May 31, 2017

Mick Mulvaney
Director
The Office of Management and Budget
725 17th Street, NW
Washington, DC 20503

RE: Office of Management and Budget Memo M-17-22

Dear Mr. Mulvaney:

The American Association of Nurse Anesthetists (AANA) welcomes the opportunity to offer our comments on the Office for Management and Budget’s (OMB) Comprehensive Plan for Reforming the Federal Government and Reducing the Federal Civilian Workforce - Memo M-17-22. This guidance describes specific actions that OMB and other federal agencies should take to chart the course for a leaner, more effective, more accountable government. The AANA supports the OMB’s efforts to create a more efficient government that works for the American people and supports the delivery of federal programs that are the highest needs to citizens. The issues addressed in our comment mainly pertain to recommendations regarding the Department of Veterans Affairs and are outlined as follows:

I. Background of the AANA and CRNAs

II. Assessment of Current and Future Access to Anesthesia Care Issues

   A. The VA’s Own Studies and Data Confirm an Access to Anesthesia Care Issue
   B. Unrequired, Unnecessary CRNA Supervision Reduces Access to Care in VHA Facilities
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III. Full Practice Authority for CRNAs is a Solution to Current and Future Access to Anesthesia Care Issues and Improves Organizational Efficiency and Effectiveness

   A. CRNA Full Practice Authority Increases Veterans’ Access to Care and Promotes Safe, Efficient Healthcare Delivery
   B. CRNA Full Practice Authority Improves Efficiency to Veterans’ Access to Care
C. CRNAs Provide Multi-Modal Pain Management which may Reduce Veterans’ Need for and Reliance on Opioids

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

I. Background of the AANA and CRNAs

The AANA is the professional association for Certified Registered Nurse Anesthetists (CRNAs) and student registered nurse anesthetists (SRNAs). AANA membership includes more than 50,000 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, 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 Economics*, 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.¹ 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.² 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.³ 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.⁴

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. 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.⁵ The study correlated CRNAs with lower-income populations and correlated

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¹ 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](http://www.aana.com/resources2/research/Documents/nec_mj_10_hogan.pdf)


anesthesiologist services with higher-income populations. Of particular importance to the implementation of public benefit programs in the United States, 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. **Assessment of Current and Future Access to Anesthesia Care Issues**

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. We support the goals of the OMB’s Comprehensive Reform plan, specifically the objectives calling to align the federal workforce to meet current and future needs rather than the requirements of the past and to strengthen agencies by removing barriers that hinder key employees from delivering results. This is why the AANA supports full practice authority for CRNAs, working in Veterans Health Administration (VHA) facilities, who help care for our nation’s veterans to the full scope of their education, training and licensure to help ensure that veterans have access to the timely anesthesia and related healthcare services they deserve.

On December 14, 2016, the VA published its final rule granting full practice authority 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. In order to help expand veterans’ access to quality anesthesia care, we urge you to do what is right for our veterans by using the evidence clearly demonstrated in this comment letter to reconsider this action. 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.

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6 Liao, op cit.

OMB Memo M-17-22 charges federal agencies, including VA, with developing reform proposals that improve delivery of services to the American people while identifying opportunities to reduce duplication or overlap. Specifically, this memo requires the VA to: begin taking immediate actions to achieve near-term workforce reductions and cost savings, including planning for funding levels in the President’s Fiscal Year (FY) 2018 Budget Blueprint; develop a plan to maximize employee performance; and submit an Agency Reform Plan to OMB in September 2017 as part of the Department’s FY 2019 Budget submission to OMB that includes long-term workforce reductions. Due to anesthesia delays, veterans are waiting for care they deserve and have earned. The decision to exclude CRNAs from full practice authority 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. We refute the final rule’s claim that there is not an access to anesthesia care issue for the reasons listed below.

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 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.8 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.”9 To help deal with this projected increased in the demand for healthcare services in the VA, the Independent Assessment stated that one of the

8 RAND Health. “Resources and Capabilities of the Department of Veterans Affairs to Provide Timely and Accessible Care to Veterans,” (2015).
http://www.rand.org/content/dam/rand/pubs/research_reports/RR1100/RR1165z2/RAND_RR1165z2.pdf

9 Ibid.
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.10

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 production of colonoscopy services in comparison with the private sector.11 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.

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

• 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.

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

**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 actually providing hands-on patient care, even though the VA does not require CRNAs to be supervised by anesthesiologists or by any other physicians. CRNAs are appropriately educated and trained to handle every aspect of the delivery of anesthesia services including general and regional anesthesia and acute, chronic, and interventional pain management services. 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. (This does not take into account hospital statutes or regulations.) Furthermore, no state or federal laws require CRNAs to be supervised by anesthesiologists. CRNA supervision leads to increased costs and reduced access to timely care, but does not lead to better healthcare outcomes as confirmed by scientific research data time and time again.

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, and also contributes to delays in physical therapy services. All of these factors compromise the patient’s ability to recover as promptly and safely as possible and leading to additional costs due to longer hospital stays.

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. 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. 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, anesthesiologists, 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.” 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

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13 Hogan op cit., http://www.aana.com/resources2/research/Documents/nec_mj_10_hogan.pdf
allocate scarce resources toward other Veteran healthcare needs.”

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

- 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 APRN rule when it was proposed last May, 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. Expanded APRN practice is considered to be 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,

14 Ibid.
and expanding innovation in health care delivery.”16 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.”17

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 access to essential surgical, emergency, obstetric, and pain management healthcare services without needless delays or having to travel long distances for care. It would also correspond with the VA Secretary David Shulkin’s May 31, 2017 address on the “State of the VA” where he remarked that the goal was to “turn the VA into the organization Veterans and their families deserve, and one that America can take pride in,” which includes, “reducing burdensome regulations that do not make sense and launching new tools that make it easier for Veterans to engage with VA.18”

C. 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

16 Ibid.
17 Ibid.
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.  

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. 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 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.\(^{22}\)

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.\(^{23}\) 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 VA 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.

III. **Full Practice Authority for CRNAs is a Solution to Current and Future Access to Anesthesia Care Issues and Improves Organizational Efficiency and Effectiveness**

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\(^{23}\) Ibid.
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, which has been proven through decades of scientific research. By standardizing care delivery models across the country via full practice authority for APRNs, including 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.

The landmark National Academy of Medicine (formerly the Institute 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 more safe 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.24 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.25 Furthermore, a 2014


25 Negrusa op cit.
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.\(^{26}\) 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.\(^{27}\) 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.\(^{28}\) 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.

\(^{26}\) 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

\(^{27}\) The Commission on Care, Final Report on the Commission on Care (June 30, 2016),

\(^{28}\) The Commission on Care, op cit.
Recognizing CRNAs to their full practice authority 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. 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.

**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.

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30 National Academy of Medicine op cit., p. 9.
• 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

According to a recent article, the VA has stated that about half of older veterans and about 60 percent of veterans returning from deployments suffer from chronic pain. The same article states that about 68,000 Veterans—13% of the total veteran population—are taking opioids to help treat their pain, which has led to many becoming caught up in the current opioid crisis. The number of veterans with opioid-use disorders has increased 55 percent from 2010 to 2015. 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. Pain is a personal experience that, if left undertreated or mismanaged, can radically change an individual’s quality of life and impact important relationships. We believe that one method to provide the maximum benefit to the patient that will help prevent reliance on opioids is to utilize a patient-centered, multidisciplinary, multimodal treatment approach to pain management as a primary pain management modality, thus helping curb the prescribed opioid epidemic. Acute and chronic pain is best treated and managed by an interdisciplinary team that actively engages with the patient to diagnose and manage their pain for improved well-being, functionality, and quality of life. As members of the interdisciplinary team, CRNAs are well positioned to provide holistic, patient-centered, multimodal pain treatment and management across the continuum of pain and in all clinical settings (e.g., hospitals, ambulatory surgical

centers, offices, and pain management clinics).  

As anesthesia experts, CRNAs are qualified pain practitioners who work in various practice settings to treat patients suffering from a wide range of acute and chronic pain conditions. CRNA chronic pain management practitioners are able to minimize the use of opioids to address chronic pain through the use of a multimodal approach that includes pharmacologic and non-pharmacologic pain mitigation strategies. Furthermore, the holistic approach that CRNA pain management practitioners employ when treating their chronic pain patients may reduce the reliance on opioids as a primary pain management modality, thus aiding in the reduction of potential adverse drug events related to opioids. 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.

For surgical pain, a preemptive, multimodal approach to acute pain management integrating regional anesthesia techniques to reduce the use of opioids has been shown to be advantageous in a wide array of surgical specialties. The use of enhanced recovery after surgery (ERAS) pathways reduces the patient’s stress response to surgery, minimizes use of opioids, shortens overall hospital length of stay, and accelerates the return to normal daily function. The patient’s pain management plan of care begins pre-procedure and continues through post-discharge using opioid-sparing techniques such as regional anesthesia, peripheral nerve blocks, non-pharmacologic approaches, and non-opioid based pharmacologic measures. 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.\textsuperscript{34}

According to a recent AANA position statement titled \textit{A Holistic Approach to Pain Management: Integrated, Multimodal, and Interdisciplinary Treatment}, “CRNAs integrate multimodal pain management as an element of enhanced recovery after surgery (ERAS) protocols to manage pain.” CRNAs are well-positioned to partner with the healthcare team to minimize or eliminate use of prescribed opioids through pharmacologic and non-pharmacologic multi-modal pain management strategies including education and the development of perioperative care pathways that integrate anesthesia expertise. These skills are core to nurse anesthesia practice. The Council on Accreditation of Nurse Anesthesia Educational Programs (COA) requires acute and chronic pain management content in the curriculum of the 115 accredited nurse anesthesia programs. The AANA offers CRNAs a continuum of educational resources for each step along the way to pain management practice that includes advanced acute and chronic pain management workshops for CRNAs to enhance their skills and increase their awareness of the complications associated with opioid use and misuse. In partnership with the AANA, Texas Christian University offers a chronic pain management fellowship, and beginning in the summer of 2017, the Middle Tennessee School of Anesthesia will offer a post-graduate acute surgical pain management fellowship.

At a time when the VA is seeing an increase in the number of veterans suffering from chronic pain, CRNAs are also uniquely poised to be part of the solution. CRNAs deliver chronic pain treatment in a compassionate and holistic manner, utilizing a variety of therapeutic, physiological, pharmacological, interventional, and psychological modalities in the management and treatment of pain—all with the goal of reducing patients’ usage and dependence on opioid drugs. 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

\textsuperscript{34} AANA op. cit.
that include multimodal analgesia, interventional techniques, and complementary and alternative approaches to pain management.\textsuperscript{35} Allowing full practice authority for CRNAs would provide access to care for an increasing number of veterans who are experiencing acute and chronic pain. CRNAs should be an integral part of any solution to decrease reliance on the use of opioids for treatment of pain in the VA. Furthermore, increasing access to primary care providers such as nurse practitioners will only compound the problems created when the VA excluded CRNAs from full practice authority, because 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. 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

\textsuperscript{35} Schoneboom B et al. Answering the call to address chronic pain in military service members and veterans: Progress in improving pain care and restoring health. \textit{Nursing Outlook} June 2016.
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.

We thank you for the opportunity to comment on this memo. As the VA works on developing reform proposals that improve delivery of services to the American people while identifying opportunities to reduce duplication or overlap, we urge the VA to reverse the final APRN rule and finalize 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. Should you have any questions regarding these matters, please feel free to contact the AANA Senior Director of Federal Government Affairs, Ralph Kohl, at 202.484.8400, rkokh@aanadc.com.

Sincerely,

Cheryl L. Nimmo, DNP, MSHSA, CRNA
AANA President

cc: Wanda O. Wilson, PhD, CRNA, AANA Executive Director
Ralph Kohl, AANA Senior Director of Federal Government Affairs
Randi Gold, MPP, AANA Associate Director Federal Regulatory and Payment Policy