Statement for the Record
to the
House Committee on Veterans' Affairs

Building a Better VA: Addressing Healthcare Workforce Recruitment and Retention Challenges

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Introduction

Chairman Takano, Ranking Member Bost, and Members of the Committee, thank you for the opportunity to offer this statement for the record. The American Association of Nurse Anesthesiology (AANA) is the professional association for Certified Registered Nurse Anesthetists (CRNAs) and student registered nurse anesthetists, with membership that includes more than 59,000 CRNAs and student nurse anesthetists representing over 90 percent of the nurse anesthetists in the United States. CRNAs are advanced practice registered nurses (APRNs) who personally administer more than 50 million anesthetics to patients each year in the United States. CRNAs provide acute, chronic, and interventional pain management services. In some states, CRNAs are the sole anesthesia providers in nearly 100 percent of rural hospitals, affording these medical facilities obstetrical, surgical, trauma stabilization, and pain management capabilities.

The AANA applauds the House Committee on Veterans' Affairs' for it's leadership in holding this timely hearing on "Building a Better VA: Addressing Healthcare Workforce Recruitment and Retention Challenges." This hearing is critically important as we continue to see the devastating effects that the COVID-19 pandemic, ongoing stress and burnout, and increasing retirements have had on the healthcare workforce.

While it is important to consider new ways to recruit and retain employees, the VA is ignoring an existing chance to do so by granting CRNAs full practice authority (FPA). CRNAs are among the most educated, well trained, and highly skilled APRNs in our healthcare workforce, yet they are the only APRN that has not been granted FPA within the VA. Moreover, 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 has stated 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 misguided lack of FPA, which has been granted to other APRNs since 2016, not only negatively affects CRNA recruitment and retention, but also negatively impacts the care that our veterans receive.

Assessment of Current and Future Access to Anesthesia Care Issues

The AANA continues to advocate for policies that will ensure a robust and cost-efficient anesthesia workforce both in the VA and in the private sector. A key component of ensuring a strong and effective anesthesia workforce is the implementation of FPA for CRNAs working within the VA. Currently, almost 1,100 CRNAs work in the VA it is projected that hundreds more will need to be hired in the coming years. FPA would allow CRNAs who provide care for our nation's veterans to work to the full scope of their education, training, and licensure thereby helping 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 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."[1] This statement ignores both the on the ground realities of anesthesia care in the VA, as well as the VA's own assessments. Reports out of the Denver Veterans Affairs Medical Center in 2017 indicated the cancellation or delay of dozens of procedures specifically due to a lack of access to anesthesia care.[2] Furthermore, recent reports continuously highlight a lack of access to anesthesia services in the VHA. The VA's Office of the Inspector General (OIG) released a report in June 2018 cited VHA staffing shortages for the fifth year in a row.[3] Out of the 141 facilities surveyed for this report, 31 facilities reported staffing shortages in the area of anesthesiology and the most frequently cited shortages were in the Medical Officer and Nurse occupations.[4]

In light of the successful implementation of FPA for nurse practitioners, nurse-midwives and clinical nurse specialists, and given the current and growing workforce shortages, it's time for the VA to revisit its 2016 FPA decision. The VA even acknowledged as much in its APRN FPA rule when it stated, "VA welcomes comment on whether lack of advanced practice authority is a hiring, recruitment, or retention barrier for CRNAs, as well as on the extent to which advanced practice authority could help to resolve these issues either directly or indirectly."

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.[5] 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.[6] *The long overdue time to re-evaluate this policy is now.*

The Case for Full Practice Authority for CRNAs

The VA, as well as multiple independent arbiters, Veterans Service Organizations (VSOs) and independent data all point to the same conclusion, that the VA's decision not to implement CRNA FPA only serves to hurt patients. Data from VA commissioned studies show clear access to care issues in VHA facilities. We are troubled as to why these objective findings were not considered to be sufficient evidence for granting FPA to CRNAs in the final 2016 APRN 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

[1] 81 Fed. Reg. 90198. https://www.gpo.gov/fdsys/pkg/FR-2016-12-14/pdf/2016-29950.pdf
[2] Low, R. (2017, October 17). VA surgeries postponed because there aren't enough anesthesiologists. KDVR Fox31. Retrieved March 14, 2022, from https://kdvr.com/news/problem-solvers/serving-those-who-serve/va-surgeries-postponed-because-there-arent-enough-anesthesiologists/
[3] VA OIG June 2018 report, "OIG Determination of Veterans Health Administration's Occupational Staffing Shortages", https://www.va.gov/oig/pubs/VAOIG-18-01693-196.pdf
[4] VA OIG, op cit.
[5] https://www.va.gov/vetdata/Utilization.asp
[6] 81 Fed. Reg. 90198. https://www.gpo.gov/fdsys/pkg/FR-2016-12-14/pdf/2016-29950.pdf

number of key specialties, as well as primary care.[7] The VA Independent Assessment stated that one of the most important changes in VA policy to help meet increases in demand for healthcare and ensure continued access to care for veterans would be formalizing FPA for all APRNs, including CRNAs. These projections on workforce shortages were in place before the COVID-19 pandemic, which has only worked to exacerbate the shortages.

In a crucial mistake and misguided decisions, the VA ignored these findings in its final rule. 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 must wait more than a month to get an appointment.[8] 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.[9] This speaks to the underutilization of existing anesthesia providers such as CRNAs, who are arbitrarily not allowed to practice to the full scope of their education, experience, and licensure. It remains unclear why the Independent Assessment's impartial findings were not sufficient evidence to allow full practice authority for CRNAs in VHA facilities. The final rule even went as far as to say that not granting CRNAs FPA had nothing to do with outcomes, writing "'The 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.' VA agrees with these comments." Simply put, CRNAs working independently yeild the same results, and there is no impetus for requiring supervision.

Requiring VA facilities to engage in superfluous supervision of CRNAs will only continue to lead to delays and exacerbate workforce shortages, ultimatelyhurting patient care. Supervision within the VA has even led to incredibly restrictive 1:1 and 1:2 supervision models, that are highly inefficient. These types of supervision models are not typically used in the private sector, specifically because they are too inefficient and costly. Our veterans deserve better. 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 at a time when demand for those services is increasing. 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

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[7] 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

[8] 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

[9] VA Independent Assessment, Appendices E – I,
http://www.va.gov/opa/choiceact/documents/assessments/Assessment_B_Health_Care_Capabilities_Appendices_E-I.pdf

is cost effective or financially viable."[10] The Lewin Group analysis concludes that allowing CRNAs to practice to the full extent of their education and training would "both ensure patient safety and result in substantial cost savings, allowing the VHA to allocate scarce resources toward other Veteran healthcare needs."[11]

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 wasting unnecessary time and resources supervising CRNAs instead of directly providing anesthesia care to veterans. 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-three 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.

Data from multiple independent studies has consistently shown that CRNAs working independently are not only the most cost-efficient method of anesthesia delivery, but is as safe as supervision models, leading to similar outcomes. A 2016 study on CRNA scope of practice laws published in the Journal of Medical Care found that there was virtually no evidence that the odds of complication differed by delivery model, as an independent CRNA model had similar outcomes to other less efficient models.[12] Data published in Health Affairs also showed that states that opted out of Medicare's supervision requirement for CRNAs saw no increase in patient deaths or complications, showing that supervision does not improve outcomes.[13] Currently 19 states have opted out of the requirement.

Independent arbiters have also consistently supported FPA for CRNAs and the removal of barriers for APRNs. The New England Journal of Medicine supported the removal of barriers to APRN practice in a 2020 article on modernizing scope of practice to put patients first.[14] The same recommendation was made by the Bipartisan Policy Center's 2020 report on Confronting

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[10] Hogan op cit., http://www.aana.com/resources2/research/Documents/nec_mj_10_hogan.pdf

[11] Ibid.

[12] Negrusa, B., PhD, Hogan, P., MS, Warner, J., PhD, Schroeder, C., BA, & Pang, B., MS. (2016, October). Scope of Practice Laws and Anesthesia Complications. Medical Care. Retrieved March 14, 2022, from https://journals.lww.com/lww-medicalcare/Abstract/2016/10000/Scope_of_Practice_Laws_and_Anesthesia.4.aspx

[13] Dulisse, op cit., http://content.healthaffairs.org/content/29/8/1469.full.pdf and Negrusa op cit., http://journals.lww.com/lww -medicalcare/Abstract/publishahead/Scope_of_Practice_Laws_and_Anesthesia.98905.aspx

[14] Froger, B PhD et al. (February 13, 2020) Modernizing Scope-of-Practice Regulations – Time to Prioritize Patients. New England Journal of Medicine. Retrieved March 14, 2022, https://www.nejm.org/doi/full/10.1056/NEJMp1911077

Rural America's Health Crisis,[15] as well as the Institute of Medicine's Future of Nursing Report in 2010.[16]

Recruitment and Retention of CRNAs Will Increase Productivity and Efficiency

The VA stated in its final APRN rule, "VA understands that there are difficulties hiring and retaining anesthesia providers." The AANA acknowledges and highlights this difficulty for the committee. In fact, this challenge was further illustrated by a major VHA workforce evaluation published in January 2015 reporting that CRNAs have been among the VHA's most difficult to recruit specialties over four of the past five years.[17] The final APRN rule also stated 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.[18]

The VA's final APRN 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."[19] The AANA 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 FPA 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 FPA to CRNAs.

Competitive Salaries and Employment Benefits

We applaud the Committee's work on the *VA Nurse and Physician Assistant RAISE Act* (H.R. 5575). Recent enactment of this legislation represents an important step to increasing pay for APRNs and other providers at the VA to ensure competitive salaries to help recruit and retain employees. While we do not expect the VA to be a pay leader in the healthcare sector, we urge the committee to remain cognizant of the healthcare workforce contractions, due to retirements, burn outs and other pandemic related stresses. The VA has fallen significantly behind the private sector in compensation and the *RAISE Act* is a critically important step to ensure that VA can remain competitive.

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[15] Bipartisan Policy Center Rural Health Task Force. (April 2020). Confronting Rural America's Health Care Crisis. Bipartisan Policy Center. Retrieved March 14, 2022, https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2020/04/WEB_BPC_Rural-Health-Care-Report.pdf

[16] National Academy of Sciences. (October 2010). The Future of Nursing, Leading Change, Advancing Health. Institutes of Medicine. Retrieved March 14,2022 from https://www.aana.com/docs/default-source/fga-aana-com-web-documents-(all)/future-of-nursing-2010-report-brief.pdf?sfvrsn=a65c49b1_4

[17] VA Office of the Inspector General, OIG Determination of Veterans Health Administration's Occupational Staffing Shortages (January 30, 2015)

[18] https://www.va.gov/vetdata/Utilization.asp.

[19] VA Impact Analysis for RIN 2900-APxx/WP 2013-036, Advanced Practice Registered Nurses. "APRN Gains and Losses for FY-12 to FY-16 (Source: 2015 VHA Workforce Planning Report): The number of Nurse Anesthetist gains and losses for FY-12 to FY-16: Total Gains – 314 / Total Losses – 226 for a net gain of 88. The number of Nurse Practitioner gains and losses for FY-12 to FY-14: Total Gains – 1499 / Total Losses – 879 for a net gain of 620."

CRNAs are in a unique position within the VA pay scale. While we appreciate the reforms brought by the *RAISE Act,* we wish to highlight that CRNAs face unique challenges with salaries, because of their advanced skills and the difficulty in recruiting and retaining these advanced providers. It is essential that we address the aggregate limit set forth in the VA handbook, "the aggregate [pay] limit on compensation for CRNAs is the annual pay received by the Vice President [of the United States.]"[20] This level is currently set at $235,100. We urge swift action to update the handbook to ensure that CRNAs, like nurse executives and other healthcare professionals, are capped at the same level as the President of the U.S. This would ensure that CRNA compensation, including incentives such as call pay, shift differential, overtime and other premium pay, incentive awards and performance-based cash award, recruitment and relocation incentive can be awarded to help with CRNA recruitment and retention in the VA.

We also encourage the committee to adopt parity between APRNs, nurses and other non-physician providers. Legislation such as H.R. 3693, the *Department of Veterans Affairs Continuing Professional Education Modernization Act.* This legislation would provide other strong incentives to help the VA recruit and retain a strong healthcare workforce. This would also help healthcare providers, including CRNAs, continue their life long education with further training in groundbreaking techniques that can help reduce or eliminate opioids, manage chronic pain more safely and efficiently, and allow them to continue to better serve our nation's veterans.

Conclusion

Granting FPA to CRNAs would make working with the VA a more desirable and feasible career path for CRNAs, and significantly aid with efforts to recruit and retain employees. The VA itself made this important argument when discussing the importance of allowing CRNAs specifically to practice to the full extent of their training. At a 2020 Congressional hearing on the VA's handling of the pandemic, Dr. Jennifer MacDonald, the Chief Consultant to the Deputy Undersecretary for Health at the VA, spoke on CRNA FPA saying, "[this change] gives us a better ability to recruit and retain those essential providers for our teams … we need that level of agility to respond effectively and deliver the access that you mentioned originally." It would maximize productivity and efficiency, making full use of the more than 1,100 CRNAs already practicing in VHA facilities and make working in VHA facilities more attractive to future CRNAs. It would also allow CRNAs who are veterans, who were previously allowed FPA in all branches of the military, to treat their fellow veterans with the same skills and under the same conditions.

Allowing CRNA FPA in the VA would not only help to increase the number of CRNAs who can provide safe, high quality and cost-effective anesthesia care for our nation's veterans, but would free up physician anesthesiologists to also provide anesthesia care to veterans, significantly increasing the scope of the anesthesia workforce. This would ensure that our nation's veterans have access to essential surgical, emergency, obstetric, and pain management healthcare services

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[20] Department of Veterans Affairs. VA Handbook 5007. October 2020. Retrieved March 14 2022: https://www.va.gov/vapubs/viewPublication.asp?Pub_ID=1270&FType=2

without needless delays or having to travel long distances for care. We also cannot ignore the need for increased pay, compensation, and benefits to help increase recruitment and retention of all APRNs. We thank the Committee for holding this hearing and look forward to working with you all towards our common goal of ensuring veteran access to care.