



Federal Government Affairs Office
25 Massachusetts Avenue NW, Suite 320
Washington, DC 20001-1450
202.484.8400
AANA.com

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April 28, 2020

Mike Pence
Vice President of the United States
Chair of the White House Coronavirus Task Force
The White House
Office of the Vice President
1600 Pennsylvania Avenue, N.W.
Washington, DC 20500

Dear Mr. Vice President:

On behalf of the American Association of Nurse Anesthetists (AANA), we wanted to express our gratification for the Department of Veterans Affairs' (VA) recent work on Directive 1899 and the accompanying memo that pointed out the importance of allowing Certified Registered Nurse Anesthetists (CRNAs) to practice to the full extent of their licensure, registration and certification. While we applaud the removal of barriers to scope of practice during this emergency, we believe that CRNAs should permanently be given authority to practice to the highest level of their education and training within the VA. The current all hands-on deck nature of the COVID-19 crisis has shown the important role and responsibilities that CRNAs hold in our healthcare system, especially when barriers to practice and education are eliminated. Since the crisis began, numerous federal agencies have ordered removal of unnecessary supervision requirements which has allowed CRNAs to utilize their full range of skills, including their experience in critical care, to treat COVID-19 patients. We believe that CRNAs should permanently be allowed full practice authority (FPA) in VA facilities.

CRNAs have been hard at work on the front lines treating COVID-19 patients and we appreciate the recognition of both the value and skill that CRNAs bring to this crisis. Barriers to CRNA practice have been removed at both the state and federal level, allowing CRNAs to provide critical, life-saving care to COVID-19 patients, including advanced airway and ventilator management, placing of invasive lines and monitors, rapid response team leadership and overseeing complex hemodynamic monitoring. Freeing up CRNAs to provide this critical care to the sickest patients is a key part of allowing the VA to achieve the three pillars of meaningful

healthcare delivery reform, providing the highest quality and most cost-effective care possible. While the directive, “encourages VA medical facilities to utilize VA health care professionals to practice and operate within the full scope of their license, registration, or certification to increase VA beneficiaries’ access to health care,” we recommend it go a step further and make this a requirement for VA facilities.

CRNAs 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 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.¹” The Independent Assessment of the healthcare delivery system and management processes of the VA recommended formalizing full practice authority for all advanced practice registered nurses (APRNs), including CRNAs, throughout the VHA.² 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.³ One solution recommended by the Commission is implementation of

¹ 81 FR 90198 (December 14, 2016), <https://www.gpo.gov/fdsys/pkg/FR-2016-12-14/pdf/2016-29950.pdf>

² 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

³ 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_FOR-WEB.pdf

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.⁴

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, 18 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.⁵ 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.⁶ Furthermore, a 2014 Cochrane Collaboration publication found no differences in care between nurse anesthetists and physician anesthesiologists.

Making full practice authority permanent would not only help address the increasing healthcare demands of our nation's veterans, it 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, pain management and critical care services. Without a policy in place to

⁴ The Commission on Care, op cit.

⁵ Negrusa B, Hogan PF, Warner JT, Schroeder CH, Pang B. Scope of Practice Laws and Anesthesia Complications: No Measurable Impact of Certified Registered Nurse Anesthetist Expanded Scope of Practice on Anesthesia-related Complications. *Med Care*. (May 20, 2016). http://journals.lww.com/lww-medicalcare/Abstract/publishahead/Scope_of_Practice_Laws_and_Anesthesia.98905.aspx

⁶ Negrusa op cit.

make FPA permanent for CRNAs, facilities will 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.⁷ The need for FPA for CRNAs and all APRNs has consistently been judged necessary by independent, third party arbiters, who look at evidence and economics. Furthermore, groups including AARP, the American Hospital Association and Americans for Prosperity,⁸ among others, have weighed in on the need for FPA. CRNA full practice authority is supported by the evidence-based recommendations advanced by the National Academy of Medicine, the congressionally mandated Independent Assessment of the VA, and the blue-ribbon Commission on Care. It is also current policy in the Army, Navy, Air Force, Combat Support Hospitals, and Forward Surgical Teams, and is supported by several Veterans Service Organizations, including the Iraq and Afghanistan Veterans of America, AMVETS, Military Officers Association of America, Air Force Sergeants Association, Reserve Officers Association, and the Naval Enlisted Reserve Association. The overwhelming evidence and support clearly indicate that FPA is the right thing to do when scientific evidence is taken into consideration.

The current COVID-19 crisis and the moves to reduce barriers by implementing FPA for CRNAs and eliminating unnecessary physician supervision across the nation have shown that these policies were not based in safety or evidence to begin with. Allowing CRNAs to practice independently as they are treating the most direly ill COVID-19 patients, in some of the most dangerous procedures, including intubation and airway management, shows that CRNAs are expertly trained and educated anesthesia professionals who are able to operate independently under the most difficult of circumstances. It's clear that the decision to not include CRNAs in the VA FPA rule in 2016 was driven by politics and guild protection, and without the interest of patients in mind. Given the current crisis and the difficult road ahead as we begin to reengage in elective procedures after this crisis abates, it's apparent that there is no place for these non-evidence-based factors in decision making. The health of patients and ensuring access to care

⁷ <http://www.lewin.com/content/dam/Lewin/Resources/AANA-CEA-May2016.pdf>

⁸ [https://www.aana.com/docs/default-source/pr-aana-com-web-documents-\(all\)/sign-on-letter-to-secretary-azar-regarding-executive-order.pdf?sfvrsn=46543c5f_4](https://www.aana.com/docs/default-source/pr-aana-com-web-documents-(all)/sign-on-letter-to-secretary-azar-regarding-executive-order.pdf?sfvrsn=46543c5f_4)

must be our top priorities. FPA 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.

Our nation's veterans deserve access to timely, cost effective and high-quality care within the VA health system. Removing unnecessary supervision and implementing FPA for CRNAs is the right decision now and will still be the right decision after this pandemic has ended. Healthcare decisions should be based on evidence and should always put the patient first, not politics. We commend you again for recognizing the importance of allowing CRNAs to practice at the top of their education and training, along with our other APRN colleagues. We urge you to move swiftly to make this policy permanent and allow all CRNAs working within the VA to work to their full scope of practice by implementing permanent FPA, and we stand ready to assist in this effort. We would welcome the opportunity to meet with the Administration's COVID-19 Task Force to further discuss this critical issue.

Sincerely,



Kate Jansky, MHS, CRNA, APRN, USA LTC (ret)
AANA President



Randall Moore, DNP, MBA, CRNA
AANA Chief Executive Officer

Cc: Deborah Birx, Response Coordinator for White House Coronavirus Task Force
Alex Azar, Secretary of the US Department of Health and Human Services
Seema Verma, Administrator of the Centers for Medicare and Medicaid Services



Robert Wilke, Secretary of the US Department of Veterans Affairs
Anthony Fauci, Director of the National Institute of Allergy and Infectious Diseases
Derek Kan, Executive Associate Director, Office of Management and Budget
Chris Liddell, White House Deputy Chief of Staff for Policy Coordination