Mr. Chairman and members of the Committee, thank you for the opportunity to submit a statement summarizing the impact of the Institute of Medicine report *The Future of Nursing: Leading Change, Advancing Health* upon the patients, practice and profession of nurse anesthesia. In my statement, I will summarize the role and work of the American Association of Nurse Anesthetists (AANA) and of Certified Registered Nurse Anesthetists (CRNAs), identify areas in practice and public policy where the report has been particularly impactful since its release in 2010, and review some specific areas within the health industry sphere where the recommendations of the report await being met. The report recommendations driving the greatest change in our sphere are the first, second, sixth and seventh, regarding full practice authority, leadership, lifelong learning, and serving as agents of healthcare system change respectively.¹

¹ See [http://www.thefutureofnursing.org/recommendations](http://www.thefutureofnursing.org/recommendations).
Background on the AANA and CRNAs

The AANA is the professional association for Certified Registered Nurse Anesthetists (CRNAs) and student nurse anesthetists. AANA membership includes over 48,000 CRNAs and student registered nurse anesthetists representing over 90 percent of the nurse anesthetists in the United States. CRNAs are APRNs and anesthesia professionals who safely administer more than 38 million anesthetics to patients each year in the United States. Nurse anesthetists have provided anesthesia care to patients in the U.S. for over 150 years, and high quality, cost effective and safe CRNA services continue to be 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 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, and Department of Veterans Affairs healthcare facilities. CRNA services include providing a pre-anesthetic 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 and chronic pain management services. CRNAs provide anesthesia for a wide variety of surgical cases and are the sole anesthesia providers in nearly 100 percent of rural hospitals, affording these medical facilities obstetrical, surgical, trauma stabilization, and pain management capabilities.

According to a 2007 Government Accountability Office (GAO) study, CRNAs are the predominant anesthesia provider where there are more Medicare beneficiaries and where the gap between Medicare and private pay is less.\(^2\) Nurse anesthesia predominates in Veterans Hospitals, the U.S. Armed Forces and Public Health Service. 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. As colleagues and competitors in the provision of anesthesia and pain management services, CRNAs and anesthesiologists have long been considered substitutes in the delivery of surgeries.\(^3\)

In its landmark publication *The Future of Nursing: Leading Change, Advancing Health*, the Institute of Medicine made its first recommendation that APRNs such as CRNAs be authorized to practice to their full scope, in the interest of patient access to quality care, and in the interest of competition to help promote innovation and control healthcare price growth.\(^4\)

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The IOM Report has Effectively Helped to Shape Healthcare Public Policy and Reimbursement, but More Remains to be Done

The publication of the IOM report prompted the AANA to initiate a collaboration with advanced practice registered nursing (APRN) organizations in order to specifically identify barriers to patient access to the services of APRNs. The document developed by the APRN Workgroup divided healthcare policy barriers at the national level into three broad areas: supervision requirements, barriers to credentialing, and inappropriately constraining eligibility to physicians (meaning in most cases allopathic or osteopathic medical doctors). The document also summarized research underscoring the role and value of APRNs for patient safety, access to care and cost savings.

That document and external events have empowered AANA and APRN organizations and their allies to develop and carry out successful advocacy campaigns to change public and reimbursement policy and to help expand patient access to care. Some of those efforts include:

- Enactment and implementation of a provider nondiscrimination provision in the Affordable Care Act (ACA) of 2010. While enactment of the provision preceded the Future of Nursing report by several months, the report has colored its implementation.\(^5\) Notably, major commercial plans in several states have moved to recognize CRNA services at 100 of the physician fee, having previously covered CRNA services at a lower fraction or not at all.
- Enactment of a Medicare regulation clarifying that Medicare covers all Medicare CRNA services within their state scope of practice, including pain management.\(^6\) In

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implementing the Pain Care Act portions of the ACA, another IOM report\(^7\) spurred the development of Interagency Pain Research Coordinating Council yielding five major workgroups, two which include leading distinguished CRNAs. The IPRCC led the U.S. Department of Health and Human Services to publish a draft National Pain Strategy recommending transformation in the prevention, diagnosis, treatment and reimbursement of pain on a population level.

- Adoption of advancements in policy and practice governing the nurse anesthesia profession, including new guidelines in pain care,\(^8\) an additional optional credential for CRNAs in nonsurgical pain management,\(^9\) new standards for educational fellowships,\(^10\) and progress toward requiring the doctoral credential by the year 2025 for entry into nurse anesthesia practice.\(^11\)

- Enactment of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)\(^12\), which repeals the problematic “sustainable growth rate” cuts from Medicare Part B and substantially reforms Medicare payment in a manner that treats CRNAs and other APRNs the same as physicians, and rewards care coordination, patient safety and optimal outcomes, and cost-efficient care delivery in a way that presages growth and opportunity for APRN services.

- Enactment of numerous state measures eliminating unnecessary supervision requirements on CRNAs,\(^13\) adoption of additional state “opt-outs” from the Medicare physician supervision requirement on CRNA anesthesia services withstanding challenges,\(^14\) and the

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\(^11\) Such a policy was adopted by the AANA Board of Directors in 2007, as well as by the COA.


\(^13\) Notably, Minnesota has enacted legislation reaffirming recognition of CRNA full practice authority, and Rhode Island has enacted legislation eliminating requirements for physician supervision of nurse anesthetists.

\(^14\) Seventeen states have opted out of the Medicare requirement for physician supervision of CRNA anesthesia services at 42 CFR §482.52 for hospitals. Of those, the most recent opt outs were adopted in Colorado (2010) and Kentucky (2012). Legal challenges by state anesthesiologist societies to opt outs in California and Colorado, rising to the Supreme Courts in both states, have failed to overturn the opt outs. For more information in general see [http://www.aana.com/advocacy/stategovernmentaffairs/Pages/Federal-Supervision-Rule-Opt-Out-Information.aspx](http://www.aana.com/advocacy/stategovernmentaffairs/Pages/Federal-Supervision-Rule-Opt-Out-Information.aspx). On the California Supreme Court upholding the opt out in that state, see [http://www.aana.com/newsandjournal/News/Pages/062212-California-Supreme-Court-Affirms-Lower-Courts-Unanimous-Decisions.aspx](http://www.aana.com/newsandjournal/News/Pages/062212-California-Supreme-Court-Affirms-Lower-Courts-Unanimous-Decisions.aspx). On the Colorado Supreme Court upholding the opt out in that state, see
involvement of the Federal Trade Commission (FTC) in combating anti-competitive policy harmful to patient access to CRNA and other APRN services.\(^{15}\)

Currently under way are efforts to implement the MACRA, and to recognize CRNAs and other APRNs to their full practice authority in Veterans Health Administration (VHA) facilities. Of all these items, it is the VHA’s proposal to recognize APRNs to their Full Practice Authority which I would like to outline at some length because it illustrates both the influence of the report and the barriers to its implementation with such clarity.

**VHA Recognition of APRNs to their Full Practice Authority is the Next Major Step in Implementation of the IOM *Future of Nursing* Report**

For more than two years, the VHA has been developing a proposal to expand Veteran access to quality care as recommended by the Institute of Medicine *Future of Nursing* report by publishing a regulation that recognizes VHA APRNs their Full Practice Authority. APRNs include CRNAs as well as Nurse Practitioners (NPs), Clinical Nurse Specialists (CNSs) and Certified Nurse-Midwives (CNMs). We strongly support this proposal for the following reasons:

- Making full use of the VHA’s available workforce promotes Veterans access to quality care – particularly critical as the Congress has underscored the agency’s challenges meeting Veterans healthcare needs. By standardizing care delivery models across the country via Full Practice Authority for APRNs, Veterans can be assured consistently high quality care delivery in any VHA healthcare facility.

- Recognizing CRNAs and other APRNs to their Full Practice Authority corresponds with the first policy recommendation from the Institute of Medicine *Future of Nursing* report.

- CRNAs and other APRNs are highly educated, qualified and capable to do this job. Today’s CRNAs earn a bachelor’s degree, hold a valid Registered Nursing license in a state, practice at least one and an average of four years in a critical care nursing environment, secure specialized didactic and clinical practice education in anesthesia in an accredited nurse anesthesia educational program over an average 27 months conferring a master’s or doctoral credential, pass a national certifying exam, secure national certification, and then pursue continuing education as part of a regular recertification process. This professional preparation, lasting an average of nearly 11 years before entry into professional practice, provides the CRNA the knowledge, skills

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\(^{15}\) See for example, Federal Trade Commission, “Policy Perspectives: Competition and the Regulation of Advanced Practice Nurses,” March 2014, [https://www.ftc.gov/system/files/documents/reports/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolicypaper.pdf](https://www.ftc.gov/system/files/documents/reports/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolicypaper.pdf). The FTC notes here that it has written state legislators warning legislatures and regulatory bodies such as Boards of Medicine about the anticompetitive nature of proposals to impair CRNAs from providing or being reimbursed for pain management services.
and abilities necessary to ensure a high level of patient safety in every practice environment.

- The proposal parallels healthcare service delivery in the U.S. Armed Forces forward surgical teams, service branches and military hospitals, as well as care delivery models in the U.S. Indian Health Service. 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 transition out of the service, join the VHA team, and provide care to those same personnel in the VHA setting.

- Already our Veterans can and do access the care of CRNAs and other APRNs acting as Full Practice Providers every time that they use their benefits authorized by the Veterans Access, Choice and Accountability Act of 2014\(^{16}\) for care in the U.S. Military, Indian Health Service, or many private health systems.

- Making use of CRNAs to their Full Practice Authority in the VHA promotes cost-efficient healthcare delivery. A survey of Veterans Affairs Medical Centers (VAMCs) found that using CRNAs to their Full Practice Authority to ensure patient safety in the most cost-efficient care delivery models may save the VHA approximately $105 million per year – resources that can be allocated to other priority Veteran health needs including primary care, mental health, and physical and vocational rehabilitation.

- The proposal has drawn broad support from both chambers of Congress, both sides of the aisle, and from outside organizations representing Veterans, nurses, and the AARP.

Opposition to the VHA proposal has been marshaled by the American Society of Anesthesiologists (ASA), which supported\(^{17}\) Sen. Mark Kirk (R-IL) introducing the “Frontlines to Lifelines Act of 2015” (S 297). Section 4 of S 297 authorizes “independent practice” for NPs and CNMs, allows such practice for CNSs in mental health only, and excludes CRNAs from among the professionals it authorizes for “independent practice.” As the AANA stated in its letter to the Chairman and Ranking Member of the Senate Veterans Affairs Committee dated Feb. 10, 2015:

> Sec. 4 of S 297, titled “Independent Practice of Certain Advanced Practice Registered Nurses of Department of Veterans Affairs,” is problematic in two respects. It does not include all four roles of Advanced Practice Registered Nurses (APRNs) and excludes Certified Registered Nurse Anesthetists (CRNAs). There are roughly 900 CRNAs currently serving in the Veterans Health Administration (VHA), many of whom are Veterans and have served in the VHA with distinction. Further, this is an unnecessary provision given the VHA has been working for over two years to develop, discuss among

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stakeholders, and publish a proposal recognizing all APRN roles to their full practice authority in the VHA.

Ensuring that CRNAs may practice within the VHA to their full practice authority is a common-sense part of the solution to the well-documented problem of Veterans being denied or delayed access to care. The evidence clearly indicates the safety of CRNAs serving every population type, including those men and women who have borne the battle and count on the VHA for excellent care. This evidence includes most recently the Cochrane Review, the preeminent journal for evidence-based healthcare delivery, which stated last July on reviewing hundreds of studies that, “no definitive statement can be made about the possible superiority of one type of anesthesia care over another.”

The Department of Veterans Affairs already has authority from Congress to recognize APRNs including CRNAs to their full practice authority. Should the Committee move S 297, we request that you include CRNAs as a provider long recognized by the VHA to deliver care within their full practice authority.

The policy set forth in S 297 is also inconsistent with the recommendations of the National Council of State Boards of Nursing (NCSBN). As that body stated in a letter to the Chairman and Ranking Member dated March 5, 2015:

Excluding CRNAs from the legislation also deviates from broad agreement among nursing groups. On July 7, 2008, NCSBN completed work on the Consensus Model for APRN Regulation, Licensure, Accreditation, Certification, and Education (Consensus Model). NCSBN collaborated with and received endorsements from 48 other nursing organizations on the development of the Consensus Model. The goal of the Consensus Model is to create uniformity among the states, provide greater access to care and increase public protection by establishing standards for licensure, education, accreditation, certification and practice of four distinct APRN roles. Those roles are the certified nurse practitioner, the certified registered nurse anesthetist, the certified nurse midwife, and the clinical nurse specialist. All four roles are referred to under the umbrella title of APRN.

Finally, the “independent practice” described in S 297 reflects an outdated term subject to misinterpretation. In the VHA and in every environment, CRNAs are a critical component of the team of healthcare professionals devoted to the care and safety of each individual patient. In the patient-centered care environment, no healthcare professional in the VHA or anywhere else provides care without there being critical relationships with other healthcare professionals or providers. The VHA anesthesia handbook\(^\text{18}\) provides VHA facilities guidance to promote “team care” involving all of the professional contributions and responsibilities of each of many types of healthcare professionals. Rather, what is being recommended by the VHA consistent with recommendations of the Institute of Medicine is that CRNAs and other APRNs be recognized to their Full Practice Authority.

Ultimately, the committee adopted parts of S 297 not relating to APRN services in the VHA, clearing the way for the VHA to publish a regulation recognizing APRNs to their Full Practice Authority.  

**CRNA Full Practice Authority Improves Veterans Access to Anesthesia Services, and May Save Up to $105 Million per Year that can be Reallocated to Priority Services such as Primary Care, Mental Health, and Physical and Occupational Therapy**

Allowing CRNAs to practice to their Full Practice Authority promotes Veterans access to care in several ways by eliminating redundancy, eliminating waits associated with delayed arrivals of supervising anesthesiologists, and promoting access to regional anesthesia services that are particularly important for orthopedic, urological, vascular and general surgery procedures common in VHA facilities.

Savings are likely to be achieved by recognizing CRNAs to their full scope of practice in the VHA. A study published by Nursing Economic$20$ found that nurse anesthesia care is 25 percent more cost effective than the next least costly anesthesia delivery model, and that 1:1 or 1:2 anesthesiologist to CRNA supervision ratios represent the least cost efficient anesthesia delivery model. A 2015 publication by Conover and Richards, titled “Economic Benefits of Less Restriction of Advanced Practice Nurses in North Carolina,” published by the Duke University Center for Health Policy and Inequalities Research, states that, “expanded use of APRNs under less restrictive regulation could produce health system savings from 0.63 to 6.2 percent.”$21$

A new survey of VHA facilities also shows that CRNA Full Practice Authority is likely to promote substantial cost savings, allowing the VHA to expand patient access to all types of healthcare services our Veterans need. Because all practice models – CRNAs, anesthesiologists, or both together – provide equal quality and safety to patients, modification of these models consistent with Full Practice Authority and current anesthesia care practices in the military, Indian Health Service and many private systems, can significantly reduce costs and improve efficiency in the VHA as well as improve access to services. Thirty-two out of 117 VA Medical Centers (VAMCs) of all sizes with anesthesia services were surveyed, with anesthesia provider counts ranging from three to 40 in each facility. Utilizing average salaries for CRNAs and anesthesiologists, estimated current costs for anesthesia services were established. The survey identified the most frequently used anesthesia practice models as anesthesiologist to CRNA of 1:1 to 1:2 – that is, one anesthesiologist supervising one or two CRNAs providing anesthesia in

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20 Hogan, op cit.


22 Dulisse, op cit.
24 of 32 facilities surveyed. Such ratios are inconsistent with current safe practice outside of the VHA system, as anesthesia services provided by CRNAs and anesthesiologists are considered extremely safe and except in rare instances a single anesthesia provider is sufficient to administer an excellent anesthetic. CRNAs administer anesthesia in all settings working in collaboration with surgeons as a surgical team and in anesthesia teams. 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.”

Modernizing the anesthesia practice models consistent with Full Practice Authority would substantially reduce costs to the VA system. The current annual cost of anesthesia services in 32 facilities was estimated at $121.2 million. Implementing a CRNA only practice model was estimated to annually cost $92.3 million, saving $28.9 million per year in the same 32 facilities. If the surveyed facilities approximate the rest of the nation’s 117 VAMCs that provide anesthesia services, extrapolating the CRNA model to all VAMCs may yield annual savings of $105.7 million from VHA anesthesia services while maintaining patient safety. Permitting CRNAs the ability to practice to their Full Practice Authority and modifying care delivery models would both ensure patient safety and result in substantial cost savings, allowing the VHA to allocate scarce resources toward other Veteran healthcare needs. The current structure duplicates staffing and increases costs. But both safety and savings can be achieved where CRNAs and anesthesiologists provide anesthesia care to Veterans, conduct clinical education, ensure CRNA Full Practice Authority and avoid costly double-staffing.

Recently, the Iowa City VA Medical Center has achieved promising results after moving to a CRNA Full Practice Authority anesthesia delivery model. According to a review by an Iowa City Veterans Affairs Medical Center surgeon, over the past year the acuity of patient cases increased while mortality rates decreased and morbidity ratios remained unchanged. Additionally, over the course of the of a year utilizing a CRNA-only anesthesia model the facility’s anesthesia department labor costs per relative value unit (a measure of case complexity plus time) decreased to $19 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 may 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.

While anesthesiologist supervision is promoted by anesthesiologist groups as a patient safety benefit, in fact anesthesiologist supervision frequently and commonly lapses, as noted by Epstein and Dexter in the journal *Anesthesiology* in 2012. Researchers reviewed 15,000 anesthesia records at a leading U.S. Hospital and concluded lapses in anesthesiologist supervision of

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CRNAs are common even under Medicare medical direction reimbursement rules. This study raises concerns about the benefits of this costly anesthesia practice model and calls into question whether supervision requirements provide a cost-benefit to the VHAs healthcare system. In facilities that demand an anesthesiologist be present before a CRNA starts a case, a task CRNAs are educated and qualified to perform themselves in service to the Veteran undergoing a procedure, each minute of delay in the anesthesiologist’s arrival contributes to increased costs, cascading delays throughout a day, inconvenience to the Veteran patient, and impairments to access to care. Extending CRNAs Full Practice Authority eliminates those waits and accumulated delays.

In some VHA facilities supervision requirements impair the quality of care. Some supervising anesthesiologists prohibit CRNAs from providing regional anesthesia services to Veterans undergoing procedures for which regional anesthesia may be the preferred choice. Such procedures include orthopedic, urological, vascular, and certain general surgery procedures. CRNAs are educated to provide regional anesthesia. Further, regional anesthesia services are frequently the best anesthetic for such patients. Many of these patients suffer from multiple chronic conditions such as lung disease, obstructive sleep apnea, and obesity. 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 putting the patient at greater risk of postoperative pulmonary problems, slower recovery times and greater postoperative pain, and contributing to delays in physical therapy services. All of these factors compromise the patient’s ability to recover as promptly and safely as possible. Therefore, allowing CRNAs to practice to their Full Practice Authority, and to offer regional anesthesia in these cases, can yield a higher quality of care, safer and faster recovery times, and higher patient satisfaction.

What savings are possible, with quality preserved and protected, across all of our VAMCs, by making greater use of CRNAs practicing to their Full Practice Authority? What additional care can be provided to our Veterans with the savings achieved?

**Addressing Common Misconceptions and Misinformation Associated with the Care Delivered by CRNAs which have been Used in Opposition to the VHA Proposal**

Two criticisms have been levied against the VHA Full Practice Authority proposal and against the care delivered by CRNAs, which we believe should be forthrightly addressed. First is the faulty notion that Full Practice Authority for APRNs would somehow eliminate team-based care or eliminate physicians from the VHA, affecting patient safety. Second is the ideology that care delivered by CRNAs is inferior to that delivered by anesthesiologists or by both providers working together.

Recognizing CRNAs and other APRNs to their Full Practice Authority does not impair team-based care delivery; in fact, it encourages it. There is no conflict between CRNAs providing care to Veteran patients as Full Practice Authority providers, and their doing so in teams with other healthcare professionals such as nurses, physicians, other therapists and providers, and
anesthesiologists. Nor is there any conflict between CRNA Full Practice Authority and the VHA Anesthesia Handbook provisions regarding anesthesia. Care provided by nurse anesthetists, anesthesiologists or both working together is very safe and getting safer, as the available literature cited above shows. Both provider types are held to the same standard of care. Both provider types expertly provide anesthesia in the same types of cases, for the same varieties of patients from the healthiest to those with multiple comorbidities. Both provider types are expertly educated to recognize, diagnose and successfully treat complications.

Nevertheless, anesthesiologist groups have cited studies by Silber\(^{26}\) and Memtsoudis\(^{27}\) in an mistaken and unfortunate attempt to show that CRNA care is inferior to that of anesthesiologists – an attempt which is uncorroborated by the evidence and should be rejected by the Committee. The Silber study, based on data gathered more than two decades ago (between 1991-94), was critiqued extensively and independently by the Medicare agency, which stated that the article “did not study CRNA practice with and without physician supervision.” Medicare also stated, “One cannot use this analysis to make conclusions about CRNA performance with or without physician supervision.”\(^{28}\) Finally, study coauthor Dr. D. Longanecker wrote, “The study … does not explore the role of (nurse anesthetists) in anesthesia practice, nor does it compare anesthesiologists versus nurse anesthetists.”\(^{29}\) The Memtsoudis paper suffers from numerous methodological flaws that invalidate the ASA’s faulty deductions. Sample size is important when comparing two provider types, yet the researcher relied on weighted data and never addressed the standard error of the sample size of individual data elements. Instead, the paper aggregated all procedures and calculated the national estimated equivalent, assuming that the categorical data would follow the presumed national estimate. The Centers for Disease Control and Prevention, the source of the data grounding this paper, specifically addresses the unreliability of these data elements in its survey highlights. Moreover, the study did not adjust for major factors common in health services research, including race, comorbidity, insurance status, and metropolitan statistical area. In short: garbage in, garbage out.

**Next Steps in IOM *Future of Nursing Report* Implementation**

Additional developments in which the IOM *Future of Nursing* recommendations must be wielded to have influence in the form of improved patient access to higher quality care at lower cost include finalization of the VHA rule on APRN Full Practice Authority. Ultimately, the VHA must publish a proposed rule, receive and evaluate public comment, publish and implement a final rule in its many healthcare facilities for Full Practice Authority to become reality and for America’s Veterans to receive its benefits. Further, the implementation of MACRA drives substantial changes in Medicare and ultimately commercial reimbursement of healthcare, which


\(^{29}\) Memorandum from Dr. Longanecker to CRNAs in the University of Pennsylvania Health System’s Department of Anesthesia, Oct. 5, 1998.
will drive innovations in healthcare delivery and practice. Among its innovations are the consolidation of several present and future Medicare quality measures into a Merit-based Incentive Payment System (MIPS) model, and payment for Medicare services through bundled Alternative Payment Models (APMs). The involvement of APRNs in the implementation of these policies will help drive care coordination, efficient care delivery, patient safety – and lives and dollars saved.

We stand at your service to continue carrying out the recommendations of this report on behalf of the patients for whom we provide care. Thank you.

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