June 25, 2018

Carolyn Clancy, MD
Executive in Charge
Veterans Health Administration
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington DC 20420

RE: VHA Directive 1123

Dear Dr. Clancy:

The American Association of Nurse Anesthetists (AANA) is greatly concerned about Veterans Health Administration (VHA) Directive 1123, which places onerous supervision requirements on Certified Registered Nurse Anesthetists (CRNAs) working in VHA facilities. We believe these changes are unnecessary, demonstrate bias against CRNAs, and will lead to reduced patient access to care and more expensive/less efficient anesthesia services for our nation’s veterans. VHA Directive 1123 fails to provide satisfactory justification for implementing new policies that move the VHA further away from their stated goal of providing the most efficient, highest quality anesthesia care. We recommend the VHA reconsider VHA Directive 1123 and instead, adhere to the evidence that clearly demonstrates that permitting full practice authority for CRNAs will ensure veterans receive the full scope of timely, high-quality anesthesia and pain management care they so rightfully deserve within VHA facilities.

The issues addressed in our comment are outlined as follows:

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I. CRNAS PROVIDE SAFE, HIGH QUALITY AND COST-EFFECTIVE HEALTHCARE

The AANA is the professional association for Certified Registered Nurse Anesthetists (CRNAs) and student registered nurse anesthetists (SRNAs). AANA membership includes more than 52,000 CRNAs and SRNAs, representing over 90 percent of the nurse anesthetists in the United States. CRNAs are advanced practice registered nurses (APRNs) who personally administer approximately 43 million anesthetics to patients each year in the United States. 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 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, managing the patient throughout the surgery and post anesthesia care. CRNAs also provide acute, chronic, and interventional pain management services. CRNAs provide anesthesia for a wide variety of surgical cases and in most 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 on the front lines in combat support hospitals and forward surgical teams. CRNAs 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 and affording these facilities the capability to provide many necessary procedures.

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. A May/June 2010 study published in the journal *Nursing Economic*,$ found no significant differences in
rates of anesthesia complications or mortality between CRNAs and anesthesiologists or among delivery models for anesthesia that involve CRNAs, anesthesiologists, or both.\textsuperscript{1} Furthermore, the study found 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.\textsuperscript{2} An August 2010 study published in \textit{Health Affairs} showed no differences in patient outcomes when anesthesia services are provided by CRNAs, physicians, or CRNAs supervised by physicians.\textsuperscript{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.\textsuperscript{4} Furthermore, a study published in \textit{Medical Care} (June 2016) found no measurable impact in anesthesia complications from nurse anesthetist scope of practice or practice restrictions.\textsuperscript{5}

CRNAs 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. 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.\textsuperscript{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

\begin{enumerate}
\item Hogan et al, op cit.
\end{enumerate}
lower median incomes and larger populations of citizens who are unemployed, uninsured, and/or Medicaid beneficiaries.  

II. AANA AREAS OF CONCERN WITH VHA DIRECTIVE 1123

Currently in VHA facilities, CRNAs are being underutilized because the U.S. Department of Veterans Affairs (VA) has not granted CRNAs the ability to practice to the full scope of their education, training, licensure, and certification. On December 14, 2016, the VA issued a final rule granting three of the four APRN specialties full practice authority (FPA), excluding only CRNAs. Now, VHA Directive 1123 presents updates to the VHA anesthesia policy that includes additional CRNA supervision requirements, which will ensure that veterans will not receive the full scope of timely, high-quality anesthesia and pain management care they so rightfully deserve. Given this fact, any new policies that implement more restrictive anesthesia delivery models are antithetical to the types of decisions the VHA needs to be making to improve access and quality for our nation’s veterans. Our concerns with VHA Directive 1123 are outlined below.

A. (Page 2) - 1. Reason for Issue

The AANA has concerns with the use of the word “anesthesiology” in the introductory sentence of this section explaining the reason for issuing VHA Directive 1123. The sentence states “This Veterans Health Administration (VHA) directive updates the required programmatic structure and procedures that are to be used for the practice of anesthesiology in VHA.” Use of the term anesthesiology, which is defined as the branch of medicine concerned with anesthesia and anesthetics, fails to recognize that anesthesia is also an advanced practice of nursing. The term anesthesiology does not acknowledge CRNA services in field of anesthesia, which also comprises roughly half of the anesthesia providers within the VA. CRNAs currently make up approximately 50% of the VHA anesthesia workforce and are a critical part of anesthesia delivery within the VA. Without CRNA care, the vast majority of veterans and VHA facilities would not have access to anesthesia services. Therefore, we recommend the word “anesthesiology” be changed to the term “anesthesia” so the that this sentence will now read as the following (new language underlined):

7 Liao, op cit.
This Veterans Health Administration (VHA) directive updates the required programmatic structure and procedures that are to be used for the practice of anesthesia in VHA.”

B. (Page 4) - 2. Background

The AANA objects to the use of the term “the medical specialty of anesthesiology” in the first sentence of this background piece. As stated in the previous section, anesthesia is not solely the practice of medicine. The specialty of anesthesia is also the practice of nursing of which CRNAs have provided anesthesia in the United States for 150 years. Nurse anesthetists have been the main providers of anesthesia care to U.S. military personnel on the front lines since WWI and CRNAs were the first to provide anesthesia to wounded soldiers during the Civil War. CRNAs provide anesthesia in collaboration with surgeons, anesthesiologists, dentists, podiatrists, and other qualified healthcare professionals. All anesthesia professionals provide anesthesia services in the same way. Also, CRNAs practice in every setting in which anesthesia is delivered: traditional hospital surgical suites and obstetrical delivery rooms; critical access hospitals; ambulatory surgical centers; the offices of dentists, podiatrists, ophthalmologists, plastic surgeons, and pain management specialists; and U.S. military, Public Health Services, the Indian Health Services and of course, the Department of Veterans Affairs healthcare facilities. To be inclusive of all types of anesthesia providers, we again recommend removal of the word “medical” and also change the word “anesthesiology” to the term “anesthesia” in this section and throughout the rest of VHA Directive 1123. We recommend the first sentence to read as the following (new language underlined):

“The specialty of anesthesia has evolved over the years, and VHA now provides a wide range of anesthesia services to Veterans, including the assessment of, consultation for, and preparation of patients for anesthesia and acute pain management as well as the management of homeostasis in the critically ill, injured, or otherwise seriously ill patient.”

C. (Page 4) - 3. Definitions (c. Anesthesia Team)

The AANA is concerned that VHA Directive 1123 requires the anesthesia team leader in the VHA to be an anesthesiologist and that an anesthesiologist is considered to be the professional with the most advanced anesthesia training. As advanced practice registered nurses, CRNAs practice with a high degree of autonomy and professional respect. There is no evidence supporting the requirement for an anesthesiologist to be the anesthesia team leader in VHA facilities. CRNAs are highly educated anesthesia experts and are fully qualified to serve in this role. In many hospitals and facilities, the
CRNA may be the only health care professional possessing expertise and training in the anesthesia specialty. The scope of nurse anesthesia practice includes responsibilities for administration and management, quality assessment, interdepartmental liaison and clinical/administrative oversight of other departments. Because CRNAs possess a strong foundation in nursing, critical care and anesthesia and pain management, CRNAs are frequently called upon to assume administrative and executive positions. With their specialty background as well as the CRNA educational preparation at the master’s and doctoral level, CRNA are being selected to function as anesthesia and surgery department administrators, chief nurse executives, chief operating officers and chief executive officers of hospitals. VHA facilities must move away from the hierarchical based physician led team to become more in line with modernization of health care with interprofessional, collaborative, veteran-centered team. Furthermore, no credible study has ever shown that a physician lead anesthesia team is superior to any other staffing model and literature has shown equally safe patient outcomes for solo provider staffing models or supervision models of 1 physician supervising two or more CRNAs. VHA facilities should be able to select the very best anesthesia leader for the job, based on merit and not on a provider’s license.

In addition, VHA Directive 1123 includes anesthesia residents and anesthesiologist assistants but does not include SRNAs as part of the anesthesia team. More than 2,400 student registered nurse anesthetists graduate each year and go on to pass the National Certification Examination to become CRNAs. As SRNAs are an integral part of the anesthesia team, they should be included as part of the anesthesia team in VHA Directive 1123.

D. (Page 7) - 5. Responsibilities (e. Deputy Director, NAS)

The AANA has concerns that the role of National Anesthesia Service (NAS), Deputy Director, as written in VHA Directive 1123, because it implies subservience to the Director, National Anesthesia.

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8 Paul F. Hogan et al., “Cost Effectiveness Analysis of Anesthesia Providers.” *Nursing Economics*. 2010; 28:159-169. http://www.aana.com/resources2/research/Documents/nec_mj_10_hogan.pdf
Service. We recommend the VHA eliminate what is listed as (1) in this new directive and keep all other Deputy Director duties as described in the VHA Handbook 1123. We also recommend the VHA add the following amendments to this job description:

- (1) Coordinating CRNAs activities through the Director, NAS, serve as the subject matter expert for nurse anesthesia for NAS and VACO.
- (2) Recommending, preparing and implementing policies, plans and professional standards regarding the practice of nurse anesthesia by VHA CRNAs.
- Keep all further responsibilities, simply changing numbers so that 4 becomes 3, -amending:
- (4) Assisting field facilities, when requested, in recruitment of anesthesia health care staff and recommending scope of practice or privileging parameters for CRNAs.
- (6) is renumbered to 5, et al. and adding:
- (9) Consult with VISN Network Director on appointment of VISN Chief CRNA Consultant.

E. (Page 7) – 5. Responsibilities (f. VISN Chief Anesthesia Consultant)

Currently VHA Directive 1123 as written does not include CRNAs as able to fill the role of VISN Chief Anesthesia Consultant. As stated above, CRNAs are highly educated anesthesia experts and are fully qualified to serve in this role and on any role in the anesthesia team in VHA facilities. The AANA recommends that the role of VISN Chief Anesthesia Consultant should include CRNA representation. If CRNAs were eligible for the role of VISN Chief Anesthesia Consultant, this would be comparable to how the Chief CRNAs have a role in the VHA facility and the Field Advisory Committee. We recommend the VCAC qualifications be amended to read (new language underlined):

(1) A. The VCAC must have the following qualifications: – A Physician actively engaged in the practice of anesthesiology at a VHA facility and a CRNA actively engaged in the practice of anesthesia at a VHA facility.

F. (Page 9) – 5. Responsibilities (i. Facility Chief, Anesthesia Services or Section)

The responsibilities of the Facility Chief, Anesthesia Services or Section in determining departmental policy should be in collaboration with the Chief CRNA. The Chief CRNA helps determine whether the facility should use privileges or scope of practice to define CRNA responsibilities and duties. We recommend this positions job description be amended to read:
(3) Determine departmental policies in collaboration with the Chief CRNA.


The AANA has concerns about the language in this section that declares, “As allowed by the State license and the local VA medical facility, a CRNA may practice as a Licensed Independent Practitioner (LIP), in collaboration with a physician, or under physician supervision. To be considered for LIP status, the CRNA must possess a DEA License through Schedule 2 Controlled Substances.” State law does not typically require a CRNA to have prescriptive authority and an individual Drug Enforcement Administration (DEA) registration to provide anesthesia care during the perioperative period. Under federal law, CRNAs can function as employees or agents under the DEA registration of the facility rather than obtaining an individual DEA registration. State law does not consider CRNAs functioning under the facility DEA registration to be more or less independent than those with an individual DEA registration; the DEA registration is used to track the use of drugs, and does not in and of itself grant prescriptive authority. Furthermore, state law concerning CRNAs rarely uses the term “licensed independent practitioner” (LIP). This is a term that originated with The Joint Commission (TJC). As LIP is used by the TJC, it concerns whether supervision is required. Use of LIP by the TJC does not concern prescriptive authority or possession of an individual DEA registration and recommend deleting use of the term LIP. Therefore, we recommend the following language to be removed from this section (language to be removed contains strikethrough):

10. Appendix B (1) “The possible maximum breadth of Certified Registered Nurse Anesthetist (CRNA) practice is controlled by the individual’s State license. As allowed by the State license and the local VA medical facility, a CRNA may practice as a Licensed Independent Practitioner (LIP), in collaboration with a physician, or under physician supervision. To be considered for LIP status, the CRNA must possess a DEA License through Schedule 2 Controlled Substances. The individual CRNA must also be granted privileges by the local VA medical facility under the recommendation of the Chief of Anesthesia. The team approach should still be the preferred model even when a CRNA has LIP status. Changes to existing CRNA Privileges are controlled by the process outlined in VHA Handbook 1100.19, Credentialing and Privileging, dated October 15, 2012 and are beyond the scope of this directive. NOTE: The possession of a DEA Controlled Substance Registration Certificate grants a health care provider the authority to prescribe or administer controlled substances.

through Schedule 2. This certificate is part of a health care provider’s state license. Some facilities may require approval from the credentialing committee before the provider may exercise this authority. See the Controlled Substances Act, 21 U.S.C. 801.”


The AANA recommends removal of Appendix B (2) because of the comparison of residents to CRNAs is inaccurate and illogical. Anesthesia residents are just beginning to build their basic anesthesiology knowledge and start subspecialty training whereas CRNAs have already completed this training. Upon graduation CRNAs have an average of 8,636 clinical hours and a minimum of 7-8 years of education in nursing and anesthesia. This education and training makes CRNAs a much more qualified practitioner than a medical resident, with almost zero training in the delivery of anesthesia and they should not be equated under CRNA practice guidelines in VHA Directive 1123. For these reasons, we request removal of Appendix B (2).


The AANA requests removal of Appendix B (3) because it contains burdensome CRNA supervision requirements. Currently in VHA facilities, CRNAs are being underutilized because the U.S. Department of Veterans Affairs (VA) refuses to grant CRNAs the ability to practice to the full scope of their education, training, licensure, and certification. Forty 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. And no states require involvement of anesthesiologists involvement in the practice of CRNAs, save for a singular provision in New Jersey relating to CRNA practice in Ambulatory Surgical Centers (ASC). CRNA supervision leads to increased costs and reduced access to timely care, but does not lead to better healthcare outcomes. Thus, we recommend removal of Appendix B (3).

J. (Page 15) – 13. Appendix E: Requirements for Anesthesia Professionals. 1. Organization (c)

13 This does not take into account hospital statutes or regulations.

14 See pages 13-16 of this comment letter.
As stated in our comments on page 6 of this letter, the AANA is concerned that VHA Directive 1123 requires the anesthesia team leader in the VHA to be an anesthesiologist and that an anesthesiologist is considered to be the professional with the most advanced training on the anesthesia team. As advanced practice registered nurses, CRNAs practice with a high degree of autonomy and professional respect, and there is no evidence supporting the requirement for an anesthesiologist to be the anesthesia team leader in VHA facilities. CRNAs are highly educated anesthesia experts and are fully qualified to serve in this role. In many hospitals the CRNA may be the only health care professional possessing expertise and training in the anesthesia specialty. The scope of nurse anesthesia practice includes responsibilities for administration and management, quality assessment, interdepartmental liaison and clinical/administrative oversight of other departments. Because CRNAs possess a strong foundation in nursing, critical care and anesthesia and pain management, CRNAs are frequently called upon to assume administrative and executive positions. With their specialty background as well as the CRNA educational preparation at the master’s and doctoral level, CRNA are being selected to function as anesthesia and surgery department administrators, chief nurse executives, chief operating officers and chief executive officers of hospitals.

Therefore, we request removal of the language in this paragraph that talks about the team model that implies an anesthesiologist should be the team leader. Therefore, we recommend the following language to be removed from this section (language to be removed contains strikethrough):

1. ORGANIZATION c. “The health care system incorporates different types of facilities with differing levels of complexity of anesthetic care. An Anesthesia Team model is preferred however we recognize that different models of anesthesiaology practice may exist including medical facilities with: (1). A team consisting of anesthesia professionals as defined in this directive. (2.) Only Anesthesiologists and (3.) Only CRNAs”.

K. (Page 16) – 13. Appendix E: Requirements for Anesthesia Professionals. 1. Organization (e)

The AANA requests removal of this paragraph because there is no evidence or studies that support the statement that supervision of CRNAs causes an increase of productivity in VHA facilities. Instead, CRNA supervision leads to increased costs and reduced access to timely care, but does not lead to better healthcare outcomes which has been confirmed by scientific research data.15

15 See pages 13-16 of this comment letter.
III. ASSESSMENT OF CURRENT AND FUTURE ACCESS TO ANESTHESIA CARE ISSUES

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. On December 14, 2016, the VA published its final rule granting full practice authority to three of the four APRN specialties, excluding CRNAs without credible, science and evidence based justification stating “due to VA’s lack of access problems in the area of anesthesiology.”\textsuperscript{16} This is a dangerously inaccurate statement that is clearly refuted by evidence. Due to anesthesia delays, veterans are indeed waiting for care they deserve and have earned, and endangering their health.

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.\textsuperscript{17} Out of the 141 facilities 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.\textsuperscript{18} 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.\textsuperscript{19} The decision to exclude CRNAs will cause veterans to continue to endure dangerously long wait times for anesthesia and other healthcare services due to the ongoing underutilization of CRNAs currently working in VHA facilities. The VA final rule also stated that if the agency learns “of access problems in the area of anesthesia care in specific facilities or more generally that would benefit from advanced practice authority, now or in the future, or if other relevant circumstances change, we will consider a follow-up rulemaking to address granting full practice authority to CRNAs.”\textsuperscript{20} 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 for the reasons listed below. We respectfully ask that the VA revisit the final APRN rule and allow CRNA full practice authority in the VHA.

\textsuperscript{17} VA OIG June 2018 report, “OIG Determination of Veterans Health Administration’s Occupational Staffing Shortages”, \url{https://www.va.gov/oig/pubs/VAOIG-18-01693-196.pdf}
\textsuperscript{18} VA OIG, op cit.
\textsuperscript{19} \url{http://kdvr.com/2017/10/11/va-surgeries-postponed-because-there-arent-enough-anesthesiologists/}
A. The VA’s Own Studies and Data Confirm an Access to Anesthesia Care Issue

Recent data from VA commissioned studies show a clear access to care issue in VHA facilities. We are troubled as to why these objective findings weren’t considered to be sufficient evidence for granting full practice authority to CRNAs in the APRN final rule. As you know, 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. The VA’s Enrollee Health Care Projection Model (EHCPM), a healthcare demand projection model, forecasts a “19-percent increase in demand for VA health care services nationally from FY 2014 to FY 2019, due to a projected 5.1-percent increase in enrollment and the aging of enrollees.”

To help deal with this projected increased in the demand for healthcare services in the VA, the Independent Assessment stated that one of the most important changes in VA policy to help meet increases in demand for healthcare over the next five years and ensure continued access to care for veterans would be formalizing full practice authority for all APRNs, including CRNAs.

Instead, the VA has chosen to exclude CRNAs from full practice authority, which means many veterans will continue to endure dangerously long wait times for needed healthcare requiring anesthesia services. 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 have to wait more than a month to get an appointment.

As we stated in our July 22, 2016, letter concerning the APRN proposed rule, 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

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22 Ibid.

23 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](http://www.va.gov/HEALTH/docs/DR60_122016_Pending_and_EWL_Biweekly_Desired_Date_Division.pdf)
production of colonoscopy services in comparison with the private sector. This speaks to the underutilization of existing anesthesia providers such as CRNAs, who are not allowed to practice to the full scope of their education, experience, and licensure. It remains unclear why the Independent Assessment’s impartial findings are not sufficient evidence to allow full practice authority for CRNAs in VHA facilities.

A logical solution to reducing or preventing delays in veterans’ access to anesthesia care in VHA facilities would be to promptly allow CRNAs to practice to the full extent of their education, training, and licensure. CRNAs are:

- Highly educated and qualified to provide anesthesia services for cardiovascular procedures. Making more efficient use of CRNA services may increase the number of cardiovascular procedures a VHA facility can provide veteran patients.
- Commonly utilized in locales outside of main operating rooms, such as gastrointestinal settings, cardiac catheterization facilities, and outpatient and ambulatory surgery. Thus, applying CRNA services to each of these settings may substantially improve patient flow and veterans’ access to care in VHA facilities offering these capabilities.
- Preferred anesthesia providers in outpatient colonoscopy facilities. Assigning CRNA coverage to VHA colonoscopy units may help substantially increase the delivery of these needed services for our veterans.

**B. 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 who spend more time supervising CRNAs than truly providing hands-on patient care, even though the VA, state and federal law do not require CRNAs to be supervised by anesthesiologists. CRNAs are appropriately educated and trained to handle patients of all health status, and every aspect of the delivery of anesthesia services including general and regional anesthesia and acute, chronic, and interventional pain management services. CRNA supervision does nothing to improve patient

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outcomes, outcomes as confirmed by scientific research data time and time again. but does lead to increased costs and reduced access to timely care.

However, observations within the VHA have found that some supervising anesthesiologists prohibit CRNAs from providing regional anesthesia services to veterans undergoing certain procedures, such as orthopedic, urological, and vascular, for which regional anesthesia may be the preferred choice. Further, many of these patients suffer from multiple chronic conditions such as lung disease, obstructive sleep apnea, and obesity. In these instances, regional anesthesia services are frequently the best option. Administering large amounts of narcotics to these patients, as in general anesthesia, introduces risks beyond those of regional anesthesia care. Instead of the surgeon authorizing the CRNA to provide regional anesthesia, anesthesiologists are ordering CRNAs to administer general anesthesia which requires a higher dosage of narcotic medications and inhalational agents and puts the patient at greater risk of postoperative pulmonary problems, slower recovery times, and greater postoperative pain, also contributing to delays in physical therapy services. All these factors compromise the patient’s ability to recover as promptly and safely as possible.

Additional observations within the VHA find CRNAs are commonly supervised by anesthesiologists at 1:1 and 1:2 ratios not generally found in the commercial healthcare delivery marketplace, and which do not correlate with improved outcomes.25 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, suicide prevention and homelessness. Anesthesia services provided by CRNAs and anesthesiologists are considered extremely safe CRNAs administer anesthesia in all settings working in collaboration with surgeons, 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.”26 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.”27

On the access to care issues raised by additional outside observations, the findings are as follows:

26 Hogan op cit., http://www.aana.com/resources2/research/Documents/nec_mj_10_hogan.pdf
27 Ibid.
• Allowing CRNAs to provide regional anesthesia to their full practice authority can yield a higher quality of care, safer and faster recovery times, and higher patient satisfaction.

• With respect to eliminating unnecessary supervision, the current structure duplicates staffing and increases healthcare costs. Granting CRNAs full practice authority and modifying care delivery models would ensure patient safety and result in substantial cost savings, allowing the VHA to allocate scarce resources to other veteran healthcare needs. Instead of needlessly supervising CRNAs, VHA anesthesiologists should be providing actual anesthesia care and chronic pain management services in the areas where veterans’ access to care is a demonstrated problem. Anesthesiologist medical direction reimbursement models contribute to increased healthcare costs without improving access or quality when medical direction requirements are not met by the anesthesiologist submitting a claim for such services. All anesthesia delivery models are equally safe according to extensive published research as noted above, but the most cost-effective safe anesthesia care delivery model is the CRNA non-medically directed model.

Furthermore, in their comments on the proposed APRN rule, the Federal Trade Commission (FTC) stated that regulatory constraints on APRNs, including CRNAs, limit the ability of APRNs to expand access to primary care services and improve current and projected health care workforce shortages. 28 Expanded APRN practice is a main solution to ease provider shortages, especially in medically underserved areas. The FTC said that removing the remaining supervision restrictions for the VHA’s APRNs, including CRNAs, could benefit VA patients nationwide “by improving access to care, containing costs, and expanding innovation in health care delivery.” 29 The FTC’s comments also state that, “To the extent that the VA’s actions would spur additional competition among health care providers and generate additional data in support of safe APRN practice, we believe those benefits could spill over into the private health care market as well.” 30

By granting full practice authority to CRNAs, the VHA would make full use of more than 900 CRNAs already practicing in VHA facilities. Many more veterans could be cared for if start times for surgical and other types of cases requiring anesthesia were no longer delayed unnecessarily while waiting for supervising anesthesiologists to become available. This would ensure that our nation’s veterans have

29 Ibid.
30 Ibid.
access to essential surgical, emergency, obstetric, and pain management healthcare services without
needless delays or having to travel long distances for care.

C. Limitations of Access to Anesthesia Care within the VA Patient-Centered
Community Care Program

The VHA Office of Community Care has attempted to build an integrated Community Care Network
to improve veterans’ access to healthcare and improve care coordination inside and outside the VA by
combining relationships with community partners and VA stakeholders to ensure that veterans’ health
needs are met. This network includes programs such as emergency care, Patient-Centered
Community Care (PC3), and the Veterans Choice Program. Anesthesia care is among the services VA
seeks from non-VA providers through programs such as PC3 and Choice Program contractors. As the
VA seeks to revamp its community care programs through the “Community Care Network” contract,
anesthesia is among the allowable services. VA has a referral hierarchy where internal resources are
always considered first before turning to its partners in the private sector. This strongly shows the
limits of the VA’s current internal anesthesia care capacity and clearly demonstrates how it could be
improved with more comprehensive use of highly qualified CRNAs.

D. CRNAs are Held to a Set of Rules Inconsistent with other APRNs Regarding
Recruitment and Retention Information

The AANA fails to understand how the VA has concluded that the current anesthesia workforce is
sufficient to meet the healthcare needs of veterans in the VA health system even though the VA states
in the final APRN rule, “VA understands that there are difficulties hiring and retaining anesthesia
providers.” We agree with this statement since 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. Furthermore, the June 2018 OIG report mentioned above cited that
the largest staff shortages in VHA facilities were in the Medical Officer and Nurse occupations.

In the final APRN rule, the VA provides data on CRNAs and anesthesiologists that is inaccurate,
troubling and does not justify the assertion that current staffing levels can meet the anesthesia needs of

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veterans. As stated in the final rule, as of August 31, 2016, the VA had 940 anesthesiologists and 937 CRNAs. 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.\(^{33}\) 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.\(^{34}\)

Looking at these numbers alone, it is clear that the VA is suffering from APRN recruitment and retention issues. With the substantial increases in the number of veterans using the VA system for healthcare over the last 10 years, it is unclear to us how only 940 anesthesiologists and 937 CRNAs are sufficient to meet the anesthesia care needs of more than 9 million veterans across the country.

Moreover, we feel that CRNAs are being held to a different and unfair standard regarding recruitment and retention data than the other categories of APRNs who were granted full practice authority in the final rule. For example, the VA states that the lack of advancement opportunities and practice autonomy were not cited as reasons for recruitment and retention challenges for CRNAs, and that it would consider future rulemaking if there’s evidence linking full practice authority to CRNA recruitment and retention. However, the VA fails to show that this same linkage was established for the other APRN categories that were granted full practice authority. The final rule also provides data on critical staffing shortages and states that CRNAs and physician anesthesiologists are not high on the list of hard to recruit and retain specialties. The VA again fails to present compelling data that reveals shortages in the other APRN categories or of their respective physician counterparts. Again, CRNAs are being held to a different and inconsistent set of rules than the other categories of APRNs. Also, in the VA’s Economic Impact Analysis for RIN-2900-AP44, the VA reports in the description of current APRN practice a net gain of 88 CRNA FTEs as a reason to exclude them from the rule, while the VA noted a net gain of 620 NP FTEs, which is far greater than the net gain for CRNAs.\(^{35}\)

\(^{33}\) [https://www.va.gov/vetdata/Utilization.asp](https://www.va.gov/vetdata/Utilization.asp)


The final 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. The AANA recently 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 full practice authority 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 full practice authority to CRNAs. By granting full practice authority to CRNAs, the VHA would make full use of more than 900 CRNAs already practicing in VHA facilities and also make working in VHA facilities more attractive to future CRNAs. Allowing CRNA full practice authority in the VHA would only help to increase the number of CRNAs who can provide safe, high quality and cost-effective anesthesia care for our nation’s Veterans. This would ensure that our nation’s veterans have access to essential surgical, emergency, obstetric, and pain management healthcare services without needless delays or having to travel long distances for care.

IV. FULL PRACTICE AUTHORITY FOR CRNAS IS A SOLUTION TO CURRENT AND FUTURE ACCESS TO ANESTHESIA CARE ISSUES

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

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 900 CRNAs are available in the VHA to provide every type of anesthesia care, as well as chronic pain management services, to veterans. The safety of CRNA services has long been recognized by the VHA and underscored by peer-reviewed scientific studies in the civilian sector. In its 2016 final rule, the VHA acknowledges 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

36 Ibid.
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.\textsuperscript{37} The landmark National Academy of Medicine report \textit{To Err is Human} found in 2000 that anesthesia was 50 times safer than in the 1980s. Though many studies have demonstrated the high quality of nurse anesthesia care, the results of a 2010 study published in \textit{Health Affairs} 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, 17 states have opted-out). The researchers found that anesthesia has continued to grow safer in opt-out and non-opt-out states alike. A June 2016 study published in the independent scientific journal \textit{Medical Care} found no measurable impact in anesthesia complications from nurse anesthetist scope of practice or practice restrictions.\textsuperscript{38} 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.\textsuperscript{39} Furthermore, a 2014 Cochrane Collaboration publication found no differences in care between nurse anesthetists and physician anesthesiologists.

In the interest of improving veterans’ access to quality healthcare, we express strong support for the VA recognizing CRNAs to practice to the full extent of their education, training, and licensure without the clinical supervision of physicians. Permitting full practice authority for CRNAs will ensure veterans receive the full scope of high-quality anesthesia and pain management care they so rightfully deserve. The Independent Assessment of the healthcare delivery system and management processes of the VA recommended formalizing full practice authority for all APRNs, including CRNAs, throughout the VHA.\textsuperscript{40} In addition, in June 2016, following an exhaustive 10-month assessment of the VHA, the independent federal Commission on Care reported that 23 percent of healthcare professionals in the

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\textsuperscript{37} 81 FR 90198 (December 14, 2016), \url{https://www.gpo.gov/fdsys/pkg/FR-2016-12-14/pdf/2016-29950.pdf}


\textsuperscript{39} Negrusa op cit.

\textsuperscript{40} U.S. Department of Veterans Affairs Assessment B - Health Care Capabilities (September 1, 2015), \url{http://www.va.gov/opa/choiceact/documents/assessments/Assessment_B_Health_Care_Capabilities.pdf}
\end{scriptsize}
VHA are not working to the top of their licensure, identifying this underuse of available resources as a major barrier to effective healthcare provision.\textsuperscript{41} One solution recommended by the Commission is implementation of policy that allows full practice authority for APRNs, which adds further data to the increasing amount of evidence in support of allowing CRNAs to practice to the full scope of their education, training, and licensure in the VHA, without physician supervision.\textsuperscript{42} This policy would not only help address the increasing healthcare demands of our nation’s veterans, but would also improve healthcare efficiency in the VHA system by reducing wait times and thereby increasing cost-effective care. Moreover, granting full practice authority to CRNAs would allow CRNAs to fully utilize their education and training to enhance the patient care team model and work collaboratively with anesthesiologists as equal partners in anesthesia delivery for surgery, labor and delivery, trauma stabilization, and chronic pain management.

Recognizing CRNAs to their full practice authority also corresponds with the first policy recommendation from the National Academy of Medicine report titled 	extit{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.\textsuperscript{43} 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.”\textsuperscript{44}

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.

\textsuperscript{41} The Commission on Care, Final Report on the Commission on Care (June 30, 2016), https://commissiononcare.sites.usa.gov/files/2016/07/Commission-on-Care_Final-Report_063016_FORWEB.pdf
\textsuperscript{42} The Commission on Care, op cit.
\textsuperscript{44} National Academy of Medicine op cit., p. 9.
B. CRNA Full Practice Authority Improves Efficiency of Veterans’ Access to Care

By granting full practice authority to CRNAs, the VHA would remove impediments to veterans’ access to timely, high-quality anesthesia care.

- Both CRNAs and anesthesiologists would be free to provide hands-on patient care simultaneously without the constraints of physician supervision on either provider.
- The start times for surgical and other types of cases requiring anesthesia would no longer be delayed unnecessarily while waiting for supervising anesthesiologists to become available, thereby increasing veterans’ access to care.
- And we would see decreased patient travel and wait times and increased veterans’ access to care in VHA facilities across the country.

C. CRNAs Provide Multi-Modal Pain Management which may Reduce Veterans’ Need for and Reliance on Opioids

Allowing full practice authority for CRNAs would provide access to care for an increasing number of veterans who are experiencing acute and chronic pain. Recent reports show that the VA has stated that about half of older veterans and about 60 percent of veterans returning from deployments suffer from chronic pain and about 68,000 veterans, 13% of the total veteran population, are taking opioids to help treat their pain. This has led to many veterans becoming caught up in the current opioid crisis. The number of veterans with opioid-use disorders has increased 55 percent from 2010 to 2015 and the VA is challenged with trying to help veterans manage their chronic pain without depending only on opioids for relief.

The AANA recognizes that solving the opioid drug epidemic is an integral part of healthcare reform, and we are committed to collaboratively working toward a common solution to this issue. CRNAs are uniquely qualified to help eradicate the opioid crisis that is tearing at the fabric of our nation. Suffering from chronic and acute pain is a personal experience that, if left untreated or mismanaged, can radically change an individual’s quality of life and impact important relationships. The AANA believes that moving from a unimodal, opioid management of chronic and acute pain, to a patient-centered, multidisciplinary, multimodal, opioid sparing treatment approach to analgesia as a primary pain management modality optimizes patient engagement in their care for relief of pain and decreased risk of

chronic pain and substance use disorder. Acute and chronic pain is best treated and managed by an interdisciplinary, collaborative team that actively engages with the patient to diagnose and manage their pain over time for improved well-being, functionality, and quality of life. As leaders and members of the interdisciplinary team, CRNAs are well positioned to provide holistic, patient-centered, multimodal pain treatment and management across the continuum of recovery and in all clinical settings (e.g., hospitals, ambulatory surgical centers, offices, and pain management clinics). 46, 47

As a main provider of pain management services, CRNAs are qualified pain practitioners who provide access to excellent care in many practice settings to treat patients suffering from a wide range of acute and chronic pain conditions. Many patients rely on CRNAs as their primary pain specialist. CRNA chronic pain management practitioners are able to minimize the use of opioids by addressing chronic pain through the use of a multimodal approach that includes opioid sparing or no opioid pharmacologic and non-pharmacologic pain mitigation strategies. These skills and treatment modalities will logically translate into clinical practice at the VHA with the goal of improving patient outcomes. A recent study called for an increased number of nursing pain specialists “to not only implement aggressive acute pain care to prevent chronic pain but also to effectively treat chronic pain with evidence-based integrative therapies that include multimodal analgesia, interventional techniques, and complementary and alternative approaches to pain management.” 48

In developing the plan of care for the patient, CRNAs obtain patient history, evaluate the patient, order and review necessary diagnostic testing, and assess the patient’s psychological and emotional state. Non-pharmacologic pain mitigation techniques are often employed in the treatment of chronic pain and considered as part of the care plan. These techniques may include patient education regarding behavioral changes that can decrease pain, such as weight loss, smoking cessation, daily exercise, stretching, and physical or chiropractic therapy. Such therapies may not be sufficient when used alone, but they have significant benefit when they are used in a complementary manner with other therapies.


As anesthesia professionals, our goal is to collaborate with the patient and the interdisciplinary team on a comprehensive plan for pain relief known as enhanced recovery after surgery (ERAS)\(^{49}\). Because CRNAs personally administer more than 43 million anesthetics to patients each year in the United States, their services are crucial to the successful development and implementation of techniques such as anesthesia ERAS programs. CRNAs and other anesthesia professionals play an integral role in these episodes of care as proper anesthesia services management can make a tremendous difference in terms of improving patient flow, patient safety, and cost savings.\(^{50}\) Conversely, research shows that suboptimal care in the preoperative, intraoperative, or postoperative phases of surgery may compromise care, resulting in poor patient outcomes and unnecessarily higher healthcare costs.\(^{51,52}\)

For surgical pain, using specific protocol-driven ERAS pathways improves patient outcomes by reducing the patient’s stress response to surgery, shortening the overall hospital length of stay, and accelerating the return to normal daily function. The patient’s pain management plan of care begins pre-procedure and continues through post-discharge using techniques such as regional anesthesia including placement of epidural catheters, targeted peripheral nerve blocks, non-pharmacologic approaches, and non-opioid based pharmacologic measures. The evidence is quite clear that careful assessment, evaluation, and treatment of acute pain, with appropriate prescribing of an opioid, may prevent access to unused opioids and development of opioid dependency and abuse, thus helping to curb the current opioid crisis. Though individual elements of an ERAS pathway are beneficial, implementation and compliance with patient appropriate elements of a comprehensive pathway across the entire perioperative continuum have been shown to improve outcomes.\(^{53}\)

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By virtue of education and individual clinical experience and competency, a CRNA may also practice chronic pain management utilizing a variety of therapeutic, physiological, pharmacological, interventional, and psychological modalities in the management and treatment of pain. From entry into practice education and certification through ongoing education and skills acquisition throughout their career, CRNAs provide robust, patient centered acute and chronic pain management services. The National Board of Certification and Recertification for Nurse Anesthetists (NBCRNA) offers a voluntary nonsurgical pain management (NSPM) subspecialty certification for CRNAs. The Council on Accreditation of Nurse Anesthesia Educational Programs (COA) requires acute and chronic pain management content in the curriculum of the 120-accredited nurse anesthesia educational programs, and for continued learning, the AANA offers CRNAs a continuum of educational resources for pain management practice. These resources include advanced acute and chronic pain management workshops for CRNAs to enhance their skills to improve quality of life. The AANA, State Nurse Anesthetist Associations, universities and other stakeholders play an active role in CRNA education and professional development in acute and chronic pain management. Professional development opportunities include educational webinars, online continuing education, conferences, and peer reviewed publications. Additionally, Texas Christian University, the University of South Florida, and Middle Tennessee School of Anesthesia offer COA accredited fellowships to CRNAs seeking to further specialize in this growing field.

CRNAs should be an integral part of any solution to decrease reliance on the use of opioids for treatment of pain in the VA, and the VHA should work to grant CRNAs full practice authority. As more veterans are diagnosed with conditions that require procedures that are only possible if anesthesia is available, anesthesia delays will compound and veterans will continue to endure long wait times for needed care.

**D. A Current Model of CRNA Full Practice Authority Shows an Increase in Veterans’ Access to Care**

The experience of the Iowa City VA Medical Center illustrates the considerable benefits to veterans and the VHA of extending full practice authority to CRNAs as well as other APRNs. The Iowa City VA Medical Center achieved promising results after moving to a CRNA full practice authority anesthesia delivery model. The latest data available is from the fourth quarter of 2016. According to a

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54 See: [http://www.nbcrna.com/NSPM/Pages/Non-Surgical-Pain-Management.aspx](http://www.nbcrna.com/NSPM/Pages/Non-Surgical-Pain-Management.aspx)
review by an Iowa City Veterans Affairs Medical Center surgeon, the mortality rate decreased from the first quarter of 2015 to the fourth quarter of 2016.

Additionally, over the same time frame and using a CRNA-only anesthesia delivery model in the facility’s anesthesia department, labor costs per relative value unit (a measure of case complexity plus time) decreased from $19 to $9 compared to $24 for the Veterans Integrated Services Network (VISN) and $68 per unit nationally. The relationship of these units to overall costs is that an average case might involve 10-15 relative value units, and an average hospital might provide thousands of cases per year.

The experience of this VHA facility is underscored by decades of scientific research stating that CRNAs provide safe anesthesia services at the lowest economic cost to the facility. Iowa is also a state where CRNAs have full practice authority. Granting full practice authority to CRNAs in VHA facilities in every state nationwide and standardizing care delivery models accordingly promises significant benefits for our veterans and the VHA.

E. Allowing Full Practice Authority for CRNAs in the VHA System would Make it Consistent with other Federal Delivery System Policies

Granting full practice authority to CRNAs would make the VHA consistent with the U.S. Military service branches—Army, Navy, Air Force, Combat Support Hospitals, Forward Surgical Teams, and Indian Health Services—and commercial healthcare, which currently allow CRNAs and other APRNs to practice to the full scope of their education, training and licensure. Nurse anesthetists, who first provided healthcare to wounded soldiers on the battlefields of the American Civil War, have been the main providers of anesthesia care on the front lines of every U.S. military conflict since World War I. It only makes sense that our military CRNAs who use their full scope of practice to provide care for severely injured military personnel in the most austere environments should also be able to provide that full scope of practice when they muster out of the service, join the VHA team, and provide care to those same personnel in the VHA setting. The use of CRNAs to their full practice authority is consistent with patient safety and cost-efficient healthcare delivery.

Given our veterans' need for high quality healthcare, and because of present and anticipated challenges Veterans face when trying to access healthcare services requiring anesthesia and pain management, limiting CRNA practice in the VHA impairs veterans’ access to care, risks lengthening delays in
healthcare delivery, increases healthcare costs, and fails to promote patient safety or to put our veterans first. This proposal is instrumental as the VA continues to improve care delivery for our nation's veterans. With over 9 million patients using VHA services across 1,700 VHA care sites each year, ensuring an adequate number of qualified health professionals will increase access to safe, high-quality care and help reduce unmet demand for services.

F. Support for CRNA Full Practice Authority is Widespread including Veterans Groups, Members of Congress, Healthcare Organizations, the Broader APRN Community and the Media

This policy change, consistent with recommendations from the National Academy of Medicine, is supported by more than 60 organizations, including Veterans groups such as the Military Officers Association of America and the Air Force Sergeants Association. The policy is also supported by AARP (whose membership includes 3.7 million veteran households), numerous healthcare professional organizations including the AANA and other APRN associations, and 80 Democrat and Republican members of Congress. Representatives Sam Graves (R-MO) and Jan Schakowsky (D-IL) introduced H.R. 1783 which authorizes the VA to allow APRNs to practice to their full scope, as defined by the applicable national professional association, under a set of VA-approved privileges, regardless of the state in which the APRNs are employed. The nursing community, which represents 61 nursing organizations, also supports this proposal. Furthermore, the media coverage has extensively supported CRNA Full Practice Authority.

We thank you for the opportunity to comment on VHA Directive 1123. Any new policies that implement more restrictive anesthesia delivery models are antithetical to the types of decisions the VHA needs to be making to improve access and quality for our nation’s veterans. We urge the VA to reconsider VHA Directive 1123, while also finalizing full practice authority for CRNAs to ensure veterans have access to the timely, high-quality healthcare that is their right and reward for service to our country. We stand ready to work together on how we can better provide safe, timely, cost-effective anesthesia care for our veterans. By standardizing care delivery models across the country via full practice authority for CRNAs, veterans will receive consistently excellent care in all VHA

55 https://www.congress.gov/bill/115th-congress/housebill/1783?q=%7B%22search%22%3A%5B%22hr1783%22%5D%7D&r=1
facilities. 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,

Bruce A. Weiner, DNP, MSNA, CRNA
AANA President

Cc: Randall Moore II, DNP, MBA, CRNA, AANA CEO
    Ralph Kohl, AANA Senior Director of Federal Government Affairs
    Randi Gold, MPP, AANA Senior Associate Director Federal Regulatory and Payment Policy