February 19, 2020

Consuela Benjamin  
Regulation Development Coordinator  
Office of Regulation Policy and Management, Office of the Secretary  
US Department of Veterans Affairs  
810 Vermont Avenue, NW  
Washington DC 20420

RE: Specialty Education Loan Repayment Program proposed rule

Dear Ms. Benjamin:

The American Association of Nurse Anesthetists (AANA) welcomes the opportunity to comment on the Specialty Education Loan Repayment Program proposed rule. While we agree that establishing a loan repayment program would be helpful in attracting providers to work for Department of Veterans Affairs (VA) facilities, we have concerns that the proposed rule implies there is a staffing shortage of only physicians and the result is that the proposed loan repayment program is geared towards recruiting only physicians to work in VA facilities. We understand there is underutilization and staffing shortages of other types of providers, including Certified Registered Nurse Anesthetists (CRNAs), and we ask that this loan repayment program be broadened to include incentives for recruitment and retention of advanced practice registered nurses (APRNs) in VA facilities. Furthermore, we request that CRNAs be granted the ability to practice to the full scope of their education, training, licensure, and certification in VA facilities to allow veterans to receive access to safe and timely anesthesia services. This step would make an anesthesia position within the VA more attractive in its own right, to prior active duty and civilian CRNAs. The issues addressed in our comment are outlined as follows:

I. CRNAs Provide Safe, High Quality and Cost-Effective Care

II. Full Practice Authority for CRNAs is a Solution to Current and Future Access to Anesthesia Care Issues

   A. The VA’s Own Studies and Data Confirm an Access to Anesthesia Care Issue
B. CRNA Full Practice Authority Increases Veterans’ Access to Care and Promotes Safe, Efficient Healthcare Delivery

I. CRNAs Provide Safe, High Quality and Cost-Effective Care

The AANA is the professional association for Certified Registered Nurse Anesthetists (CRNAs) and student registered nurse anesthetists (SRNAs). AANA membership includes nearly 54,000 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 more than 49 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, and managing the patient throughout the surgery. CRNAs also provide acute, chronic, and interventional pain management services. CRNAs provide anesthesia for a wide variety of surgical cases and in some states are the sole anesthesia providers in nearly 100 percent of rural hospitals, affording these medical facilities obstetrical, surgical, trauma stabilization, and pain management capabilities. Nurse anesthesia predominates in Veterans Hospitals and in the U.S. Armed Services. CRNAs work in every setting in which anesthesia is delivered including hospital surgical suites and obstetrical delivery rooms, ambulatory surgical centers (ASCs), pain management facilities, and the offices of dentists, podiatrists, and all types of specialty surgeons.

Numerous peer reviewed studies have shown that CRNAs are safe, high quality and cost effective anesthesia professionals who should practice to the full extent of their education and abilities. According to a May/June 2010 study published in the journal *Nursing Economic*, CRNAs acting as the sole anesthesia provider are the most cost-effective model for anesthesia delivery, and there is no measurable difference in the quality of care between CRNAs and other anesthesia providers or by
anesthesia delivery model. An August 2010 study published in *Health Affairs* showed no differences in patient outcomes when anesthesia services are provided by CRNAs, physicians, or CRNAs supervised by physicians. 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. Most recently, a study published in *Medical Care* (June 2016) found no measurable impact in anesthesia complications from nurse anesthetist scope of practice or practice restrictions.

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. The study correlated CRNAs with lower-income populations and correlated anesthesiologist services with higher-income populations. Of particular importance to the implementation of public benefit programs in the U.S., the study also showed that compared with anesthesiologists, CRNAs are more likely to work in areas with lower median incomes and larger populations of citizens who are unemployed, uninsured, and/or Medicaid beneficiaries.

II. **Full Practice Authority for CRNAs is a Solution to Current and Future Access to Anesthesia Care Issues**

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1 Paul F. Hogan et al., “Cost Effectiveness Analysis of Anesthesia Providers.” *Nursing Economic$.* 2010; 28:159-169. [http://www.aana.com/resources2/research/Documents/nec_mj_10_hogan.pdf](http://www.aana.com/resources2/research/Documents/nec_mj_10_hogan.pdf)


6 Liao, op cit.
The AANA advocates on numerous issues to help 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. 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 published its final rule granting full practice authority (FPA) to three of the four APRN specialties, illogically excluding CRNAs from the rule “due to VA’s lack of access problems in the area of anesthesiology.” This is an inaccurate statement that is clearly refuted by evidence. Due to anesthesia delays, veterans in Veterans Health Administration (VHA) facilities are waiting for care and do not receive the full scope of timely, high-quality anesthesia and pain management care they so rightfully deserve and have earned.

A. The VA’s Own Studies and Data Confirm an Access to Anesthesia Care Issue

Recent reports continuously highlight a lack of access to anesthesia services in the VHA and 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 final rule. The VA sponsored the congressionally mandated 2015 RAND Corporation Independent Assessment of the VHA, which reported that wait times for VA care are getting longer and current VA workforce capacity may not be sufficient to provide timely care to Veterans across a number of key specialties, as well as primary care. 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.

9 Ibid.
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. Furthermore, 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.

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 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. 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. 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. To ensure veterans’ access to timely anesthesia care, CRNAs must receive full practice authority in VHA facilities.

B. 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

10 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
12 https://www.va.gov/vetdata/Utilization.asp
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 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.14”

The landmark National Academy of Medicine report 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 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 Medical Care found no measurable impact in anesthesia complications from nurse anesthetist scope of practice or practice restrictions.15 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.16 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

16 Negrusa op cit.
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. 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 VHA are not working to the top of their licensure, identifying this underuse of available resources as a major barrier to effective healthcare provision. 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. 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 *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. 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.”

Access to care should be measured by whether veterans are getting the services they need.

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17 U.S. Department of Veterans Affairs Assessment B - Health Care Capabilities (September 1, 2015), [http://www.va.gov/opa/choiceact/documents/assessments/Assessment_B_Health_Care_Capabilities.pdf](http://www.va.gov/opa/choiceact/documents/assessments/Assessment_B_Health_Care_Capabilities.pdf)


19 The Commission on Care, op cit.


21 National Academy of Medicine op cit., p. 9.
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.

We appreciate the opportunity to comment on this proposed rule to address how we can better provide safe, timely, cost-effective anesthesia care for our veterans. As we have shown there is an access to anesthesia issue in VHA facilities and we believe that an important solution to this problem would be expansion of the proposed loan repayment program to include both physicians and APRNs to increase recruitment and retention of all types of providers in VHA facilities. We also recommend standardizing care delivery models across the country via full practice authority for CRNAs, so veterans will receive consistently excellent care in all VA facilities. 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 these 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,

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AANA President

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