American Association of
NURSE ANESTHESIOLOGY

May 16, 2022

via email to: PCORTF@ahrq.hhs.gov

To Whom It May Concern,

The American Association of Nurse Anesthesiology (AANA) welcomes the opportunity to comment on the request for information entitled ‘‘Request for Information: AHRQ’s Proposed Patient-Centered Outcomes Research Trust Fund (PCORTF) Strategic Framework.

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 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

[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

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]

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.

The AANA supports the agency's PCORTF Strategic Framework consistent with AHRQ's broader goal of improving the quality, safety, equity, and value of healthcare delivery. We are committed to our work with the agency to help reduce barriers to CRNA practice and ensuring patients have access to timely, cost effective and high-quality care. As the agency looks to use this framework to guide long-range planning and the development of projects and investments to advance the overall vision of advancing equitable whole-person care across the lifespan, we recommend including research on the value of permanent CRNA supervision removal as part of the Medicare Part A Conditions of Participation and Conditions for Coverage, which would help support both increased patient access to care and workforce retention efforts.

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[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] 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.

A recent article in Health Affairs entitled *A Worrisome Drop in the Number of Young Nurses* highlights the issues that we are facing with the nursing workforce. According to the article, "Now, two years into the COVID-19 pandemic, the supply of RNs is under threat again" and that new data "covering the entirety of 2021, show the total supply of RNs decreased by more than 100,000 in one year—a far greater drop than ever observed over the past four decades." The COVID-19 Public health emergency (PHE) has shown the important need for health care professionals to work to the top of their scope to care for patients and highlights the important role that CRNAs play in our healthcare system, especially when workforce barriers to practice are eliminated. Throughout the PHE, facilities have required all providers to work to the top of their education and state scope of practice.

In their roles as Advanced Practice Registered Nurses (APRNs), many CRNAs have stepped up in these challenging times by assisting on the frontlines of the pandemic to provide expert care to the sickest patients. During this pandemic, we have seen barriers to CRNA practice removed at both the state and federal levels, allowing CRNAs to provide critical, lifesaving care to patients. CRNAs are practicing independently during this crisis, working under stressful conditions in facilities across America, 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. 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.[8]

During the PHE, a number of rules and regulations related to healthcare have been temporarily suspended, in order to ensure that the healthcare workforce is maximized to deal with the overwhelming demand brought on by COVID. The Centers for Medicare and Medicaid Services (CMS) established a temporary waiver that removed physician supervision requirements of CRNAs during the PHE. CRNAs practice autonomously and are qualified to make independent judgments based on their education, licensure, and certification and removing this requirement permanently will benefit patients and the larger healthcare system. Given the important role that CRNAs are playing in providing care during the pandemic through the removal of unnecessary rules, the AANA supports a thorough and evidence-based approach to ensure that any rules that have been suspended during the PHE are only re-enacted if they serve a meaningful purpose in the healthcare delivery system. In addition to being an important part of the response to the PHE, removing physician supervision of CRNA practice aligns the recommendations from the New England Journal of Medicine[9] and also aligns with the National Academy of Medicine's recommendation, "[a]dvanced practice registered nurses should be able to practice to the full extent of their education and training."[10]

Medicare's physician supervision requirement for CRNAs is unnecessary that does not improve safety and only serves to increase costs and decrease access to care. This outdated and superfluous regulation adds an extra burden on states by overriding state laws to add unnecessary supervision requirements. Currently, only

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

[9] Frogner, Fraher,Spetz, Pittman, Moore, Beck, Armstrong and Buerhaus. (2020) Modernizing scope-ofPractice regulations –Time to Prioritize Patients. New England Journal of Medicine.382;7.p591-593.

[10] National Academy of Medicine. The future of nursing: leading change, advancing health. Washington, DC: The National Academies Press, p. 3-13 (pdf p. 108) 2011.

seven states require supervision of CRNA services according to state nursing laws. There is no evidence that physician supervision of CRNAs improves patient safety or quality of care. In fact, there is strong and compelling data showing that physician supervision does not have any impact on quality and may restrict access and increase healthcare costs. Studies have repeatedly demonstrated the high quality of nurse anesthesia care, and a gold standard study published in Health Affairs[11] led researchers to recommend that costly and duplicative supervision requirements for CRNAs be eliminated. 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 become safer in opt-out and non-opt-out states alike. In reviewing the study, the New York Times stated, "In the long run, there could also be savings to the health care system if nurses delivered more of the care."[12]

The AANA appreciates the opportunity to comment to this strategic framework and we recommend further research on the value of permanent CRNA supervision removal for future investments in this strategic framework. 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,

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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

[11] Dulisse, op. cit

[12] Who should provide anesthesia care? (Editorial) New York Times, Sept. 6, 2010.