American Association of
NURSE ANESTHESIOLOGY

Written Statement for the Record by:

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House Veterans Affairs Committee
"Restoring Focus: Putting Veterans First in Community Care"

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Background on AANA and CRNAs

Chairman Bost, Ranking Member Takano, 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 65,000 CRNAs and student nurse anesthetists representing over 88 percent of the nurse anesthetists in the United States. CRNAs are advanced practice registered nurses (APRNs) who provide anesthesia, as well as 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. CRNAs are highly trained and skilled anesthesia providers who have full practice authority in the Army, the Navy, and the Air Force, as well as the Indian Health Service. CRNAs are the primary provider of anesthesia on the battlefield, including in forward surgical hospitals.

AANA applauds the Committee's continued oversight of the ways the Department of Veterans Affairs (VA) provides quality care and services for our nation's veterans. This hearing is an important opportunity to address inefficient models of care within the VA health system that can lead to veterans seeking and receiving care in the community. The VA has unnecessarily restrictive practice models for anesthesia that intentionally underutilize CRNAs, driving up costs for taxpayers, increasing wait times for veterans, and creating significant inefficiencies and unnecessary redundancies in the system. This was readily apparent at the Hampton, Virginia VA Medical Center (VAMC), where a lack of physician anesthesiologists meant that CRNAs were not allowed to provide anesthesia despite being trained and educated to do so. This directly led to unnecessary delays in care, diversion to other facilities, and wasted money and resources.[1] We appreciate the leadership of Chairman Bost and Chairwoman Kiggans on investigating the matter at Hampton VAMC. We also applaud the Trump Administration for their leadership on reducing barriers to care for APRNs, including CRNAs, both by temporarily removing supervision requirements for CRNAs, as well as putting out a report that called for allowing all APRNs to work to the top of their training, which we strongly encourage the VA to follow.

Many of the veterans who turn to community care live in rural and underserved areas. According to data from the VA, there are 4.4 million veterans living in rural areas, and a higher percentage of rural veterans are enrolled in the VA health system than those in urban areas.[2] Additionally, veterans in rural areas are more likely to experience difficulty in accessing care, with longer waits and greater distances to care. In these areas, veterans who opt to utilize community care are far more likely to receive anesthesia from a CRNA. CRNAs make up approximately 80% of rural anesthesia providers and are the sole provider of anesthesia in nearly 100% of rural hospitals.[3] Despite the fact that veterans who are sent out into the community for care are more likely to receive anesthesia from a CRNA, the VA health system itself utilizes an unnecessarily

[1] https://veterans.house.gov/news/documentsingle.aspx?DocumentID=6424
[2] Department of Veterans Affairs. *Rural Veteran Health Care Challenges.* Office of Rural Health. https://www.ruralhealth.va.gov/aboutus/ruralvets.asp
[3] https://www.aana.com/about-us/about-crnas/

restrictive anesthesia model that significantly contributes to veterans being forced to seek care outside of the VA health system in the first place because it is so inefficient.

The continued requirement of physician supervision of CRNAs within the VA is a persistent roadblock to the delivery of healthcare to our veterans. The practice is costly and dangerous, as it means veterans will see their care delayed or cancelled when an anesthesiologist is not available, despite the VA health system having ample CRNAs who are ready and able to provide care. This model of care is also incongruent with the vast majority of state laws, which do not require physician supervision of CRNA services, and runs counter to the preponderance of peer-reviewed evidence on CRNA safety, which shows that CRNAs can practice independently without any safety concerns. In fact, numerous studies have shown that patient health outcomes are identical when anesthesia services are performed by CRNAs versus physician anesthesiologists. CRNAs possess the education and training to provide care to all patients, even those with complex medical conditions.

To better provide the care that our veterans have earned and deserve, the VA health system must remove costly, unnecessary barriers to care. The VA health system could realize considerable cost savings and improved wait times, all without sacrificing healthcare quality, by allowing CRNAs full practice authority at all VA health facilities. This would allow a considerable number of veterans to receive care within the VA health system should they so choose. Otherwise, the VA health system will continue to face fiscal shortfalls in coming years and our veterans will be forced out into community care in ever greater numbers.

The Important Voice of Nurses

The AANA would like to applaud the committee for including Kelley Saindon, DNP, RN, NE-BC, CHPN as a witness at the hearing. The voice of nurses is critical to our healthcare system and to finding solutions that work for patients. Too often, the thoughts and opinions of the nation's more than four million nurses are forgotten in the halls of Congress. For the twenty-third year in a row, nurses remain the most trusted professional in the country.[4] Given the role that nurses play on the front lines of patient care, their consistent role in interacting with patients, and the incredible public trust they have garnered because of that service, it's important that we learn from them, and we thank you for including a nurse at this hearing. We hope the Committee will continue to engage with nurses as we work together toward our common goal of ensuring that all veterans have access to healthcare.

VA Unnecessarily Creating Delays and Inefficiencies

As Chairman Bost mentioned in his opening remarks, the goal of Community Care is to "eliminate barriers to care and expand access for veterans nationwide". This has long been a policy priority for the AANA in both veterans' healthcare and in our broader healthcare system. Too often, outdated and inefficient barriers to care have made accessing healthcare difficult for

[4] Saad, Lydia. (January 13, 2025). *Americans' Ratings of U.S. Professions Stay Historically Low.* https://news.gallup.com/poll/655106/americans-ratings-professions-stay-historically-low.aspx

patients. Community Care plays a significant role in ensuring that veterans have access to timely care.

The VA must get out of its own way when it comes to providing timely access to care. The VA health system continues to utilize incredibly inefficient anesthesia models that increase waits times for veterans, increase costs to taxpayers, and harm veterans' health by delaying or denying care. In too many cases, the VA health system uses 1:1 and 1:2 supervision ratios, wherein a physician anesthesiologist, making close to $400,000 a year, supervises a single CRNA on a single case at a time.[5] This is a comically inefficient use of taxpayer money and healthcare resources. Such supervision models continue to lead to the VA unnecessarily delaying care and forcing veterans to seek care outside of the VA health system, even if that is their preferred provider. These same models of care are rare in the private sector, and veterans who seek community care will almost certainly receive care from a far less restrictive anesthesia model, one that allows CRNAs to work far more independently and efficiently than the VA health system currently does.

We have seen firsthand at the Hampton VAMC the damage that the VA health system's inefficient anesthesia models can cause. The facility previously employed just one physician anesthesiologist and had canceled or delayed care when that physician was unavailable. The VA was therefore paying multiple CRNAs at the Hampton VAMC, who were not being allowed to provide care when the physician anesthesiologist was not present, despite being fully capable of doing so. Not only was this a waste of taxpayer dollars, but an affront to our veterans. The Hampton VAMC, due to this misguided policy, had to divert patients to other facilities and borrow physician anesthesiologists from other Veteran Integrated Services Networks (VISNs), furthering the inefficiency of care already guaranteed by the artificial limits to CRNAs' scope of practice at the VA.

As VISN 6 leadership has admitted, they are forced to contract with outside anesthesia providers, unnecessarily increasing costs for care at a time the VHA is facing budget shortfalls. The VISN 6 leadership also mentioned that they are working with the Department of Defense to recruit active-duty providers in the region. This is ironic as active-duty CRNAs, under the rules of the Defense Health Agency, enjoy full practice authority everywhere, including when they practice within the state of Virginia. The current anesthesia models within the VA health system are untenable for our veterans, and it is the result of a misguided policy employed by both the VA in general and the Hampton VAMC specifically, and represents a broken promise made by the VA nearly a decade ago.

Community Care and CRNAs

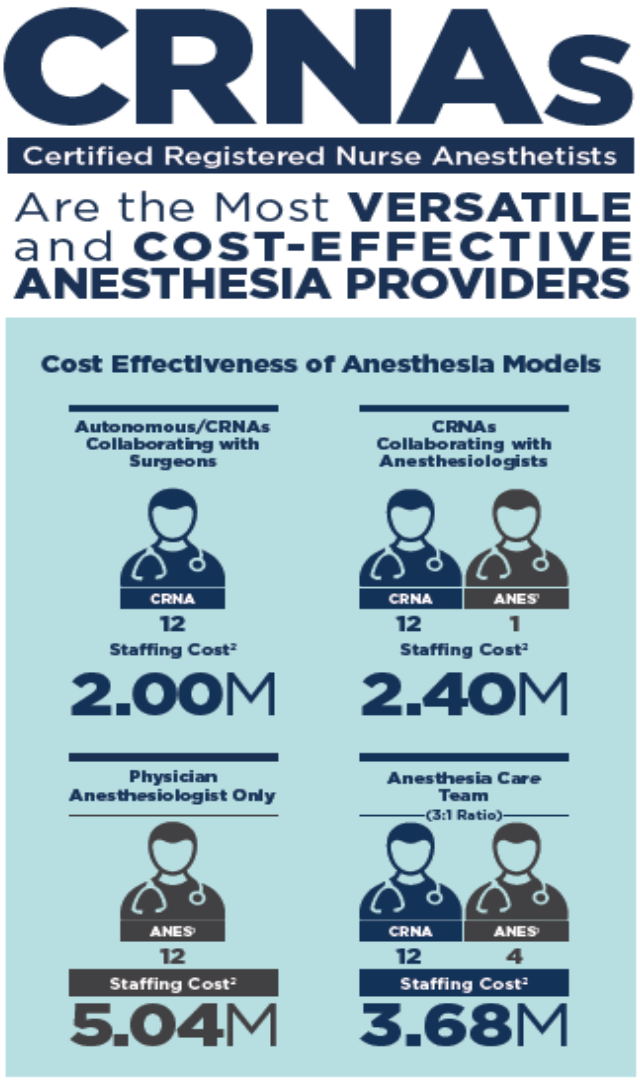
The AANA strongly believes that the VA should move to grant CRNAs full practice authority to increase access to care, so that every veteran who wants to access care within the VA can do so, especially with the increasing number of veterans eligible for care under the PACT Act. For those who cannot access care within the VA system, Community Care represents an option that will help to increase access and improve timeliness of care. Yet, a major disconnect occurs

[5] https://www.va.gov/OHRM/Pay/2021/PhysicianDentist/PayTables_20210103.pdf

between the VA and all other practice environments. While the VA utilizes overly strict supervision models that impede access to care without any corresponding increase in outcomes, the majority of states do not require these supervision models. The VA even quixotically uses these restrictive and inefficient models when they are in conflict with state requirements.

Currently, only seven states have supervision requirements for CRNAs in their Nurse Practice Act, Board of Nursing rules, or their equivalent, and twenty-five states have opted out of Medicare's supervision requirements for CRNA services. The trend of states opting out of supervision requirements for CRNAs has accelerated recently, with eight states opting out just in the last five years. This represents an ongoing, bipartisan trend towards increasing access to care and removing administrative burdens that harm patients.

When we meet veterans where they are to provide care, it is often CRNAs who are providing that anesthesia, particularly in the rural and underserved communities that are most reliant on community care. If CRNA led anesthesia care is good enough for Community Care, and is good enough for the Defense Health Agency and every branch of the military, why isn't it good enough for the VA health system? While there are legitimate concerns that sending more care out into the community created budgetary issues for the VA, the delivery of anesthesia is one area where the private sector has moved to be more efficient. It is time to bring the VA in line with the rest of the country by allowing CRNAs to provide high-quality, timely care. They must be granted full practice authority within the VA if we are to live up to our promise to care for our veterans.



Comparing various methods of anesthesia delivery, an autonomous CRNA collaborating with a surgeon is the most cost-effective model for anesthesia delivery. Current trends in the QZ modifier, which is utilized when a CRNA is billing for anesthesia without supervision, have shown a steady increase in the utilization of this billing modifier, implying an increase in CRNA autonomous practice. The anesthesia care team model, of 1:3 supervision is one of the most expensive anesthesia delivery models possible. Allowing for autonomous practice by CRNAs allows facilities the flexibility to choose a model that meets their needs and helps to keep costs down. Unfortunately, the VA health system is known for significant waste in their anesthesia delivery models, including the utilization of the highest cost 1:1 supervision model, and incurring millions of dollars in costs due to outside anesthesia contracts. Veterans and taxpayers deserve better than VA's inefficient anesthesia delivery models.

Independent Recommendations and Clinical Data

While the VA continues to utilize inefficient models and waste taxpayer dollars while simultaneously harming veterans' access to care, they have made it clear multiple times that they do not see evidence that CRNA independent practice provides outcomes any different than other, more restrictive anesthesia models. On the contrary, the VA has supported CRNA independent practice as equally safe as our anesthesiologists' colleagues, stating in a 2016 rule, "'over 900 CRNAs provide every type of anesthesia care, as well as chronic pain management services, for our Veterans in the VHA. 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."[6] Additionally, the VA agreed in their materials published with this rule that "anesthesia care by CRNAs was equally safe with or without physician supervision."[7]

The evidence is overwhelming that CRNA independent practice is just as safe as the anesthesia care provided under supervision or by our physician anesthesiologists colleagues. In a study that the VA commissioned from Temple University, it was found that "studies have found that CRNAs who had an expanded scope of practice did not have worse patient outcomes, complications, or mortality when compared to anesthesiologists."[8] A peer reviewed study published in the Journal of Medicare Care in 2016 looked at anesthesia related complications for CRNA only, anesthesiologist only, and a team-based approach and found there were no differences in complication rates based on delivery model.[9] This corroborates an earlier peer reviewed study published in Health Affairs in 2010 that looked at the differences in outcomes in states that had opted out of Medicare's supervision requirement for CRNAs were no different than outcomes in states that maintained supervision.[10] A comprehensive review completed by the Cochrane Library in 2014 further reinforced these finding, when it reviewed the literature on anesthesia staffing and found that there could be no definitive statement can be made about the superiority of anesthesia delivery models.

During his first Presidency, the Trump Administration released a report on "Reforming America's Healthcare System Through Choice and Competition" that included recommendations to "allow all healthcare providers to practice to the top of their licensure, utilizing their full skill sets".[11] President Trump also put in place policy during the Public Health Emergency to

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[6] "Advanced Practice Registered Nurses" (A rule by the Veterans Affairs Department, 2016). https://www.federalregister.gov/documents/2016/12/14/2016-29950/advanced-practice-registered-nurses

[7] Department of Veterans Affairs, op. cit.

[8] Baumle, op. cit.

[9] "Scope of Practice Laws and Anesthesia Complications" (Negrusa, Hogan, Warner, Schroeder, and Pang, 2016). https://journals.lww.com/lww-medicalcare/abstract/2016/10000/scope_of_practice_laws_and_anesthesia.4.aspx

[10] "No Harm Found When Nurse Anesthetists Work Without Supervision by Physicians" (Dulisse and Cromwell, 2010). https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2008.0966?journalCode=hlthaff

[11] Department of Health and Human Services. (December 3, 2018). *Reforming America's Healthcare System Through Choice and Competition.* https://public3.pagefreezer.com/browse/HHS.gov/31-12-2020T08:51/https://www.hhs.gov/about/news/2018/12/03/reforming-americas-healthcare-system-through-choice-and-competition.html

temporarily waive the supervision requirement for CRNA services. The VA Health system needs to continue in this vein. The situation will become even more dire in the coming years, both within the VA and in Community Care as the Association of American Medical Colleges predicts as shortage of specialty physicians, including anesthesiologists, of between 10,300 and 35,600 by 2034.[12] The combined physician shortage and nursing shortage makes clear that we can no longer rely on outdated anesthesia models that are already untenable, and will become increasingly dangerous with a growing and aging veteran population. It is imperative that all qualified anesthesia providers, including CRNAs and our physician anesthesiologists' colleagues, need to be providing direct patient care-especially to ensure that our veterans have the timely access to care they deserve, either at the VA or through Community Care. Veterans and taxpayers can no longer afford to pay healthcare providers to stand around and provide unnecessary supervision when they could be, and should be, providing actual patient care. Not only is this the right thing to do for veterans, but it aligns with the Department of Government Efficiency's goal of removing administrative burdens and more efficiently using taxpayer funds.

Conclusion

The VA continues to create its own problems with its woefully outdated anesthesia models that hurt veterans and taxpayers equally. The VA needs to make changes now. We applaud the work of your committee and the vision that that Trump administration has laid out to remove barriers to APRNs and to increase competition and choice within the healthcare system. We believe this will benefit veterans at every level and save American taxpayers money. We hope to be helpful partners in your work to provide our veterans with the highest quality care possible.

[12] Heise, Stuart. (June 11, 2021). *AAMC Report Reinforces Mounting Physician Shortage.* https://www.aamc.org/news/press-releases/aamc-report-reinforces-mounting-physician-shortage