

Congress of the United States
Washington, DC 20515

October 25, 2022

The Honorable Denis McDonough
Secretary of Veterans Affairs
810 Vermont Ave., NW
Washington, D.C. 20420

Dear Secretary McDonough:

As the Department of Veterans Affairs (VA) develops a National Standard of Practice (NSP) for Certified Registered Nurse Anesthetists (CRNAs), we write to express our strong support for VA following the evidence and granting full practice authority to CRNAs.

As you know, CRNAs are Advanced Practice Registered Nurses (APRNs) who have completed postgraduate education and training and have been certified in the provision and managing of anesthesia.¹ CRNAs administer more than 50 million anesthetics to patients each year in the United States,² particularly in areas with the greatest need: CRNAs have historically been the predominant providers of anesthesia care in the smallest and most remote hospitals in the United States.³ CRNAs also tend to serve more vulnerable populations as compared to anesthesiologists, including low-income, uninsured, and unemployed individuals.⁴

The most comprehensive review of the effects of granting full practice authority to CRNAs, published in *Health Affairs*, found no evidence that removing physician oversight requirements for CRNAs resulted in increased inpatient deaths or complications.⁵ The high quality of care that CRNAs can be trusted to provide is reflected in our military, where TRICARE allows CRNAs to practice independent of physician referral and supervision.⁶ CRNAs can also practice independently in the majority of U.S. states.⁷

¹ Sidath Viranga Panangala & Jared S. Sussman, *Full Practice Authority for VA Registered Nurse Anesthetists (CRNAs) During the COVID-19 Pandemic* (May 27, 2020).

² American Association of Nurse Anesthetists, *Certified Registered Nurse Anesthetists Fact Sheet* (accessed June 30, 2022).

³ Peter J. Dunbar, *Availability of Anesthesia Personnel in Rural Washington and Montana* (March 1998).

⁴ C Jason Liao, Jihan A Quraishi, and Lorraine M Jordan, *Geographical Imbalance of Anesthesia Providers and its Impact On the Uninsured and Vulnerable Populations* (Sep.-Oct. 2015).

⁵ Brian Dulisse and Jerry Cromwell, *No Harm Found When Nurse Anesthetists Work Without Supervision By Physicians* (August 2010).

⁶ 32 CFR § 199.6

⁷ NCSBN, *CRNA Independent Practice Map* (accessed June 30, 2022).

VA has already granted full practice authority to other APRNs pursuant to a 2016 final rule.⁸ However, VA stated that CRNAs were not granted full practice authority through the rule because of “VA’s lack of access problems in the area of anesthesiology,” though VA explicitly acknowledged that the exclusion of CRNAs did “not stem from the CRNAs’ inability to practice to the full extent of their professional competence.”⁹ Moreover, the rule made clear VA would reconsider the exclusion of CRNAs from the full practice authority rule if anesthesia access shortages were demonstrated.¹⁰

Subsequent to the finalization of the 2016 rule, access problems at VA have emerged. For example, VA’s Office of Inspector General published a national review of occupational staffing shortages at the Veterans Health Administration (VHA) for fiscal year 2021, finding anesthesiology shortages at numerous VHA facilities, including in Massachusetts, Rhode Island, New York, Pennsylvania, North Carolina, Florida, Tennessee, Michigan, Indiana, Illinois, Louisiana, Arkansas, Colorado, Oklahoma, Washington State, California, and Minnesota.¹¹

These anesthesiology workforce shortages have real consequences for our veterans, limiting access to high-quality care at a time when demand is growing for surgical procedures due to an aging veteran population.^{12,13} In this context, it is more important than ever that VA ensures CRNAs can practice to the full extent of their education and training. Therefore, we urge VA to swiftly complete the Department’s NSP development process for CRNAs and grant full practice authority to these health care professionals who provide essential health care services to veterans in communities across the United States every day. We also request written responses to the following questions by November 30, 2022:

1. How many VA facilities currently utilize 1:1 and 1:2 models of anesthesia supervision?
2. What is the difference in costs to VA of providing care using 1:1 and 1:2 models of anesthesia supervision compared to providing care without such supervision requirements on average per case?
3. Given the absence of evidence to suggest that 1:1 or 1:2 models of anesthesia supervision increase patient safety, what is the justification for the continued use of these models of care?

⁸ Federal Register, *81 FR 90198* (December 14, 2016).

⁹ Federal Register, *81 FR 90198* (December 14, 2016).

¹⁰ *Ibid.*

¹¹ Department of Veterans Affairs Office of Inspector General, *OIG Determination of Veterans Health Administration’s Occupational Staffing Shortages, Fiscal Year 2021* (September 28, 2021).

¹² Lindsay Daugherty, Raquel Fonseca Benito, Krishna B. Kumar, and Pierre-Carl Michaud, *Is There a Shortage of Anesthesia Providers in the United States?* (2010).

¹³ Angela Richard-Eaglin, Janet G. Campbell, and Queen Utley-Smith, *The aging veteran population: Promoting awareness to influence best practices* (July-August 2020).

Thank you for your prompt attention to this matter. Please contact Jack DiMatteo in Congresswoman Lauren Underwood's office (Jack.DiMatteo@mail.house.gov) and Emily Henn in Congressman Sam Graves' office (Emily.Henn@mail.house.gov) with any questions.

Sincerely,

Lauren Underwood
Member of Congress

Sam Graves
Member of Congress

Joe Courtney
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Chuck Fleischmann
Member of Congress

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Member of Congress

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Lucille Roybal-Allard
Member of Congress

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Marc Veasey
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cc: Shereef Elnahal, M.D., Deputy Under Secretary for Health