervision by a physician, this does not make it the rule. Facilities still have the flexibility to determine whether physician oversight is needed. In other words, the state may allow for independent practice of CRNAs, but the organization may still require supervision.

For those states for which physician supervision is required, or for those medical staffs who have imposed supervision regardless of the state requirements, the oversight may be provided through a variety of mechanisms. Examples might include approval of each patient's anesthesia plan by the Anesthesiologist prior to the procedure, immediate availability of an Anesthesiologist by phone for consultation, and retrospective review of medical records. Oversight may be provided by an Anesthesiologist or by the operating practitioner. The details should be clearly defined within the Medical Staff Bylaws or Rules and Regulations.

CRNAs are privileged and credentialed through the Medical Staff Office and are subject to the same vetting that physicians undergo when joining the medical staff. Proctoring requirements should mirror what is required of the Anesthesiologists and include evaluating pre- and post-anesthesia assessment/management and documentation, intra-operative technique, judgement, documentation, and the recognition and treatment of complications (if any). CRNAs and nurse anesthetists should also be included in the Ongoing Professional Practice Evaluation (OPPE) process and include a minimum of two specialty-specific indicators as is required for the Anesthesiologists.

Healthcare organizations will need to review their own local regulations, Medical Staff Bylaws, Rules and Regulations and policies to determine what is permitted in their particular setting, and by what care model anesthesia care will be delivered if CRNAs are on staff, as well as what extent of supervision that should be implemented.

For more information on the Use of CRNAs in Hospitals and Surgical Care Settings contact Steven Hirsch & Associates at (800) 624-3750.