POLICY BRIEF

Temple University
Beasley School of Law

Center for
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Law Research

Certified Registered Nurse Anesthetist Scope of Practice Laws

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Introduction

Certified Registered Nurse Anesthetists (CRNAs) are advanced practice registered nurses (APRNs) who specialize in the administration of anesthesia. CRNAs can work in a variety of medical settings, including hospitals, free-standing ambulatory surgery centers, office-based settings, and pain management clinics, although restrictions on their authority may vary widely in those settings. State-level scope of practice laws govern the autonomy of CRNAs to provide anesthesia-related care with or without physician oversight and collaboration. These laws can also govern whether and to what extent CRNAs are able to provide pre- and post-operative care, order and prescribe medications, and perform pain management.

APRNs, including CRNAs, are typically more accessible to historically underserved populations and geographical areas. For instance, rural facilities are more heavily reliant on CRNAs for anesthesia and surgical practices,[1] and CRNAs are more likely to be anesthesia providers for lower-income, uninsured, unemployed, and Medicaid-eligible patients.[2] Evolving healthcare demands, especially in light of physician shortages and the COVID-19 pandemic, have led organizations and advocates to call for the removal of barriers from APRN (including CRNA) authority and to allow those practitioners to practice according to their full expertise and certification authority.[3,4]

This brief provides an overview of the legal landscape of state CRNA scope of practice laws, summarizes key findings of evidence evaluating the impact of these laws and CRNA practice generally, and provides policy and research recommendations moving forward.

Policy Landscape

As of September 15, 2022, all 50 states, the District of Columbia, and Puerto Rico have laws governing CRNA scope of practice. These laws vary widely across jurisdictions, according to a scientific legal mapping study conducted by the Center for Public Health Law Research (CPHLR) at Temple University's Beasley School of Law, which identified statutes, regulations, governor opt-out letters, and executive orders related to CRNA scope of practice.[5]

The study showed that jurisdictions have taken a variety of approaches to regulating CRNA scope of practice. Some jurisdictions have several specific statutes and regulations that explicitly define the details of CRNA authority in various settings. Other jurisdictions have several laws that govern APRN authority more generally (including, but not limited to, CRNAs). Still others have only a few laws regulating CRNA or APRN scope of practice, and are silent on issues such as authority to administer anesthesia, conduct pre-anesthesia testing, or perform pain management. For example, the study revealed (as captured in Question 15 of the legal dataset) that all states except for Iowa and Wisconsin have a law allowing CRNAs to administer regional anesthesia — either broadly authorizing the administration of anesthesia and/or explicitly authorizing the administration of regional anesthesia in particular. However, the absence of a law specifically authorizing CRNAs to administer anesthesia does not mean that CRNAs are prohibited from doing so — the law is simply silent on that issue in Iowa and Wisconsin.

Regardless of the breadth or detail of their laws, many jurisdictions restrict CRNA scope of practice in various and overlapping ways. Twenty-seven jurisdictions require the direction, supervision, and/or on-

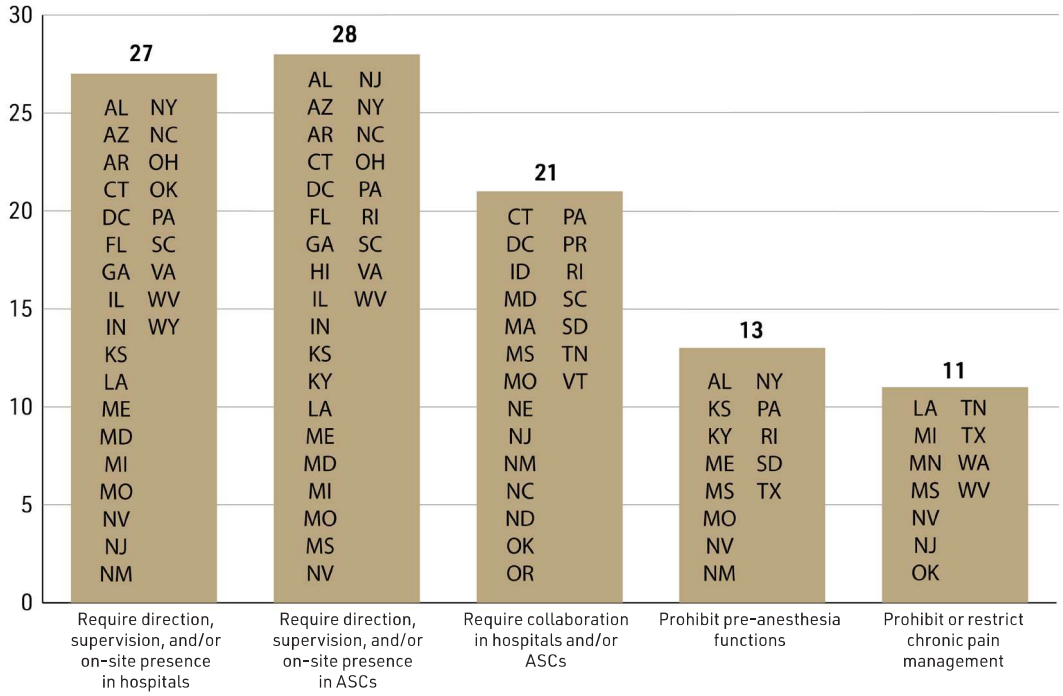

Figure 1. Many jurisdictions restrict CRNA scope of practice in various and overlapping ways, as of September 15, 2022.

site presence of a physician, anesthesiologist, or other healthcare professional in hospital settings, and 28 jurisdictions impose direction, supervision, and/or on-site presence requirements in ambulatory surgery centers. Additionally, 21 jurisdictions require CRNAs to collaborate with other healthcare providers in hospitals, ambulatory surgery centers, or both. Thirteen states prohibit CRNAs from performing certain pre-anesthesia functions (such as conducting physical assessments or ordering tests) in at least one setting. Most jurisdictions' laws are silent about CRNA authority to perform pain management, but one state (Louisiana) explicitly prohibits CRNAs from conducting chronic pain management and ten states impose restrictions on CRNA authority to perform chronic pain management.

On the other hand, several jurisdictions have chosen to expand CRNA scope of practice in at least some ways. As authorized by the Centers for Medicare & Medicaid Services rule published in 2001, 22 states have opted out of the federal requirement that CRNAs be supervised by a physician. Twelve states' laws do not require direction, supervision, on-site presence, or collaboration in either hospitals or ambulatory

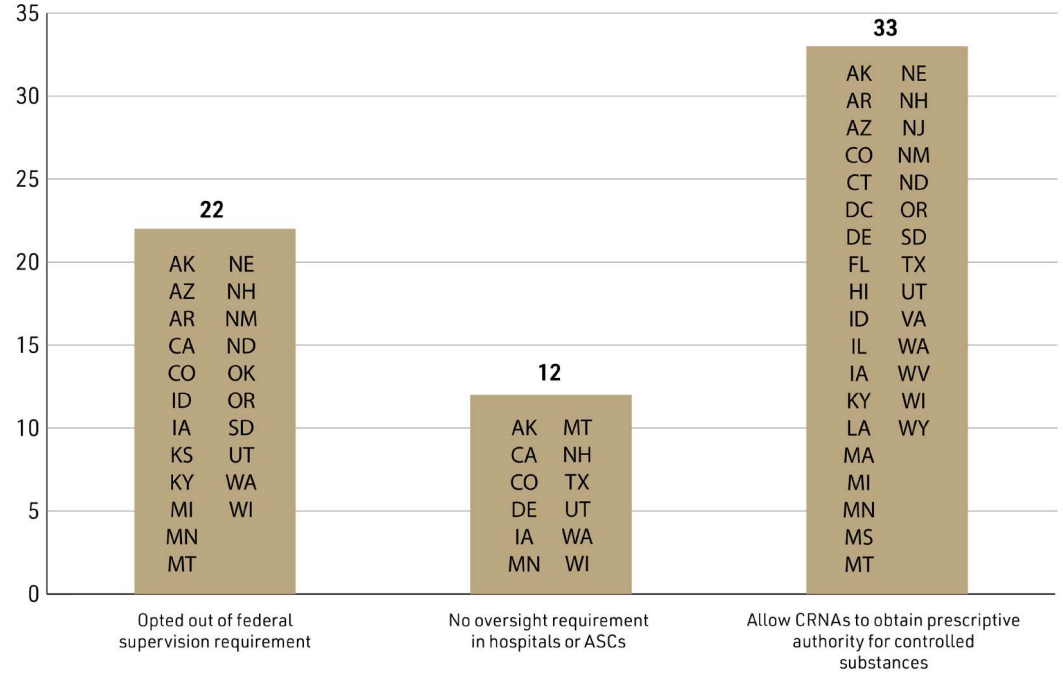

Figure 2. Many other jurisdictions have opted to expand CRNA scope of practice, as of September 15, 2022.

surgery centers. Thirty-three jurisdictions allow CRNAs to prescribe controlled substances (either automatically or through application), but many of those laws impose additional educational, licensing, or oversight requirements on that prescriptive authority.

Evidence

Some evidence has shown that expanded scope of practice for CRNAs does not negatively impact anesthesia patient outcomes. Specifically, studies have found that CRNAs who had an expanded scope of practice did not have worse patient outcomes, complications, or mortality when compared to anesthesiologists.[6,7] One of those studies even found that CRNAs who practice independently in opt-out states had a significantly lower rate of complications than anesthesiologists who practiced independently in non-opt out states.[6] Some studies have also found that anesthesia care teams composed of both anesthesiologists and CRNAs have better outcomes than anesthesiologists alone.[8,9] Additionally, one study found that CRNAs with expanded scope of practice reported higher levels of collaboration and cooperation with other practitioners, but also reported higher levels of occupational stress.[10]

There is less robust, and mixed, research measuring the impact of scope of practice *laws* on CRNA practice, patient outcomes, and access to care. One study confirmed that, where states have chosen to opt out of the federal supervision requirement and expand CRNA scope of practice laws, CRNAs practice pursuant to that broader authority, especially in rural communities.[11] However, another study found that most CRNAs who have the option to obtain prescriptive authority do not choose to do so.[12] In terms of the law's effect on patients, one study concluded that opting out had no significant effect on patient outcomes — although opt-out states had lower incidences of complications and mortality compared to states that never opted out, that was true both before and after those states had opted out.[6] Another study found that opt-out status and expanded scope of practice laws were correlated with an increase in CRNAs in rural settings.[13] However, other research indicates that there has been little-to-no significant increase in access to care in opt-out states.[14,15]

Policy Recommendations

Based on the evidence that expanded CRNA scope of practice has no negative effects on patient outcomes, several researchers and CRNA interest groups argue that more states should opt out of the federal supervision requirement and expand CRNA scope of practice laws.[4,16] On the other hand, physician-interest groups, including the American Medical Association and the American Society of Anesthesiologists, have strong influence over policymakers,[17,18] and argue that APRN (including CRNA) scope of practice should remain restricted.[19,20]

Although more research is needed, policymakers should be guided by the currently-available evidence when considering amendments to CRNA scope of practice laws. Removing restrictions and allowing more CRNAs to practice autonomously is documented to have no negative impact on patient outcomes, may potentially provide a cost-effective solution to physician shortages, and may increase access to care.[4,6] Especially given the fact that CRNAs often provide services to populations that have historically lacked access to quality health care, including rural, uninsured, and lower-income communities, policymakers should work toward ensuring CRNA scope of practice laws do not impede access to care.[2,4]

Research Agenda

Current evidence shows that overall, expanding the scope of practice for CRNAs does not have a negative impact on anesthesia patient outcomes. However, evidence is mixed as to whether and how CRNA scope of practice laws can result in expanded access to care. Future studies can use the dataset created by CPHLR to fill the gaps in existing research. Given the wide variation among CRNA scope of practice laws — including differences in requirements for direction, on-site presence, supervision, and/or collaboration in various settings, the ability to obtain prescriptive authority, and the scope of prescriptive authority when available — robust comparative research and evaluation may help better determine which specific provisions expand or restrict access to care. The CPHLR dataset, which provides quantitative legal data on more detailed and granular aspects of CRNA scope of practice laws, can facilitate robust evaluation that could lead to a better understanding of the impact of these laws.

Conclusion

Laws governing CRNA scope of practice and authority vary widely across jurisdictions and settings. While some states restrict CRNA practice by requiring physician oversight and prohibiting CRNAs from performing certain functions, others have expanded CRNA authority to include independent practice and prescriptive authority. Multiple studies have shown that CRNAs with expanded authority have similar, or even better, patient outcomes as anesthesiologists. However, more robust and detailed research and evaluation is needed to determine which specific provisions of CRNA scope of practice laws best enhance (or hinder) patient outcomes and access to care. In the meantime, policymakers should use currently-available research to inform decisions regarding changes to CRNA scope of practice laws, recognizing that CRNAs play a crucial role in anesthesia care, especially for populations that have been underserved and under-resourced by the healthcare system.

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