AANA
American Association of
NURSE ANESTHESIOLOGY

August 1, 2022

Shereef Elnahal, M.D.
Under Secretary for Health
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Dr. Elnahal:

On behalf of the nation's more than 59,000 members of the American Association of Nurse Anesthesiology (AANA), I wish to congratulate you on your confirmation as the Under Secretary for Health of the U.S. Department of Veterans Affairs (VA). We are strongly committed to continue our work with the agency to ensure our nation's veterans have access to timely, cost effective and high-quality care and reduce barriers to Certified Registered Nurse Anesthetists' (CRNA) practice. We know that additional work needs to be accomplished on these critical issues, and we would like to meet with you to discuss our recommendations, which include ensuring permanent full practice authority (FPA) within the scope of their license to CRNAs providing anesthesia services in VA facilities in every state. I ask to meet with you to discuss this pertinent issue.

The AANA is the professional association for Certified Registered Nurse Anesthetists (CRNAs) and student registered nurse anesthetists (SRNAs), representing over 90 percent of the nurse anesthetists in the United States. CRNAs are advanced practice registered nurses (APRNs) who personally administer more than 50 million anesthetics to patients each year in the United States. CRNAs have provided anesthesia in the United States for 150 years. CRNAs are involved in every aspect in providing anesthesia services, including a pre-anesthesia patient assessment, obtaining informed consent for anesthesia administration, developing a plan for anesthesia administration, administering the anesthetic, monitoring and interpreting the patient's vital signs, and managing the patient throughout the surgery. CRNAs also provide acute, chronic, and interventional pain management services. CRNAs provide anesthesia for a wide variety of surgical cases and in some states are the sole anesthesia providers in nearly 100 percent of rural hospitals, affording these medical facilities obstetrical, surgical, trauma stabilization, and pain management capabilities. Nurse anesthesia predominates in Veterans Hospitals and in the U.S. Armed Services, including the Army, Navy and Air Force, in addition to combat support hospitals, and forward surgical teams where they are afforded full practice rights. CRNAs work in every setting in which anesthesia is delivered including hospital surgical suites and obstetrical delivery rooms, ambulatory surgical centers (ASCs), pain management facilities, and the offices of dentists, podiatrists, and all types of specialty surgeons.

Nurse anesthetists are experienced and highly trained anesthesia professionals who provide high-quality patient care, demonstrated through evidence in decades of scientific research. By standardizing care

delivery models across the country via full practice authority for CRNAs, veterans will receive consistently safe and high-quality care delivery in any VHA facility. More than 1000 CRNAs are available in the VHA to provide every type of anesthesia care, as well as chronic pain management services, to veterans. Numerous peer reviewed studies have shown that CRNAs are safe, high quality and cost-effective anesthesia professionals who should practice to the full extent of their education and abilities. In its 2016 final rule, the VHA acknowledged the safety of CRNAs working as full practice authority providers, stating that "[t]he safety of CRNA services has long been recognized by the VHA and underscored by peer-reviewed scientific studies, including a major study published in Health Affairs which found that anesthesia care by CRNAs was equally safe with or without physician supervision.[1]" The landmark National Academy of Medicine report *To Err is Human* found in 2000 that anesthesia was 50 times safer than in the 1980s.

According to a May/June 2010 study published in the journal *Nursing Economic$*, CRNAs acting as the sole anesthesia provider are the most cost-effective model for anesthesia delivery, and there is no measurable difference in the quality of care between CRNAs and other anesthesia providers or by anesthesia delivery model.[2] An August 2010 study published in *Health Affairs* showed no differences in patient outcomes when anesthesia services are provided by CRNAs, physicians, or CRNAs supervised by physicians.[3] Examining Medicare records from 1999-2005, the study compared anesthesia outcomes in 14 states that opted-out of the Medicare physician supervision requirement for CRNAs with those that did not opt out. (To date, 19 states have opted-out). The researchers found that anesthesia has continued to grow safer in opt-out and non-opt-out states alike and led researchers to recommend that costly and duplicative supervision requirements for CRNAs be eliminated. Researchers studying anesthesia safety found no differences in care between nurse anesthetists and physician anesthesiologists based on an exhaustive analysis of research literature published in the United States and around the world, according to a scientific literature review prepared by the Cochrane Collaboration, the internationally recognized authority on evidence-based practice in healthcare.[4] A study published in *Medical Care* found no measurable impact in anesthesia complications from nurse anesthetist scope of practice or practice restrictions.[5] The study, which is the first to focus on the effects of state scope of practice laws and anesthesia delivery models on patient safety, also concluded that limitations on CRNA practice such as state scope of practice restrictions and physician supervision reduce patient access to quality care and increase costs of healthcare services.[6]

We appreciate the work the agency has already accomplished to protect our nation's veterans, especially during the ongoing public health emergency (PHE). The COVID-19 PHE has shown the urgent need for health care professionals to care for patients and also highlights the important role that CRNAs play in our healthcare system, especially when workforce barriers to practice are eliminated both at the state and federal levels. Throughout the COVID-19 PHE, facilities have required all providers to work to the top of their

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[1] 81 FR 90198 (December 14, 2016), https://www.gpo.gov/fdsys/pkg/FR-2016-12-14/pdf/2016-29950.pdf

[2] Paul F. Hogan et al., "Cost Effectiveness Analysis of Anesthesia Providers." *Nursing Economic$.* 2010; 28:159-169. http://www.aana.com/resources2/research/Documents/nec_mj_10_hogan.pdf

[3] B. Dulisse and J. Cromwell, "No Harm Found When Nurse Anesthetists Work Without Physician Supervision." *Health Affairs*. 2010; 29: 1469-1475. http://content.healthaffairs.org/content/29/8/1469.full.pdf

[4] Lewis SR, Nicholson A, Smith AF, Alderson P. Physician anaesthetists versus non-physician providers of anaesthesia for surgical patients. *Cochrane Database of Systematic Reviews* 2014, Issue 7. Art. No.: CD010357. DOI: 10.1002/14651858.CD010357.pub2. http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD010357.pub2/abstract

[5] Negrusa B et al. Scope of practice laws and anesthesia complications: No measurable impact of certified registered nurse anesthetist expanded scope of practice on anesthesia-related complications. *Medical Care* June 2016, http://journals.lww.com/lww-medicalcare/Abstract/publishahead/Scope_of_Practice_Laws_and_Anesthesia.98905.aspx.

[6] Negrusa op cit.

education and state scope of practice. CRNAs are working under stressful conditions in facilities across America, by providing invaluable support by using their expertise in rapid systems assessment, airway management, managing ventilators, vascular volume resuscitation, placing of invasive lines and monitors, overseeing complex hemodynamic monitoring, emergency preparedness, and resource management. CRNAs practice autonomously and are qualified to make independent judgments based on their education, licensure, and certification. We are proud of the way that so many CRNAs in their roles as APRNs as have stepped up in these challenging times, assisting on the frontlines of the pandemic and working with the VA and veterans to providing critical, lifesaving expert care to the sickest COVID-19 patients. The AANA is also proud to have worked hand in hand with the Veterans Health Administration (VHA) at the outset of the PHE on the Nurse Travel program, to help the VHA ensure that it would have a sufficient nursing workforce to deal with the pandemic. Recent data from CMS shows that CRNAs are one of the top specialties serving the most Medicare beneficiaries during the first three months of the pandemic (March – June) in 2020[7].

We appreciate the VA and VHA's recognition of CRNAs' value and skill to healthcare, including the work on Directive 1899 that emphasized the importance of allowing CRNAs to practice to the full extent of their training. We strongly applaud the move by the VHA to remove barriers to care for our nation's veterans, including encouraging facilities to implement full practice authority for CRNAs, to allow them to practice to the top of their scope and education. This move allowed the VHA greater flexibility to care for our veterans, in a more efficient and cost effective that increases access to care. While we applaud the temporary removal of workforce barriers during this emergency, our nation's veterans deserve access to timely, cost effective and high-quality care within the VA health system at all times, and we think that it's critical that full practice authority for CRNAs working within the VA be made permanent. While we know the development of National Standards is in process, full practice authority for CRNAs is an immediate step that VA needs to take to fully utilize its current workforce, to best serve our nation's veterans by expanding access to care immediately.

Recent reports continuously highlight a lack of access to anesthesia services in the VA and the Veterans Health Administration (VHA) and we have seen the effect of lack of access to anesthesia care, which can have a domino effect in delaying other procedures. The VA's Office of the Inspector General (OIG) released a report in July 2022 citing 2,622 severe occupational staffing shortages across 285 occupations in fiscal year, which was an increase from 2,152 severe occupational staffing shortages from the previous year.[8] The report stated that 91% of facilities reported severe shortages of nurses and many reported shortages for both CRNAs and anesthesiology in general.[9] In 2017, it was reported that 65 to 90 surgeries were canceled or postponed at the Denver Veterans Affairs Medical Center due to a lack of anesthesia providers availability caused by the facilities utilization of 1:1 and 2:1 supervision models.[10] Instead of relaxing supervision requirements to allow CRNAs to help take care of patients, the medical center chose to keep utilizing models of care that drive up costs, increase wait times without improving safety for our nations veterans by hiring four additional anesthesiologists at $400,000 each for a total of $1.6 million. Instead of hiring additional staff at that rate, this money could have better served many other healthcare interests and issues to

[7] CMS Report January 2021 "Putting Patients First: The Center for Medicare and Medicaid Services Record of Accomplishment from 2017-2020."

[8] VA OIG July 2022 report, "OIG Determination of Veterans Health Administration's Occupational Staffing Shortages FY 2022", https://www.va.gov/oig/pubs/VAOIG-22-00722-187.pdf

[9] VA OIG, op cit.

[10] http://kdvr.com/2017/10/11/va-surgeries-postponed-because-there-arent-enough-anesthesiologists/

provide needed care to our veterans. How many other important jobs such as suicide prevention hotline operators, or social worker could this 1.6 million have supported? This example shows that if full practice authority is not granted permanently for CRNAs after the PHE, veterans will endure dangerously long wait times for anesthesia and other healthcare services due to the ongoing underutilization of CRNAs currently working in VHA facilities.

Recent publications have highlighted how important full practice authority is for access to care within the VA. A major VHA workforce evaluation published in January 2015 reported that CRNAs have been among the VHA's most difficult to recruit specialties over four of the past five years.[11]

We continue to hear from providers and veterans alike that the VA is using highly inefficient models, creating unnecessary redundancies, wasting money and creating wait times and backlogs through unnecessary supervision of CRNAs. We believe removing unnecessary and costly physician supervision requirements will also help reduce long wait times for our nation's veterans. Supervision requirements for CRNAs at VHA facilities continue to waste money on unnecessary and duplicative supervision in anesthesia delivery that have no scientific or evidence-based reason. Supervision has not been shown to improve quality of care, only to impede access and increase costs.[12] This not only affords the hospital the ability to handle a number of cases and provide many services it otherwise wouldn't be able to, it also provides access to opioid-sparing pain management, an important service for our veterans who so often suffer chronic pain. Without the low-cost access to care that is afforded so many rural and underserved communities by CRNAs and the anesthesia services they provide when allowed to practice to the top of the licensure without unnecessary supervision, wait times outside of the VA in the private market would continue to increase. The VA needs to revisit CRNA full practice authority right now, our veterans don't have time to wait years for new practice standards to be developed, they need care now and CRNA full practice authority is a proven way to expand access and lower costs immediately.

During this current pandemic, we have seen barriers to CRNA practice removed at both the state and federal level, allowing CRNAs to provide critical, lifesaving care to COVID-19 patients. Freeing up CRNAs to provide this critical care to the sickest patients is a key part of allowing the VA to achieve the three pillars of meaningful healthcare delivery reform, providing the highest quality and most cost-effective care possible. The need for FPA for CRNAs and all advanced practice registered nurses (APRNs) has consistently been judged necessary by independent, third party arbiters, who look at evidence and economics. Groups including AARP, Multiple Veterans Service Organizations (VSOs) and Americans for Prosperity,[13] among others, have weighed in on the need for FPA, and both the Congressionally mandated Commission on Care[14] and the VA's Independent Assessment[15] argued the necessity of implementing FPA. The overwhelming

[11] VA Office of the Inspector General, OIG Determination of Veterans Health Administration's Occupational Staffing Shortages (January 30, 2015) http://www.va.gov/oig/publications/report-summary.asp?id=3276

[12] http://www.lewin.com/content/dam/Lewin/Resources/AANA-CEA-May2016.pdf

[13] https://www.aana.com/docs/default-source/pr-aana-com-web-documents-(all)/sign-on-letter-to-secretary-azar-regarding-executive-order.pdf?sfvrsn=46543c5f_4

[14] https://s3.amazonaws.com/sitesusa/wp-content/uploads/sites/912/2016/07/Commission-on-Care_Final-Report_063016_FOR-WEB.pdf

[15] https://www.rand.org/content/dam/rand/pubs/research_reports/RR1100/RR1165z2/RAND_RR1165z2.pdf

evidence and support clearly indicate that FPA is the right thing to do when scientific evidence is taken into consideration.

Recognizing CRNAs to their full practice authority also corresponds with the first policy recommendation from the National Academy of Medicine report titled *The Future of Nursing: Leading Change, Advancing Health.* This report outlines several paths by which patient access to care may be expanded, quality preserved or improved, and costs controlled through greater use of APRNs.[16] The National Academy of Medicine report specifically recommends that, "advanced practice registered nurses should be able to practice to the full extent of their education and training."[17]

Access to care should be measured by whether veterans are getting the services they need. Notwithstanding the VA's efforts to reform access issues, veterans are still experiencing long wait times for care, which has been identified in numerous instances by published government reports, the VHA Independent Assessment, and observations within the VHA. Such delays justify prompt implementation of full practice authority for VHA CRNAs. Thus, we urge the VA to allow full practice authority for CRNAs to continue improving healthcare for our veterans throughout the country.

Our nation's veterans deserve access to timely, cost effective and high-quality care within the VA health system. Removing unnecessary supervision and implementing permanent FPA for CRNAs will improve healthcare and practice excellence by increasing veteran's access to a safe, high-quality healthcare workforce in the VA. The evidence is clear that CRNA full practice authority is the safest, most cost effective method of anesthesia delivery and given the recent OIG report shorting drastic increases in VA healthcare workforce shortages, we need to allow CRNAs to work to the top of their scope, just like all other APRNs in the VA do.

We would like to meet with you to *discuss our recommendations regarding making this policy permanent and* we look forward to hearing from you and working with you. Should you have any questions, please feel free to contact the AANA Senior Director of Federal Government Affairs, Ralph Kohl, at 202-741-9080 or rkohl@aanadc.com.

Sincerely,

William Bruce, MBA, CAE
AANA Chief Executive Officer

cc: Lorraine Jordan, PhD, CRNA, CAE, FAAN, AANA Chief Advocacy Officer and AANA Foundation CEO

[16] National Academy of Medicine (formerly Institute of Medicine). (2011). The Future of Nursing: Leading Change, Advancing Health. Washington, DC: The National Academies Press. http://www.iom.edu/Reports/2010/The-Future-of-Nursing-Leading-Change-Advancing-Health.aspx

[17] National Academy of Medicine op cit., p. 9.

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