American Association of
NURSE ANESTHESIOLOGY

Written Statement for the Record by:

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House Veterans' Affairs Committee Subcommittee on Health

360 Cannon House Office Building
Washington, DC 20515

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Background on AANA and CRNAs

Chairwoman Miller-Meeks, Ranking Member Brownley, and Members of the subcommittee, 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 61,000 CRNAs and student nurse anesthetists representing over 85 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.

CRNAs are highly trained and skilled anesthesia providers who have full practice authority in the Army, Navy, and Air Force. CRNAs are the primary providers of anesthesia on the battlefield, including in forward surgical hospitals. Despite offensive and denigrating claims by the group Physicians for Patient Protection and their allies in the medical community, CRNAs are not the primary provider of anesthesia in forward surgical units because they are 'more expendable' than their physician colleagues, but because of their high level of education and skill to provide anesthesia in the most difficult circumstances possible. These same skills are the reason that the VA should develop National Standards of Practice (NSP) that allow CRNAs and other providers to work to the top of their education and training.

Department of Veterans Affairs (VA) National Standards of Practice

In December 2020, the VA announced their intention to develop National Standards of Practice for more than fifty different providers currently working within the VA[1]. These standards are an important part of ensuring continuity of care across the VA and ensuring veterans at every VA facility receive the highest quality care. It is also an important part of ensuring the VA's Electronic Health Record (EHR) system works across the entire enterprise.

The VA's efforts to develop National Standards of Practice should be an evidence-based decision-making process that takes into account clinical competency and scientific evidence. This will allow providers to work to their full education and training. AANA is outraged, but not surprised, by the American Medical Association (AMA) and the American Society of Anesthesiologists (ASA) efforts to stop the establishment of practice standards for Certified Registered Nurse Anesthetists (CRNAs) and other providers, as they have a vested and self-serving financial interest in restricting our practice. These organizations strongly oppose efforts to establish autonomous practice standards for CRNAs and have consistently and blatantly misrepresented CRNA education, competency, and safety. We should not be injecting politics into this process. Our veterans and taxpayers deserve better.

[1] Authority of VA Professional to Practice Health Care. 85 FR 71838. (12 November 2020.) https://www.federalregister.gov/documents/2020/11/12/2020-24817/authority-of-va-professionals-to-practice-health-care

The ASA, AMA, and other physician groups have consistently complained about the process for the development of NSPs within the VA. The VA, however, has been deliberate and open throughout the process. In April of this year, the VA attended a roundtable hosted by members of this committee to discuss the development of NSPs. Despite inaccurate claims made against CRNAs and other providers by some attendees at the roundtable (see Appendix A), the VA provided transparency about the NSP project. Throughout August and September, the VA has hosted a number of open listening sessions to gather feedback on the NSPs from all stakeholders as well. To increase transparency, the VA has a website set up specifically on NSPs, including posting of any NSPs that have been developed and allowing for a sixty-day comment period on every set of standards.

While the VA process has been slower than is ideal, it has been thorough, thoughtful and transparent. The mission is important, and we believe all standards should be judged individually, based on how they address safety, veteran access to care, effects on wait times, and cost-effectiveness. As opposed to the VA, the ASA has engaged in the process in a way that abuses important VA safety systems to the detriment of veterans, spams the VA regulatory system with anti-CRNA comments on unrelated regulations, and fearmongers with outrageous and inaccurate statements about the intentions of the VA NSP project. The ASA has abused the VA's 'Stop the Line' system for pointing out safety violations to complain about the NSP process. There has also been a complete misrepresentation of intent of the NSP project, with completely false claims that the VA is seeking to replace all physician anesthesiologists with nurse anesthesiologists. This is a deliberate and malicious falsehood. The AANA does not support eliminating physician anesthesiologists from the VA, but strongly believes it is in the best interest of our veterans to have physician anesthesiologists providing direct care to veterans, instead of wasting time, money, and resources with unnecessary supervision of CRNAs. Our veterans deserve better.

CRNA Safety and Outcomes

In 2016, the VA moved forward with implementing full practice authority for Nurse Practitioners, Nurse-Midwives, and Clinical Nurse Specialists. In their final APRN rule, the VA declined to provide CRNAs with full practice authority because of a perceived lack of anesthesia shortages. In the final rule however, the VA explicitly stated that CRNAs are fully capable of practicing independently[2].

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. A peer reviewed study published in the Journal of Medicare Care in 2016[3] 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. This corroborates an earlier

[2] Advance Practice Registered Nurses. 81 FR 90198. (14 December 2016). https://www.federalregister.gov/documents/2016/12/14/2016-29950/advanced-practice-registered-nurses

[3] Negrusa, Brighita PhD; Hogan, Paul F. MS; Warner, John T. PhD; Schroeder, Caryl H. BA; Pang, Bo MS. Scope of Practice Laws and Anesthesia Complications: No Measurable Impact of Certified Registered Nurse Anesthetist Expanded Scope of Practice on Anesthesia-related Complications. Medical Care 54(10):p 913-920, October 2016. | DOI: 10.1097/MLR.0000000000000554

peer reviewed study published in Health Affairs in 2010[4] that looked at the differences in outcomes in states that had opted out of Medicare's supervision requirement for CRNAs and found they were no different than outcomes in states that maintained supervision. Similar findings were apparent in the maternal healthcare space as well, with a study published in Health Services Research in 2009[5] showing that hospitals that utilized a CRNA only model of anesthesia did not have poorer outcomes for maternal care than hospitals that utilized a supervisory or anesthesiologist only model, and a study published in the Journal of Nursing Research[6] found that outcomes were the same for various models when it came to cesarean deliveries. 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.

Some low-quality studies have purported to claim that CRNAs providing anesthesia without supervision negatively affects outcomes. A 25-year-old study that was not published in a peer-reviewed Journal, but rather in the Journal run by the ASA, has major methodological issues that lead the Centers for Medicare and Medicaid to dismiss the study as too flawed to be used, stating, "One cannot use this analysis (Silber) to make conclusions about CRNA performance with or without physician supervision."[7] This study looked at outcomes for 30-days post operative period, which is well outside the 48-hour period for anesthesia related complications. In point of fact, the AANA can find no reputable and scientifically rigorous study that indicates poorer outcomes from CRNA care, except those that have been funded directly or indirectly by the ASA.

The VA itself agreed that CRNAs are capable of practicing independently within the VA without harming patient access to care. In the 2016 APRN Final Rule issued by the VA, the rule stated, "Several other commenters stated "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"[8] Only the ASA and the AMA continue to push a false narrative that CRNA care is unsafe in an effort to protect their turf and their wallets.

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[4] Dulisse, Brian; Cromwell, Jerry. No Harm Found When Nurse Anesthetists Work Without Supervision by Physicians. (August 2010). Health Affairs. Vol. 29. No. 8.

[5] Needleman J, Minnick AF. Anesthesia provider model, hospital resources, and maternal outcomes. Health Serv Res. 2009 Apr;44(2 Pt 1):464-82. doi: 10.1111/j.1475-6773.2008.00919.x. Epub 2008 Nov 4. PMID: 19178582; PMCID: PMC2677049.

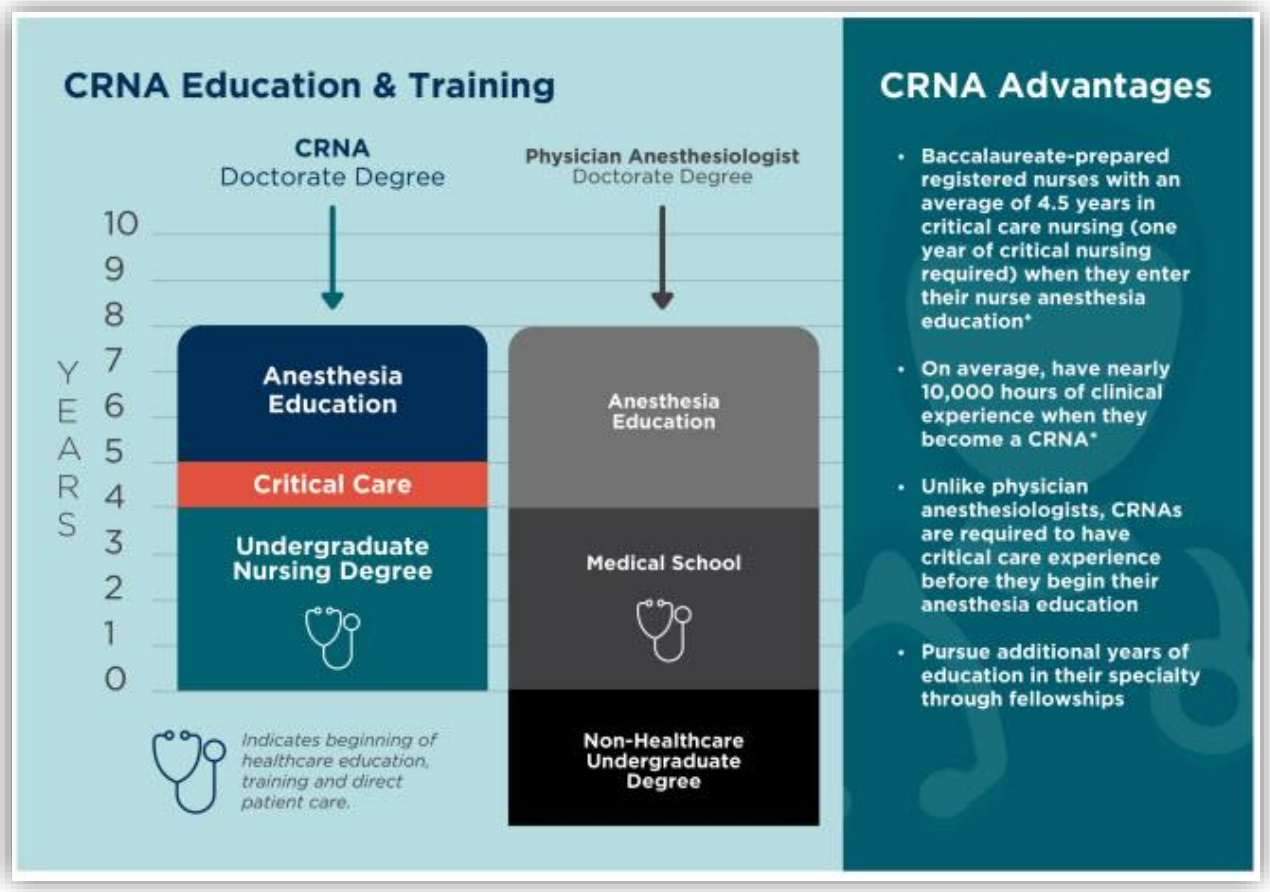
[6] Simonson, Daniel C.; Ahern, Melissa M.; Hendryx, Michael S.. Anesthesia Staffing and Anesthetic Complications During Cesarean Delivery: A Retrospective Analysis. Nursing Research 56(1):p 9-17, January 2007.

[7] Medicare and Medicaid Programs; Hospital Conditions of Participation: Anesthesia Services. 66 FR 4674. (18 January 2001).

[8] Ibid.

The AMA has recently been touting another flawed study out of the Hattiesburg VA and claiming this study applies to CRNAs and other advance practice providers. This is deeply and intentionally dishonest as the Hattiesburg study only looks at primary care provided by nurse practitioners, not CRNAs, and is not a quality study. CRNAs and nurse practitioners have different education standards and provide different types of care. Currently, all CRNAs graduating from a nurse anesthesia program are doctorally prepared, which is not a requirement for other APRNs. In addition, CRNAs are prepared at the bachelor's level as an RN and are required to practice for a minimum of one year as an intensive care nurse before they can attend a nurse anesthesia program. The highly questionable Hattiesburg study has no relevance to CRNA practice.

For the last three years, Medicare had waived the supervision requirement for CRNAs, and the VA put forth a memo calling for VA facilities to utilize CRNAs to the top of their scope. During the public health emergency (PHE) when these restrictions were lifted, there was no evidence that outcomes deteriorated. In fact, during the same period, seven new states (Arizona, Oklahoma, Utah, Michigan, Arkansas, Wyoming, and Delaware) signed some form of opt-out from Medicare's supervision requirements for CRNAs, further demonstrating how unnecessary such restrictions are.

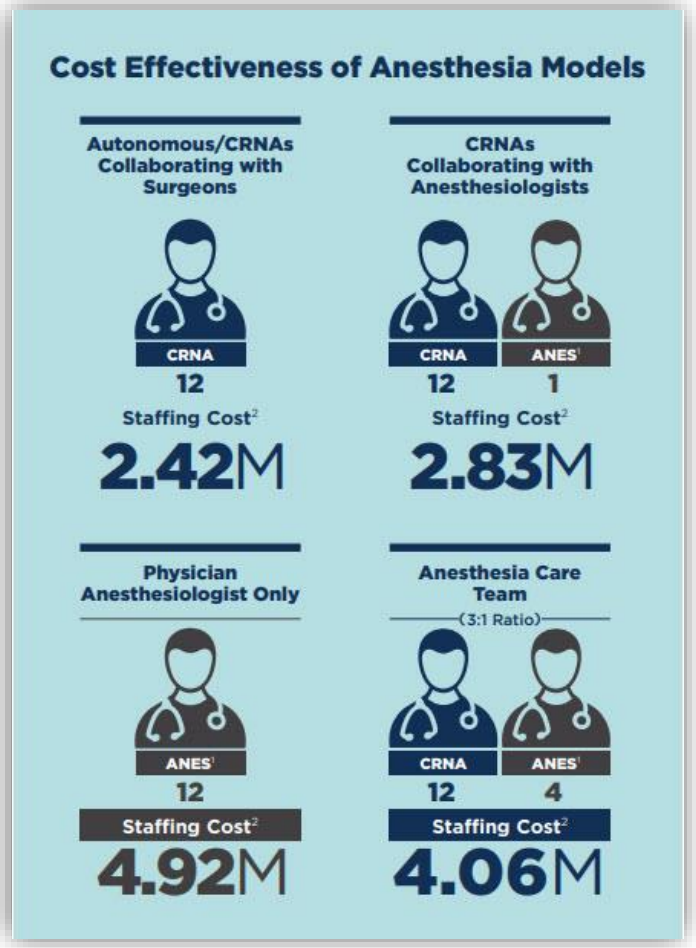


CRNA Education and Training Information

CRNA Supervision: At What Cost?

Currently, only seven states have rules in their Nurse Practice Acts or the State Boards of Nursing that require physician supervision of CRNA services. Twenty-four states have already opted out of Medicare's supervision requirement for CRNAs as well. Only one state requires the supervision by a physician anesthesiologist when a CRNA is providing care, and only at ambulatory surgical centers. Supervision has no proven benefits to patients but has proven costs and detriments.

Comparing various methods of anesthesia delivery, an autonomous CRNA collaborating with a surgeon is the most cost-effective model for anesthesia delivery. Recent 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.



Cost Effectiveness of Various Anesthesia Delivery Models

Supervision requirements, in addition to providing no value to patients and increasing costs, can have a deleterious effect on access to care. A 2015 study that looked at anesthesia providers and practice settings, found that CRNA provided anesthesia correlated with lower-income populations, as well as more vulnerable populations, including Medicaid-eligible patients, uninsured, and underserved populations[9]. CRNAs predominate in rural areas and are a critical linchpin to rural and critical access facilities. CRNAs represent more than 80% of anesthesia providers in rural counties. Additionally, half of rural hospitals utilize a CRNA only model of anesthesia care for obstetric care. Supervision requirements add untenable cost and regulatory burdens on these facilities and their patients, without any return on investment in the way of improved outcomes.

Independent Recommendations

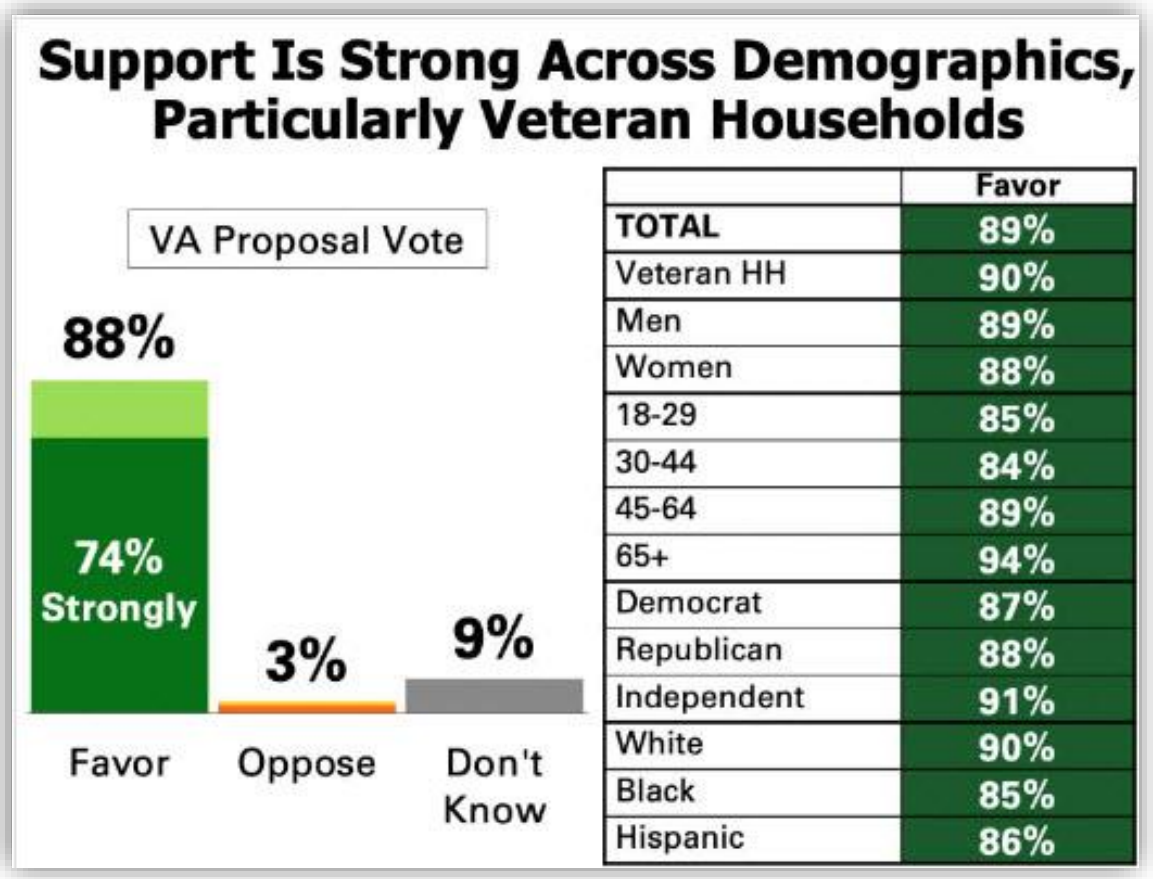
The development of national standards of practice within the VA is meant to provide critical consistency across the VA and improve veteran's experience. Unfortunately, the AMA, ASA, and others in organized medicine have used the development of NSPs as a rallying cry to limit the ability of other providers to practice to the full extent of their education and training and turned the process into an unnecessary and highly political turf battle, that does not serve the interest of our nation's veterans, who deserve better.

Looking outside of the provider sphere, there are numerous independent groups who have weighed in supporting the removal of restrictions on CRNAs and other APRNs. Perhaps most critically, veterans themselves overwhelming support the VA allowing direct access to CRNA services. A 2022 survey found that an overwhelming 88% majority support this change, and nearly three-quarters (74%) strongly support it. This wide support extends across party, age, gender, race and all other key demographics, but is especially strong among veterans and their families. Among veteran households, 90% are in favor[10].

Across the ideological spectrum, groups have weighed in with support for removing barriers to care for APRNs, to increase access to care and to reduce costs. Among the groups that have supported the removal of restrictions are the Bipartisan Policy Center, Americans for Prosperity, The Brookings Institute, the National Rural Health Association, AARP, and LeadingAge. Full practice authority for CRNAs is also supported by the VA's own Independent Assessment as well as the Bipartisan Commission on Care. Multiple veterans service organizations have also weighed in, supporting the development of NSPs and allowing providers to work to the top of their education and training.

[9] Liao, C.J., Quraishi, J.A., & Jordan, L.M. (2015). Geographical Imbalance of Anesthesia Providers and its Impact On the Uninsured and Vulnerable Populations. *Nursing economic$, 33 5*, 263-70 .

[10] Veterans Need Care Now. (23 May, 2022). National Omnibus Poll of Registered Voters: Voters Overwhelmingly Support Giving Veterans Access to CRNA Care
The Mellman Group. https://www.veteransneedcarenow.org/voters-overwhelmingly-support-giving-veterans-direct-access-to-crna-care/



Veterans Need Care Now survey shows strong support for CRNA autonomous practice in the VA

Conclusion

The effort by the VA to develop NSPs is an important process for ensuring veterans have timely access to the highest quality care. All clinical and scientific evidence, as well as overwhelming support from independent groups and veterans, militates for CRNAs to be allowed to perform to the top of their education and training without superfluous and costly supervision. The NSP project has been a transparent and open process focused on providing the best care for our veterans. We appreciate that the VA has actively solicited input from all stakeholders on this project. There can be no room for self-serving fear mongering or turf wars, our veterans deserve better. We look forward to continuing to work with Congress and the VA on this important project.

APPENDIX A

AANA Letter to the Committee

Re: National Standards of Practice Roundtable

11 May 2023

September 15, 2023

The Honorable Mariannette Miller-Meeks
Chair
House Veterans Affairs Health Subcommittee
1034 Longworth House Office Building
Washington, DC 20515

The Honorable Julia Brownley
Ranking Member
House Veterans Affairs Health Subcommittee
2262 Rayburn House Office Building
Washington, DC 20515

Dear Chairwoman Miller-Meeks and Ranking Member Brownley:

On behalf of the American Association of Nurse Anesthesiology (AANA), I sincerely appreciated the invitation to participate in the recent roundtable to discuss the Department of Veterans Affairs (VA) initiative to write National Standards of Practice for a range of providers working within VHA. I also appreciated the opportunity to discuss this important effort by the VA to ensure veterans have access to the care they need and deserve. However, I will take this opportunity to correct the record on some of the erroneous statements and implications made during the roundtable.

The VA's efforts to develop National Standards of Practice should be an evidence-based decision-making process that takes into account clinical competency and scientific evidence. This will allow providers to work to their full education and training. AANA was disappointed by the Committee's decision to invite the American Medical Association (AMA) and the American Society of Anesthesiologists (ASA) to discuss the establishment of practice standards for Certified Registered Nurse Anesthetists (CRNAs), as they do not represent us and have a vested economic interest in restricting our practice. These organizations strongly oppose efforts to establish autonomous practice standards for CRNAs and have consistently and blatantly misrepresented CRNA education, competency, and safety. We should not be injecting politics into this process. Our veterans and taxpayers deserve better.

It was also disappointing that this important roundtable was not focused on the VA's process to develop national standards, but instead served as an opportunity to push a political agenda and talking points from the AMA. Particularly egregious were the inaccurate statements made about the National Bureau of Economic Research and Hattiesburg studies attacking advanced practice registered nurses (APRNs). Not only is the data of these studies highly flawed, but these studies did not even look at CRNAs, as was implied during the roundtable. Neither of the studies looked at a single CRNA in their research, and to claim their findings apply to CRNAs is an outright falsehood. There is a wealth of research on CRNA practice, and studies published in both the

Journal of Medical Affairs[11] and in *Health Affairs*[12] that have abundant scientific data empirically validating that CRNAs practicing autonomously are safe.

As a CRNA I have served in the largest Afghanistan medical facility as the Anesthesia Team Lead, and as the sole anesthesia provider at a Special Forces Forward Operating Base, and I have led both physician and nurse anesthesiologists in the field. I know first-hand the quality services provided by CRNAs that are successfully and safely accomplished without supervision. I have practiced autonomously in the most difficult circumstances possible while serving in the military. Veterans undoubtedly have unique health concerns. However, to assert that CRNAs are safe to provide anesthesia without supervision to active-duty members wounded in combat, with some of the most severe and difficult injuries imaginable but claim we are not safe to practice autonomously within the VA simply because veterans are older, is a specious and insulting argument.

As a practicing CRNA, I am frustrated my profession is required to repeatedly prove its worth for political reasons, including anesthesiologists' fabricated and feigned fear of being shut out of the VA. This false flag of victimhood is one of their own making, designed to create the impression that CRNAs are attempting to supplant anesthesiologists in the VA. Nothing could be further from the truth. Quite the opposite, CRNAs encourage anesthesiologists to actually practice anesthesia and patient care, rather than unproductively claim to supervise those who do not need their supervision. Simply put, there is a complete lack of scientific and clinical evidence to support antiquated, costly and duplicative supervision requirements.

Allowing CRNAs and other APRNs to work to the full extent of their education and training is supported by numerous independent groups across the political spectrum, from the American Enterprise Institute[13], to the Bipartisan Policy Center[14], to the Brookings Institute[15] as well as Veterans Service Organizations (VSOs). It is also supported by both the Bipartisan Commission on Care report[16] and the VA's own Independent Assessment. Even when the VA made the political decision to remove CRNAs from the APRN full practice rule, VA acknowledged the ability to CRNAs to safely work autonomously and acknowledged the significant scientific and clinical evidence that supports CRNA autonomous practice. The VA even went so far as to accuse the ASA of "stuffing the ballot box" with meaningless comments in opposition. There is broad agreement across the board, from the VA, to VSOs, to independent think tanks, to scientific assessments that support CRNA autonomous practice. It is the ASA and AMA who continue to deny and obstruct what so many have supported.

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[11] Negrusa, Brighita PhD; Hogan, Paul F. MS; Warner, John T. PhD; Schroeder, Caryl H. BA; Pang, Bo MS. Scope of Practice Laws and Anesthesia Complications: No Measurable Impact of Certified Registered Nurse Anesthetist Expanded Scope of Practice on Anesthesia-related Complications. Medical Care 54(10): p 913-920, October 2016. | DOI: 10.1097/MLR.0000000000000554

[12] Dulisse, Brian; Cromwell, Jerry. No Harm Found When Nurse Anesthetists Work Without Supervision by Physicians. Health Affairs Vol 29 No 8.

[13] https://campaignforaction.org/wp-content/uploads/2016/11/Freemarketcasefullpractice.pdf

[14] https://bipartisanpolicy.org/report/confronting-rural-americas-health-care-crisis/

[15] https://www.brookings.edu/wp-content/uploads/2018/06/am_web_0620.pdf

[16] Commission on Care. June 30, 2016. Final Report. https://s3.amazonaws.com/sitesusa/wp-content/uploads/sites/912/2016/07/Commission-on-Care_Final-Report_063016_FOR-WEB.pdf

It was also unfortunate to hear during the roundtable, a comparison of CRNAs working autonomously, which we are educated and trained to do, to a provider working outside of their scope. When CRNAs provide high quality anesthesia and pain management care autonomously, we are not working outside of our scope. We are doing exactly what CRNAs have been trained to do. Implying that CRNAs are working out of our scope when providing anesthesia care without unnecessary physician supervision, as we do to some of the most difficult patients possible, in the most extreme circumstances, is outrageous. The claim made during the roundtable that veteran care is inherently more difficult than caring for wounded warriors on the battlefield, many of whom may have lost limbs and suffered severe burns across their bodies, and therefore requires an anesthesiologist, when they are absent in the field is ridiculous and contemptible. I and many other CRNAs have treated these soldiers without supervision, and we should be allowed to provide that same care to our fellow veterans. While older veterans may have additional issues, there is no more difficult patient or circumstance than caring for a wounded soldier in the field. To suggest that CRNAs do not have the skills and education to safely treat veterans within the VA system flies in the face of all evidence and the realities on the ground.

It is AANA's hope that in the future, the dialogue around VA's National Standards of Practice, and the education and skills that CRNAs provide will be based on facts and science, rather than self-serving hyperbole. Our veterans deserve better than scare tactic and misinformation spouted for political reasons to serve the interests of turf protection, not patients. We stand by the VA's movement to create standards that best serve our veterans and are based on science and clinical evidence.

Thank you again for your invitation. We look forward to continuing our dialogue on this issue and working with Congress and the administration on finding ways to best serve our veterans. If you have any questions, please do not hesitate to reach out to Matthew Thackston, Director of Federal Government Affairs at the AANA at mthackston@aana.com or (202) 741-9081. I appreciate your time and attention to this important issue.

Sincerely,

Janet Setnor, MSN, CRNA, Col (ret.) USAFR NC
Vice President
American Association of Nurse Anesthesiology

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