AANA
American Association of
NURSE ANESTHESIOLOGY

October 5, 2023

Mr. Ethan Kalett
Office of Regulations, Appeals and Policy (10BRAP)
Veterans' Health Administration
Department of Veterans Affairs
810 Vermont Avenue NW,
Washington, DC 20420

Dear Mr. Kalett,

The American Association of Nurse Anesthesiology (AANA) appreciates the opportunity to provide the Veterans Health Administration (VHA) the following information as a follow-up to the September 21, 2023, National Standards of Practice Listening Session related to Certified Registered Nurse Anesthetists (CRNA). While we sincerely value the agency's desire to ensure an open discussion on national practice standards, we were dismayed that the American Society of Anesthesiology (ASA) and its surrogates were given most of the meeting time to continue to spread disinformation on the safety and effectiveness of CNRAs. It is well known that the ASA desires to be actively engaged in the development of CRNA practice standards to limit practice and keep CRNA's under an antiquated and inefficient physician led supervision model. AANA strongly opposes this blatant intrusion by a medical specialty into CRNAs practice authority and we urge the VA to take the ASA's arguments for what they are – fearmongering and misinformation to try to maintain the status quo.

We recognize that politics plays a role in scope of practice issues – both at the federal and state level. In 2016 the VHA had the opportunity to recognize CRNAs for full practice authority in the review of all advanced practice nurses practice acts. Unfortunately, while the final rule acknowledged that CRNAs provide safe and effective care with outcomes comparable to that of a physician anesthesiologist, the agency chose to exclude CRNAs from full practice authority within the VA while granting this authority to the other three advanced practice nurse providers. The rational – that was called out by ASA at the time was that there was no demonstrated shortage of anesthesia providers at that time.

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.[1] The report stated that 91% of facilities reported severe shortages of nurses and many reported shortages for both CRNAs and anesthesiology in general.[2] 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.[3] 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.

Given the more recent GAO's findings, the VHA's 2016 argument that full practice authority for CRNAs was not necessary because there was no shortage of anesthesia provider now rings hollow. Continued documented shortages, coupled with continued evidence that that CRNAs provide safe and effective lend to the argument that there is no clear rationale for the VHA to deny CRNAs full practice authority which includes autonomous practice as the national standard of care.

VARIANCES IN STATE SCOPE OF PRACTICE

AANA continues to question the state scope of practice data that has been shared by the ASA at the listening session which indicates that 44 states require supervision. This is a blatant falsehood. Any variances in state laws are due to politics. CRNAs do not have to be supervised by an anesthesiologist in all but one state -New Jersey, and only in certain types of facilities.

The VA authorized full practice authority in 2016 for the other APRNs - nurse practitioners, clinical nurse specialists, and certified nurse midwives. These APRN roles also have variability in the state laws that address their practice. However, authorizing full practice authority for these APRNs has [now provided access to high quality care to VA patients without any resulting harm to these patients. In addition, practice without restrictive physician involvement for all APRN roles, including CRNAs, is consistent with the *Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education*.[4] This consensus document was endorsed by over 40 national nursing organizations, including the National Council of State Boards of Nursing, the national membership organization for state boards of nursing. These standards are already in effect, and they were created to help remove practice barriers for APRNs, including CRNAs.

We submit for the official record:

- State law requirements for physician involvement in CRNA practice are typically consistent in that they do not require that these be fulfilled by a physician anesthesiologist. These

[1] 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

[2] VA OIG, op cit.

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

[4] Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education https://www.ncsbn.org/public-files/Consensus_Model_for_APRN_Regulation_July_2008.pdf

requirements can be fulfilled by any MD/DO surgeon or proceduralist and, in many states, also by a dentist or podiatrist.
- CRNAs practice autonomously in every state.
- State laws may have requirements for CRNA to practice with the involvement of other providers that use various terminology, for example, “supervision” or “collaboration.” Regardless of the term that is used, this does not change the scope of anesthesia care CRNAs can provide.
- Twenty-four states have opted out of Medicare supervisions requirements.

We also would like to clear up falsehoods shared by physician groups regarding state supervision requirements. Currently, in 43 states, the state legislatures determined that it us unnecessary to require physician “supervision” in the state nurse practice act, state board of nurse rules, state medical practice act, and state medical board rules. The trend is that states are continuing to remove outdated terms like “supervision” and “direction” and replacing those with language that more accurately reflects the relationship between the operating practitioner and the CRNA. Terms such as “Supervision” and “direction,” do not accurately reflect the collaborative relationship between the CRNA and the operating practitioner, whether it is a physician, podiatrist, or dentist. There is no expectation that these providers “control” the actions of the CRNA. The CRNA is responsible and accountable for the anesthesia care provided. The proceduralist does not have this expertise and defers to the CRNA regarding the anesthesia care of the patient. The ASA in its own testimony conceded anesthesiologists with no anesthesia expertise is sufficient, and that anesthesiologist involvement is not necessary. They are asking the VA to require that physicians with no knowledge of or background in anesthesia “supervise” the CRNA. CRNAs have proven that their services are safe and effective.

AUTONOMOUS/INDEPENDENT PRACTICE

During the listening session, ASA and its planted spokespersons continue to assert that CRNAs currently practice under a physician directed team model. Their intent is to sow the seed of doubt that CRNAs do not practice independently/autonomously because there is a physician in the room. CRNAs are working autonomously in the delivery and management of anesthesia, though they coordinate with the larger surgical team. The surgeon is not directing the work of the CRNA, rather they are focused on their part of the surgery while the CRNA is focused on ensuring appropriate anesthesia services.

CRNAs are anesthesia and airway experts who have always worked autonomously in a team setting. The term, “physician-led” is intentionally and misleadingly used by physician anesthesiologists to create the impression that anesthesia “teams” are always led by physician anesthesiologists. This is an outright falsehood. By definition and by law, the preponderance of states permits any MD or DO, (and in some cases, podiatrists,) to direct anesthesia care during procedures they are conducting. Predominantly, these individuals have no anesthesia or airway training. “Physician-led” simply means the surgeon, MD or DO, focuses on the procedure requiring anesthesia while other members of the team focus on their respective responsibilities and the anesthesia provider (either CRNA or anesthesiologist) focuses on the anesthesia care.

An excellent model for autonomous care can be seen in the Iowa City and Des Moines, VA hospitals in Iowa, the first state in the nation to opt out of physician supervision. These facilities employ both CRNAs and physician anesthesiologists, but many of the providers are CRNAs. Most of their patients are high acuity, critical patients and their cases are complex. In these facilities, CRNAs and physician anesthesiologists are assigned their own rooms and their own cases. CRNAs practice without supervision and practice autonomously to the full extent of their education and training.

The beauty of the Iowa facilities and others with similar practice models, is that they decrease wait times, increase access to quality care and improve patient safety and satisfaction. Both facilities consistently rank among the most highly rated VA facilities although they are not the only two VA facilities with this practice model. These facilities reinforce the fact that while the VA does not have a critical shortage of anesthesia providers, they are crippled by a shortage of anesthesia providers who are actually providing anesthesia care. Duplicative, wasteful, and costly "supervision" of CRNAs by anesthesiologists must be eliminated for the sake of our veterans and to properly utilize this precious pool of talent.

Across the country, CRNAs can administer all levels of anesthesia in every state – local, sedation, regional and general. Regardless of the provider who is performing and assumes responsibility for the procedure, such as the MD/DO, dentist, or podiatrist, the CRNA is responsible and accountable for the anesthesia care provided to the patient. CRNAs also select, order, prescribe, and administer medications, including controlled substances. CMS supervision requirements in the Medicare Conditions of Participation for hospitals, ASCs and CAHs may also be met by any provider that CRNAs can practice with under state law, including an MD or DO, or dentists or podiatrists. No one is trying to replace the physicians and we need to maximize the use of all health care providers to the full extent of their credentials and training to provide care.

CRNA EDUCATION, TRAINING AND CERTIFICATION

AANA strongly believes that VA should address state variances by requiring board certification, with all anesthesia providers required to demonstrate competencies before being permitted to practice.

As stated, state variances in CRNA scope and oversight are politically influenced and should not be used as the sole basis of decision making on national standards. CRNAs have advanced education and clinical expertise that has proven time and again to be instrumental in delivering quality healthcare to our veterans and do not require redundant supervision. For entry into practice,

For the record:

CRNA preparation requires at least 7–8.5 calendar years of education and experience. This includes:

- Completion of a Doctor of Nursing practice as the entry requirements to the profession. A baccalaureate or graduate degree in nursing or another appropriate major was the former requirement.
- An unencumbered license as a registered professional nurse and/or APRN in the United States or its territories
- At least one year of full-time work experience as a registered nurse in a critical care setting
- Building on the critical care foundation, CRNAs successfully complete a comprehensive didactic and clinical practice curriculum at a nurse anesthesia program accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs.
- Graduation with a minimum of a master's degree from a nurse anesthesia educational program accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs (COA) which is the credentialing body for nurse anesthetists.
- Graduates are board certified as CRNAs following successful completion of the National Certification Examination.

Additionally, CRNAs are responsible to the public for professional excellence through lifelong learning and practice, continued certification, continuous engagement in quality improvement and professional development, and compliance with the Standards for Nurse Anesthesia Practice and Code of Ethics for the Certified Registered Nurse Anesthetist.

EVOLUTION OF HEALTH CARE

Physicians have been aggressively pursuing a campaign they call scope creep against nonphysician providers, including CRNAs, dedicating a web site where they are fighting for physician led care at both the state and federal levels. The AMA has been fighting against legislation for scope expansions of nonphysicians since 2019. The practice of nursing is governed by nursing and is often challenged by our physician colleagues with the spreading of lies that physicians should lead care teams because they want to protect safe and effective care. CRNAs support a team-based approach where each provider practices to their full scope of knowledge and training. Standards of practice should not be an us-versus-them situation when caring for patients. This is not about competition, rather it's about veteran safety and giving them the best care, they deserve. The AMA and ASA need to stop advancing the false and offensive narrative in this campaign, which suggests nonphysician provider care is not safe and jeopardizes patient safety. Instead of pushing scope creep, they should realize that this is the evolution of health care where new technologies and new methods of care are helping to deliver healthcare more efficiently and safely. APRNs are perfectly educated, trained and board certified to provide safe and effective care and is the step in the right direction in giving veterans the care they need.

RESEARCH/PUSH POLLS

AANA continues to maintain that the studies provided by ASA regarding CRNA outcomes and safety are inaccurate and fly in the face of existing research on the outcomes and safety of a CRNA providing anesthesia as well as the VA's own findings.

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 training.

Other recent studies have identified CRNAs as crucial care providers that have not been used to their full potential; APRNs provided care that resulted in decreased length of stay, ventilator days, mortality rate, and medication cost per patient; and no significant difference in quality-of-care outcomes when comparing APRNs to other providers.

This also corroborates an earlier peer reviewed study published in Health Affairs in 2010[5] that looked at the differences in outcomes in states that had opted out of Medicare's supervision requirement for CRNAs and found they were no different than outcomes in states that maintained supervision. Similar findings were apparent in the maternal healthcare space as well, with a study published in Health Services Research in 2009[6] showing that hospitals that utilized a CRNA only model of anesthesia did not have poorer outcomes for maternal care than hospitals that utilized a supervisory or anesthesiologist only model, and a study published in the Journal of Nursing Research[7] found that outcomes were the same for various models when it came to cesarean deliveries. A comprehensive review completed by the Cochrane Library in 2014 further reinforced these finding, when it reviewed the literature on anesthesia staffing and found that there could be no definitive statement can be made about the superiority of anesthesia delivery models.

The VA itself agreed that CRNAs are capable of practicing independently within the VA without harming patient access to care. In the 2016 APRN Final Rule issued by the VA, the rule stated, "Several other commenters stated "Over 900 CRNAs provide every type of anesthesia care, as well as chronic pain management services, for our Veterans in the VHA. 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.[8]"

Some low-quality studies have purported to claim that CRNAs providing anesthesia without supervision negatively affects outcomes. A 25-year-old study that was not published in a peer-reviewed Journal, but rather in the Journal run by the ASA, has major methodological issues that lead the Centers for Medicare & Medicaid to dismiss the study as too flawed to be used, stating, "One cannot use this analysis (Silber) to make conclusions about CRNA performance with or without physician supervision."[9] This study looked at outcomes for 30-days post operative period, which is well outside the 48-hour period for anesthesia related complications.

The AMA has recently been pushing another flawed study out of the Hattiesburg VA and claiming this study applies to CRNAs and other advanced practice providers. AMA's assertations are

---

[5] Dulisse, Brian; Cromwell, Jerry. No Harm Found When Nurse Anesthetists Work Without Supervision by Physicians. (August 2010). Health Affairs. Vol. 29. No. 8

[6] Needleman J, Minnick AF. Anesthesia provider model, hospital resources, and maternal outcomes. Health Serv Res. 2009 Apr;44(2 Pt 1):464-82. doi: 10.1111/j.1475-6773.2008.00919.x. Epub 2008 Nov 4. PMID: 19178582; PMCID: PMC2677049

[7] Simonson, Daniel C.; Ahern, Melissa M.; Hendryx, Michael S.. Anesthesia Staffing and Anesthetic Complications During Cesarean Delivery: A Retrospective Analysis. Nursing Research 56(1):p 9-17, January 2007.

[8] Medicare and Medicaid Programs, op cit.

[9] Medicare and Medicaid Programs; Hospital Conditions of Participation: Anesthesia Services. 66 FR 4674. (18 January 2001).

intentionally misleading because it only looks at primary care provided by nurse practitioners, not CRNAs, and is not a quality study. CRNAs and nurse practitioners have different education standards and provide different types of care. The highly questionable Hattiesburg study has no relevance to CRNA practice. The same goes for the flawed American Legion survey touted at the September 21 listening session which contained misleading questions and such a low number of respondents that the results should not even be valid.

THE COST OF SUPERVISION

During the public health emergency (PHE), Medicare waived the supervision requirement for CRNAs, and the VA put forth a memo calling for VA facilities to utilize CRNAs to the top of their scope. When these restrictions were lifted, there was no evidence that outcomes deteriorated. In fact, during the same period, seven new states (Arizona, Oklahoma, Utah, Michigan, Arkansas, Wyoming, and Delaware) signed some form of opt-out from Medicare's supervision requirements for CRNAs, further demonstrating how unnecessary such restrictions are.

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.[10] 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, and 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.

OUTSIDE SUPPORT FOR FULL PRACTICE AUTHORITY

Across the ideological spectrum, groups have weighed in with support for removing barriers to care for APRNs, to increase access to care and to reduce costs. Allowing CRNAs and other APRNs to work to the full extent of their education and training is supported by numerous independent groups across the political spectrum, from the American Enterprise Institute[11], to the Bipartisan Policy Center[12], to the Brookings Institute[13] as well as Veterans Service Organizations (VSOs). It is also supported by both the Bipartisan Commission on Care report[14] and the VA's own Independent Assessment. Even when the VA made the political decision to remove CRNAs from the APRN full practice rule, VA acknowledged the ability to

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

[11] https://campaignforaction.org/wp-content/uploads/2016/11/Freemarketcasefullpractice.pdf

[12] https://bipartisanpolicy.org/report/confronting-rural-americas-health-care-crisis/

[13] https://www.brookings.edu/wp-content/uploads/2018/06/am_web_0620.pdf

[14] Commission on Care. June 30, 2016. Final Report. https://s3.amazonaws.com/sitesusa/wp-content/uploads/sites/912/2016/07/Commission-on-Care_Final-Report_063016_FOR-WEB.pdf

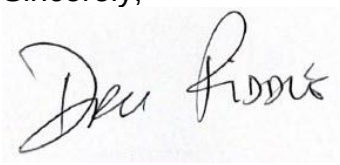
CRNAs to safely work autonomously and acknowledged the significant scientific and clinical evidence that supports CRNA autonomous practice.

CONCLUSION

Decisions on scope of practice should not be based on political influence but should be based on clinical and scientific evidence and what is in the best interest of veterans. Extending autonomous practice privileges to CRNA's is essential in addressing surgical wait times for our veterans without compromising care. Development of National Standards of Practice will not lower the standard of care. Allowing both physician anesthesiologists and CRNAs the ability to provide direct patient care without redundant supervision requirements will facilitate this relief.

AANA appreciates the opportunity to comment and looks forward to being a continued resource. Should you have any questions regarding our comments, please feel free to contact the AANA Senior Associate Director, Federal Regulatory and Payment Policy, Randi Gold, at 202-741-9082 or rgold@aana.com.

Sincerely,



Dru Riddle, PhD, DNP, CRNA, FAAN
AANA President

cc: William Bruce, MBA, CAE, AANA Chief Executive Officer
Ingrida Lusis, AANA Chief Advocacy Officer
Randi Gold, MPP, AANA Senior Associate Director Federal Regulatory and Payment Policy