March 30, 2022

Department of Veterans Affairs
Special Medical Advisory Group
Attn: LaTonya L. Small
Federal Advisory Committee Management Officer
Office of Under Secretary for Health (10)
Veterans' Health Administration
810 Vermont Avenue, NW
Washington, DC 20420

Dear Ms. Small,

The American Association of Nurse Anesthesiology (AANA) welcomes the opportunity to comment on the April 6, 2022, meeting of the Special Medical Advisory Group (the Committee). We appreciate the work the Department of Veterans Affairs has done to protect our nation's veterans, especially during the ongoing public health emergency (PHE), and we are firmly committed to our continued work together to help ensure our nation's veterans have access to timely, cost effective and high-quality care. Our comments include the following:

I. Background of the AANA and CRNAs

II. Assessment of Current Access to Anesthesia Care Issues in VA Facilities

III. CRNA Full Practice Authority Increases Veterans' Access to Care and Promotes Safe, Efficient Healthcare Delivery

IV. Unrequired, Unnecessary CRNA Supervision Reduces Access to Care in VHA Facilities

V. Recruitment and Retention of CRNAs Will Increase Productivity and Efficiency

I. Background of the AANA and CRNAs

The AANA is the professional association for Certified Registered Nurse Anesthetists (CRNAs) and student registered nurse anesthetists (SRNAs). AANA membership includes more than 59,000 CRNAs and SRNAs, representing about 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

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in the United States and are among the nation's most trusted professions according to Gallup[1]. Nurse anesthetists have provided anesthesia in the United States for 150 years, and high-quality, cost-effective CRNA services are in high demand. CRNAs are Medicare Part B providers and since 1989 have billed Medicare directly for 100 percent of the physician fee schedule amount for services. CRNAs also play an essential role in assuring that rural America has access to critical anesthesia services, often serving as the sole anesthesia provider in rural hospitals, affording these facilities the capability to provide many necessary procedures.

CRNAs are involved in every aspect of 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 and recovery. 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. 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.

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. 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] 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] Most recently, a study published in *Medical Care* (June 2016) found no measurable impact in anesthesia complications from nurse anesthetist scope of practice or practice restrictions.[5]

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[1] Gallup "U.S. Ethics Ratings Rise for Medical Workers and Teachers (December 22, 2020), https://news.gallup.com/poll/328136/ethics-ratings-rise-medical-workers-teachers.aspx

[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.

The importance of CRNA services in rural areas was highlighted in a recent study which examined the relationship between socioeconomic factors related to geography and insurance type and the distribution of anesthesia provider type.[6] The study correlated CRNAs with lower-income populations and correlated anesthesiologist services with higher-income populations. Of particular importance to the implementation of public benefit programs in the U.S., the study also showed that compared with anesthesiologists, CRNAs are more likely to work in areas with lower median incomes and larger populations of citizens who are unemployed, uninsured, and/or Medicaid beneficiaries.[7] This information highlights the importance of CRNAs who provide high-quality, evidence-based care to millions of Americans living and working in rural and underserved areas. Allowing them to participate in rural emergency hospitals will increase needed access to care for patients who live in these areas.

II. Assessment of Current Access to Anesthesia Care Issues in VA Facilities

The AANA continues to advocate for policies that will ensure a robust and cost-efficient anesthesia workforce both in the Department of Veterans Affairs (VA) and in the private sector. The AANA supports activities that improve healthcare, patient safety and practice excellence by working to increase access to healthcare, make healthcare more affordable, and improve the quality of the care available to all patients, including our nation's veterans. A key component of ensuring a strong and effective anesthesia workforce is the implementation of Full Practice Authority (FPA) for CRNAs working within the VA. Currently, almost 1,100 CRNAs work in the VA it is projected that hundreds more will need to be hired in the coming years. FPA would allow CRNAs who provide care for our nation's veterans to work to the full scope of their education, training, and licensure thereby helping ensure that veterans have access to the timely anesthesia and related healthcare services they deserve.

On December 14, 2016, the VA published its final rule granting FPA to three of the four APRN specialties, illogically excluding CRNAs from the rule "due to VA's lack of access problems in the area of anesthesiology."[8] This statement ignores both the on the ground realities of anesthesia care in the VA, as well as the VA's own assessments. Due to anesthesia delays, veterans are indeed waiting for care they deserve and have earned and endangering their health. We have seen the effect of lack of access to anesthesia care, which can have a domino effect in delaying other procedures. Reports out of the Denver Veterans Affairs Medical Center in 2017 indicated the cancellation or delay of dozens of procedures specifically due to a lack of access to anesthesia care.[9] Furthermore, recent reports continuously highlight a lack of access to anesthesia services in the VHA. The VA's Office of the Inspector General (OIG) released a report in June 2018 cited VHA staffing shortages for the fifth year in a row.[10] Out of the 141 facilities

[6] Liao CJ, Qurashi JA, Jordan LM. Geographical Imbalance of Anesthesia Providers and its Impact on the Uninsured and Vulnerable Populations. Nurs Econ. 2015;33(5):263-270. http://www.aana.com/resources2/research/Pages/NursingEconomics2015.aspx

[7] Liao, op cit.

[8] 81 Fed. Reg. 90198. https://www.gpo.gov/fdsys/pkg/FR-2016-12-14/pdf/2016-29950.pdf

[9] Low, R. (2017, October 17). VA surgeries postponed because there aren't enough anesthesiologists. KDVR Fox31. Retrieved March 14, 2022, from https://kdvr.com/news/problem-solvers/serving-those-who-serve/va-surgeries-postponed-because-there-arent-enough-anesthesiologists/

[10] VA OIG June 2018 report, "OIG Determination of Veterans Health Administration's Occupational Staffing Shortages", https://www.va.gov/oig/pubs/VAOIG-18-01693-196.pdf

surveyed for this report, 31 facilities reported staffing shortages in the area of anesthesiology and the most frequently cited shortages were in the Medical Officer and Nurse occupations.[11]

In light of the successful implementation of FPA for nurse practitioners, nurse-midwives and clinical nurse specialists, and given the current and growing workforce shortages, it's time for the VA to revisit its 2016 FPA decision. The VA even acknowledged as much in its APRN FPA rule when it stated, "VA welcomes comment on whether lack of advanced practice authority is a hiring, recruitment, or retention barrier for CRNAs, as well as on the extent to which advanced practice authority could help to resolve these issues either directly or indirectly." In addition, data from the VA's Center for Veterans Analysis and Statistics show a growth in total veteran enrollees (6.8 million in 2002 to 9.1 million in 2014), outpatient visits (46.5 million to 92.4 million) and inpatient admissions (565,000 to 707,000) in the VA healthcare system over the last 12 years.[12] The final rule also states that the 2015 independent survey of VA general facility Chief of Staffs conducted by the RAND Corporation showed that about 38% reported problems recruiting or hiring advanced practice providers and 30% reported problems retaining advanced practice providers.[13] With all of the overwhelming evidence showing there are access to anesthesia care issues in the VHA, we refute the VA's claim in the APRN final rule that there is not an access to anesthesia care issue. The long overdue time to re-evaluate this policy is now.

III. CRNA Full Practice Authority Increases Veterans' Access to Care and Promotes Safe, Efficient Healthcare Delivery

While we applaud the temporary removal of workforce barriers during this PHE, our nation's veterans deserve consistent access to timely, cost effective and high-quality care within the VA health system and we think that it's critical that full practice authority for CRNAs working within the VA be made permanent. This is critically important as we continue to see the devastating effects that the COVID-19 pandemic, ongoing stress and burnout, and increasing retirements have had on the healthcare workforce.

The VA, as well as multiple independent arbiters, Veterans Service Organizations (VSOs) and independent data all point to the same conclusion, that the VA's decision not to implement CRNA FPA only serves to hurt patients. Data from VA commissioned studies show clear access to care issues in VHA facilities. We are troubled as to why these objective findings were not considered to be sufficient evidence for granting FPA to CRNAs in the final 2016 APRN rule. The VA sponsored the congressionally mandated 2015 RAND Corporation Independent Assessment of the VHA, which reported that wait times for VA care are getting longer and current VA workforce capacity may not be sufficient to provide timely care to veterans across a number of key specialties, as well as primary care.[14] The VA Independent Assessment stated that one of the most important changes in VA policy to help meet increases in demand for healthcare and ensure continued access to care for veterans would be formalizing FPA for all APRNs, including CRNAs. These projections on workforce shortages were in place before the COVID-19 pandemic, which has only worked to exacerbate the shortages.

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[11] VA OIG, op cit.

[12] https://www.va.gov/vetdata/Utilization.asp

[13] 81 Fed. Reg. 90198. https://www.gpo.gov/fdsys/pkg/FR-2016-12-14/pdf/2016-29950.pdf

[14] RAND Health. "*Resources and Capabilities of the Department of Veterans Affairs to Provide Timely and Accessible Care to Veterans,"* (2015). http://www.rand.org/content/dam/rand/pubs/research_reports/RR1100/RR1165z2/RAND_RR1165z2.pdf

In a crucial mistake, the VA ignored these findings in its final rule. A report released by the VA in December 2016 showed there are 150 VHA facilities reporting that more than 10% of their appointments have a wait time of more than 30 days, meaning that veterans must wait more than a month to get an appointment.[15] The VA Independent Assessment reported access to care challenges due to anesthesia delays. Specifically, the VA Independent Assessment identified delays in cardiovascular surgery for lack of anesthesia support, rapidly increasing demand for procedures requiring anesthesia outside of the operating room, and slow production of colonoscopy services in comparison with the private sector.[16] This speaks to the underutilization of existing anesthesia providers such as CRNAs, who are arbitrarily not allowed to practice to the full scope of their education, experience, and licensure. It remains unclear why the Independent Assessment's impartial findings were not sufficient evidence to allow full practice authority for CRNAs in VHA facilities. The final rule even went as far as to say that not granting CRNAs FPA had nothing to do with outcomes, writing "'The 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.' VA agrees with these comments." Simply put, CRNAs working independently yield the same results, and there is no impetus for requiring supervision.

Requiring VA facilities to engage in superfluous supervision of CRNAs will only continue to lead to delays and exacerbate workforce shortages, ultimately hurting patient care. Supervision within the VA has even led to incredibly restrictive 1:1 and 1:2 supervision models, that are highly inefficient. These types of supervision models are not typically used in the private sector, specifically because they are too inefficient and costly. Our veterans deserve better. Because these arrangements are so costly compared with alternatives, they divert resources from VHA delivery of other priority services such as primary care, women's healthcare, or mental healthcare at a time when demand for those services is increasing. Anesthesia services provided by CRNAs, and anesthesiologists are considered extremely safe and, except in rare instances, a single anesthesia provider is sufficient to administer an excellent anesthetic. CRNAs administer anesthesia in all settings working in collaboration with surgeons, anesthesiologists, and other healthcare professionals as part of the patient care team. A Lewin Group peer-reviewed economic analysis noted, "There are no circumstances examined in which a 1:1 direction model is cost effective or financially viable."[17] The Lewin Group analysis concludes that allowing CRNAs to practice to the full extent of their education and training would "both ensure patient safety and result in substantial cost savings, allowing the VHA to allocate scarce resources toward other Veteran healthcare needs."[18]

IV. Unrequired, Unnecessary CRNA Supervision Reduces Access to Care in VHA Facilities

Concerns over anesthesia delays in VHA facilities stem from the underutilization of CRNAs who are not allowed to practice to the full scope of their education, experience, and licensure, as well as anesthesiologists wasting unnecessary time and resources supervising CRNAs instead of directly providing

[15] Department of Veterans Affairs Report "Pending appointments and Electronic Wait List Summary – National, Facility, and Division Level Summaries Wait Time Calculated from Preferred Date" (December 2016). http://www.va.gov/HEALTH/docs/DR60_122016_Pending_and_EWL_Biweekly_Desired_Date_Division.pdf

[16] VA Independent Assessment, Appendices E – I, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_B_Health_Care_Capabilities_Appendices_E-I.pdf

[17] Hogan op cit., http://www.aana.com/resources2/research/Documents/nec_mj_10_hogan.pdf

[18] Hogan, op cit

anesthesia care to veterans. CRNAs are appropriately educated and trained to handle every aspect of the delivery of anesthesia services including general and regional anesthesia and acute, chronic, and interventional pain management services. Forty-three states plus the District of Columbia have no supervision requirement concerning nurse anesthetists in nurse practice acts, board of nursing rules/regulations, medical practice acts, board of medicine rules/regulations, or their generic equivalents, allowing CRNAs to practice autonomously consistent with their education, training, and licensure. (This does not take into account hospital statutes or regulations.) Furthermore, no state or federal laws require CRNAs to be supervised by anesthesiologists. CRNA supervision leads to increased costs and reduced access to timely care but does not lead to better healthcare outcomes as confirmed by scientific research data time and time again.

Data from multiple independent studies has consistently shown that CRNAs working independently are not only the most cost-efficient method of anesthesia delivery, but is as safe as supervision models, leading to similar outcomes. A 2016 study on CRNA scope of practice laws published in the Journal of Medical Care found that there was virtually no evidence that the odds of complication differed by delivery model, as an independent CRNA model had similar outcomes to other less efficient models.[19] Data published in Health Affairs also showed that states that opted out of Medicare's supervision requirement for CRNAs saw no increase in patient deaths or complications, showing that supervision does not improve outcomes.[20] Currently 19 states have opted out of the requirement.

Independent arbiters have also consistently supported FPA for CRNAs and the removal of barriers for APRNs. The New England Journal of Medicine supported the removal of barriers to APRN practice in a 2020 article on modernizing scope of practice to put patients first.[21] The same recommendation was made by the Bipartisan Policy Center's 2020 report on Confronting Rural America's Health Crisis,[22] as well as the Institute of Medicine's Future of Nursing Report in 2010.[23]

V. Recruitment and Retention of CRNAs Will Increase Productivity and Efficiency

The VA stated in its final APRN rule, "VA understands that there are difficulties hiring and retaining anesthesia providers." The AANA acknowledges and highlights this difficulty for the committee. In fact, this challenge was further illustrated by a major VHA workforce evaluation published in January 2015 reporting that CRNAs have been among the VHA's most difficult to recruit specialties over four of the past

[19] Negrusa, B., PhD, Hogan, P., MS, Warner, J., PhD, Schroeder, C., BA, & Pang, B., MS. (2016, October). Scope of Practice Laws and Anesthesia Complications. Medical Care. Retrieved March 14, 2022, from https://journals.lww.com/lww-medicalcare/Abstract/2016/10000/Scope_of_Practice_Laws_and_Anesthesia.4.aspx

[20] Dulisse, op cit., http://content.healthaffairs.org/content/29/8/1469.full.pdf and Negrusa op cit., http://journals.lww.com/lww -medicalcare/Abstract/publishahead/Scope_of_Practice_Laws_and_Anesthesia.98905.aspx

[21] Froger, B PhD et al. (February 13, 2020) Modernizing Scope-of-Practice Regulations – Time to Prioritize Patients. New England Journal of Medicine. Retrieved March 14, 2022, https://www.nejm.org/doi/full/10.1056/NEJMp1911077

[22] Bipartisan Policy Center Rural Health Task Force. (April 2020). Confronting Rural America's Health Care Crisis. Bipartisan Policy Center. Retrieved March 14, 2022, https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2020/04/WEB_BPC_Rural-Health-Care-Report.pdf

[23] National Academy of Sciences. (October 2010). The Future of Nursing, Leading Change, Advancing Health. Institutes of Medicine. Retrieved March 14,2022 from https://www.aana.com/docs/default-source/fga-aana-com-web-documents-(all)/future-of-nursing-2010-report-brief.pdf?sfvrsn=a65c49b1_4

five years.[24] The final APRN rule also stated that the 2015 independent survey of VA general facility Chief of Staffs conducted by the RAND Corporation showed that about 38% reported problems recruiting or hiring advanced practice providers and 30% reported problems retaining advanced practice providers.[25]

The VA's final APRN rule also references current and future recruitment and retention of CRNAs, stating that it is possible resources might be available to address some of these underlying issues if efficiencies were realized as a result of advanced practice nursing authority."[26] The AANA surveyed its membership, which includes more than 90% of the nation's nurse anesthetists, and found that over 90% of respondents indicated that the decision to not grant FPA to CRNAs would deter them from seeking employment in the VHA in the future. This chilling effect on the ability of the VHA to hire skilled CRNAs will have a lasting impact on its ability to meet the healthcare needs of veterans. Conversely, 98% of the survey respondents said they would be more inclined to work for the VHA if it took the appropriate steps to grant FPA to CRNAs.

The AANA appreciates the opportunity to comment to this Committee on this important issue. 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 inside the VA. We urge you to help make this policy permanent and allow all CRNAs working within the VA to work to their full scope of practice by implementing permanent FPA. We stand ready to assist in this effort and we would be happy to meet with the committee to discuss our recommendations in greater detail. Should you have any questions regarding our comments, please feel free to contact the AANA Senior Director of Federal Government Affairs, Ralph Kohl, at 202-741-9080 or rkohl@aanadc.com.

Sincerely,

Dina Velocci, DNP, CRNA, APRN
AANA President

cc: David Hebert, JD, AANA Interim Chief Executive Officer
Ralph Kohl, BA, AANA Senior Director of Federal Government Affairs
Randi Gold, MPP, AANA Senior Associate Director Federal Regulatory and Payment Policy

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[24] VA Office of the Inspector General, OIG Determination of Veterans Health Administration's Occupational Staffing Shortages (January 30, 2015)

[25] https://www.va.gov/vetdata/Utilization.asp.

[26] VA Impact Analysis for RIN 2900-APxx/WP 2013-036, Advanced Practice Registered Nurses. "APRN Gains and Losses for FY-12 to FY-16 (Source: 2015 VHA Workforce Planning Report): The number of Nurse Anesthetist gains and losses for FY-12 to FY-16: Total Gains – 314 / Total Losses – 226 for a net gain of 88. The number of Nurse Practitioner gains and losses for FY-12 to FY-14: Total Gains – 1499 / Total Losses – 879 for a net gain of 620."