American Association of
NURSE ANESTHESIOLOGY

Written Statement for the Record by:

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House Veterans Affairs Committee
Subcommittee on Oversight and Investigations

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Washington, DC 20515

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Background on AANA and CRNAs

Chairwoman Kiggans, Ranking Member Mrvan, 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 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 Subcommittee'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 persistent staffing issues with respect to the VA's anesthesia models and inefficiencies. Although the focus of this hearing is on the VA Medical Center in Hampton, this is not the only VA Medical Center for which inefficient anesthesia models have been, or continue to be, an issue. It is unthinkable that our nation would allow for our veterans to go without care when the resources exist to provide the services they need.

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 having ample CRNAs available to provide care. As Chairwoman Kiggans mentioned, moving veterans out of the Hampton VAMC disrupts their care, increases the safety concerns, and makes coordination more difficult, all putting the financial interests of physician anesthesiologists ahead of our veterans' wellbeing. 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 healthcare outcomes under CRNAs and physician anesthesiologists are identical. CRNAs are capable of providing care to all patients, even those with complex medical conditions.

To better provide the care we have promised our veterans, the VA must remove costly, unnecessary barriers to care. The VA could see considerable cost savings and improved wait times, all without sacrificing healthcare quality, if they allow CRNAs full practice authority at all VA facilities. Without this development, the VA will continue to face fiscal shortfalls in coming years and our veterans will be forced out into community care, where the complexity of their medical needs may not be readily understood or easily addressed.

CRNAs possess all the necessary skills and training to be granted full practice authority at the VA. Should CRNAs be allowed to practice anesthesia autonomously at the VA, the Department

will enjoy considerable cost savings, and our veterans would be afforded increased access to the healthcare our nation has promised them, all without compromising the quality of care delivered. For these reasons, 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.

Hampton: What Went Wrong

Concerns regarding the quality of care at the Hampton VA Medical Center (VAMC) have gone years without being fully remedied. The culmination of the rampant mismanagement of the facility led to several reports by the Office of the Inspector General (OIG) at the VA in 2022, 2023, and 2024, eventually prompting the replacement of the Chief of the surgical service. Complaints about the Hampton VAMC have been made known to Members of Congress and the public through various channels, including hearings in this Subcommittee as well as through public reporting. While the facility and the VA leadership have had ample opportunity to rectify these wrongs and do right by the veterans whose care they are responsible for, serious problems remain unresolved.

One of the most persistent problems at the Hampton VAMC—and arguably the most easily remedied—is their continued inefficient utilization of anesthesia providers. Currently, the facility employs just one physician anesthesiologist and has been canceling or delaying care when that physician is not available. This means the VA pays multiple CRNAs at the Hampton VAMC, who are not allowed to provide care, despite being fully capable of doing so. Not only is this a waste of taxpayer dollars, but it is also an affront to our veterans. This is an untenable situation for our veterans, 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.

While the State of Virginia does not currently extend full practice authority to CRNAs, they also do not require physician anesthesiologist supervision of CRNAs. This is a critical difference in policy that seems to have been overlooked by the leadership at the Hampton VAMC. Virginia law provides for the option to have CRNAs supervised by any physician, including dentists and podiatrists, not just physician anesthesiologists. Further, Virginia state law does not have any standards for what qualifies as supervision, making the requirement even less stringent than what the VA utilizes. If the Hampton VAMC so chose, there would be no reason to cancel or postpone operations when their only physician anesthesiologist is absent or otherwise indisposed. While AANA maintains that any supervision of CRNAs is unnecessary, costly, and inefficient, we implore the Hampton VAMC to rethink their current practice of requiring supervision by a physician anesthesiologist. In fact, just last year, the American Society of Anesthesiologists noted in response to a question from Congresswoman Brownley in a hearing similar to this before the HVAC Health Subcommittee, that they do not advocate for anesthesiologist-led care but rather for physician-led care.[1] Even within guidelines that are contradictory to science, evidence, and the best interests of our veterans, the Hampton VAMC has the ability to remedy

[1] "VA's Federal Supremacy Initiative: Putting Veterans First?" Hearing before the Subcommittee on Health of the Committee on Veterans' Affairs U.S. House of Representatives. (2022). https://docs.house.gov/meetings/VR/VR03/20230919/116306/HHRG-118-VR03-Transcript-20230919.pdf

some of these shortages right now. There is simply no reason for veterans who depend on this facility to continue to struggle to access care. The Hampton VAMC, due to this misguided policy, has had to divert patients to other facilities and borrow 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 admitted, they are forced to contract with outside anesthesia providers, increasing costs unnecessarily for care at a time with 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.

Further, arguments regarding state-level requirements are specious as the VA has the authority to override state laws in the provision of care to veterans. While the state of Virginia does not extend full practice authority to CRNAs currently, the same can be said regarding all other APRNs in the State. Despite this, within the VA, Nurse Practitioners, Nurse-Midwives, and Clinical Nurse Specialists are all able to practice independently. This particular barrier was lifted for our APRN peers in December of 2016, when the VA issued their final rule on APRN practice in the VA.[2] While three APRN designations were granted full practice authority at VA facilities, CRNAs were left out following waves of political pressure and fearmongering devoid of scientific or evidence-based conclusions. The VA, however, did profess that they would revisit the exclusion of CRNAs from this rule if shortages in anesthesia staff were shown. This is one example in a series of reports showing just that. In fact, this is not unlike a similar shortage that caused significant delays in care seven years ago across the country in Denver, Colorado.[3] The situation currently playing out at the Hampton VAMC is symbolic of similar issues that have been occurring at different VA facilities across the nation since the exclusion of CRNAs in 2016. This is a systematic failure and a pattern of broken promises that have perpetuated harmful healthcare outcomes for our veterans, increased costs, and contributed to the inefficiencies and budgeting shortfalls at the VA that have been the topic of so many recent hearings in front of this Committee.

AANA believes it to be irresponsible for the VA to allow this to continue. It is time for the VA to follow the evidence and revisit including CRNAs in their final rule for APRN full practice authority. Every day that these artificial barriers to healthcare remain, veterans will suffer the consequences. As the Hampton VAMC medical director noted, there has been a significant increase in veterans seeking care within the VHA following the passage of the PACT Act. It is unconscionable that the VA would unnecessarily limit their access to that care. While our colleagues at the ASA have falsely claimed that CRNAs need physician supervision to ensure veteran safety, the situation at both Hampton and Denver VAMC shows that they are willing to sacrifice veterans care and safety, to protect their own turf. Instead of being focused on providing

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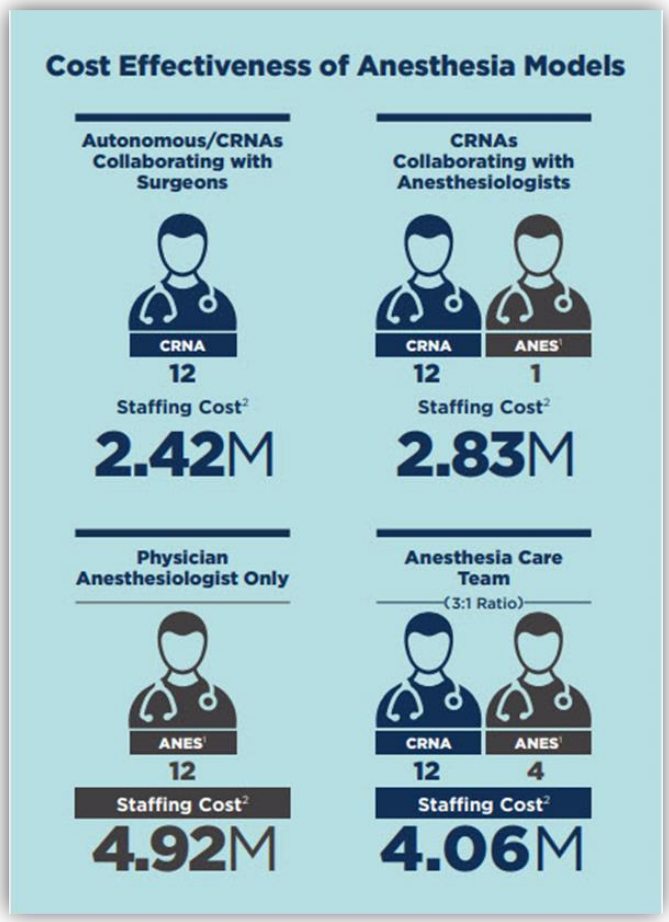
[2] "Advanced Practice Registered Nurses" (A rule by the Veterans Affairs Department, 2016). https://www.federalregister.gov/documents/2016/12/14/2016-29950/advanced-practice-registered-nurses

[3] "Dozens of Surgeries at Denver VA Hospital Put Off Because of Doctor Shortage" (Migoya, 2017). https://www.denverpost.com/2017/10/12/dozens-surgeries-denver-va-hospital-put-off-because-doctor-shortage/

care to veterans, they are working to unfairly rig the VA system against veterans to ensure that they get paid for supervision without having to provide direct patient care, at a time when healthcare provider shortages are ravaging our healthcare system. For the sake of those who have served, those who care for them, and the American taxpayers that fund this healthcare, the VA must grant full practice authority to CRNAs.

CRNA Supervision: At What Cost?

In late September 2022, Temple University published a study that had been commissioned by the Office of Nursing Services at the VA. The study, "Certified Registered Nurse Anesthetist Scope of Practice Laws," found that policy decisions on CRNA standards should be guided by currently available data.[4] After analyzing the available data, the study arrives at the conclusion that "removing restrictions and allowing more CRNAs to practice autonomously is documented to have no negative impact on patient outcomes, may potentially provide a cost-effective solution to physician shortages, and may increase access to care."



Outside of the VA, only seven states have requirements in their Nurse Practice Acts or the State Boards of Nursing rules that require physician supervision of CRNA services. Twenty-five states have already opted out of Medicare's supervision requirement for CRNAs as well. Only one state requires the involvement of a physician anesthesiologist when a CRNA is providing care. Every branch of the military allows for CRNAs to practice autonomously. 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. 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

[4] "Certified Registered Nurse Anesthetist Scope of Practice Laws" (DeAnna Baumle, JD, MSW, 2022). https://www.va.gov/STANDARDSOFPRACTICE/docs/CRNA_PolicyBrief_Temple.pdf

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 is known for significant waste in their anesthesia delivery models, including the utilization of the highest cost 1:1 supervision model, and employing millions of dollars in outside anesthesia contracts. Veterans and taxpayers deserve better than VA's inefficient anesthesia delivery models.

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 the 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.**

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 the above-mentioned 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."[5] 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.[6] 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.[7] 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.

The VA agreed that CRNAs can practice independently within the VA without harming patient access to care. In the 2016 APRN Final Rule issued by the VA, the rule 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] Additionally, the VA agreed in their materials published with this rule that "anesthesia care by CRNAs was equally safe with or

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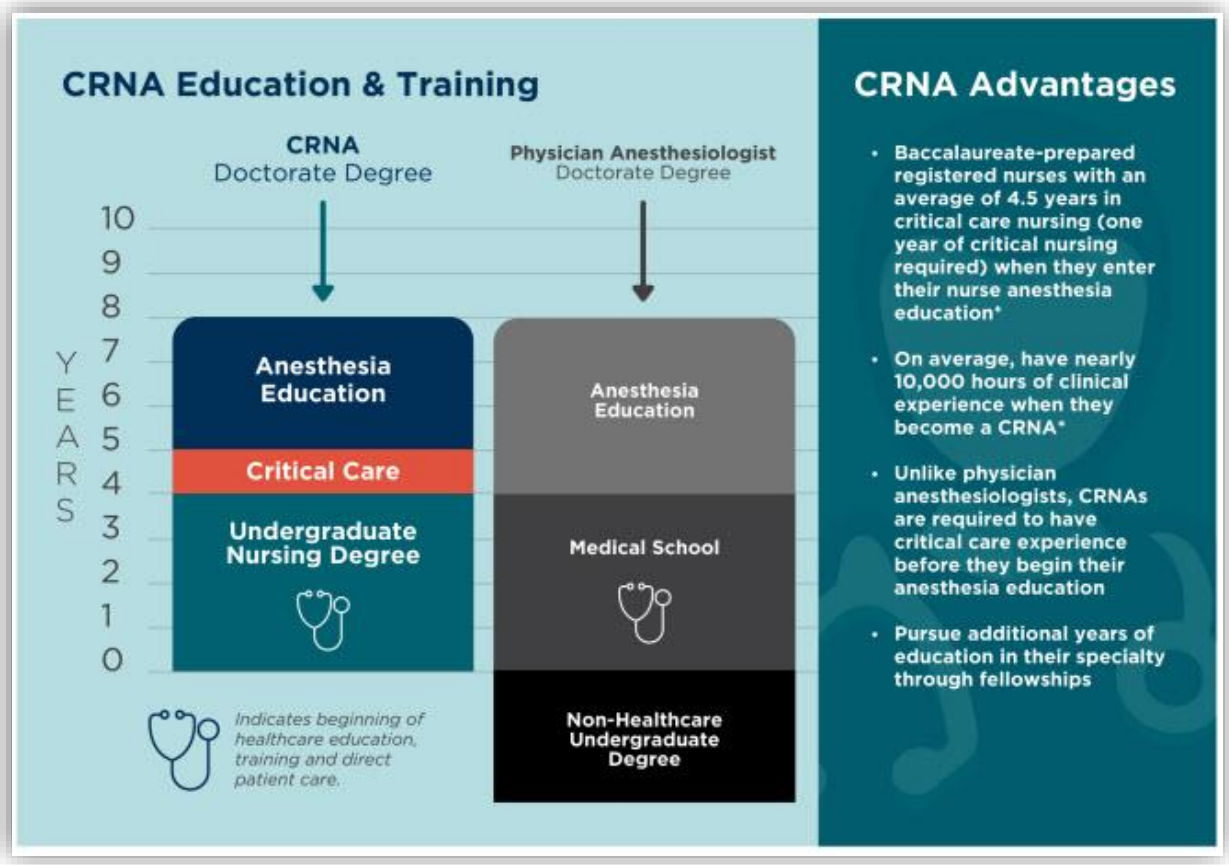
[5] Baumle, op. cit.
[6] "Scope of Practice Laws and Anesthesia Complications" (Negrusa, Hogan, Warner, Schroeder, and Pang, 2016). https://journals.lww.com/lww-medicalcare/abstract/2016/10000/scope_of_practice_laws_and_anesthesia.4.aspx
[7] "No Harm Found When Nurse Anesthetists Work Without Supervision By Physicians" (Dulisse and Cromwell, 2010). https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2008.0966?journalCode=hlthaff
[8] "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

without physician supervision."[9] Only the ASA and the American Medical Association (AMA) continue to push a false narrative that CRNA care is unsafe to protect their turf.



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. These standards are an important part of ensuring continuity of care across the VA and ensuring that 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 National Standards of Practice offer the VA an opportunity to address CRNA full practice authority, which could allow the VA to save money and increase access to care without sacrificing quality.

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 American Medical Association and the American Society of Anesthesiologists efforts to stop the establishment of practice standards for CRNAs and other providers, as they have a vested economic interest in restricting our practice. It is our understanding the AMA has explicitly threatened to undermine national standards for all 51 providers if that VA implements

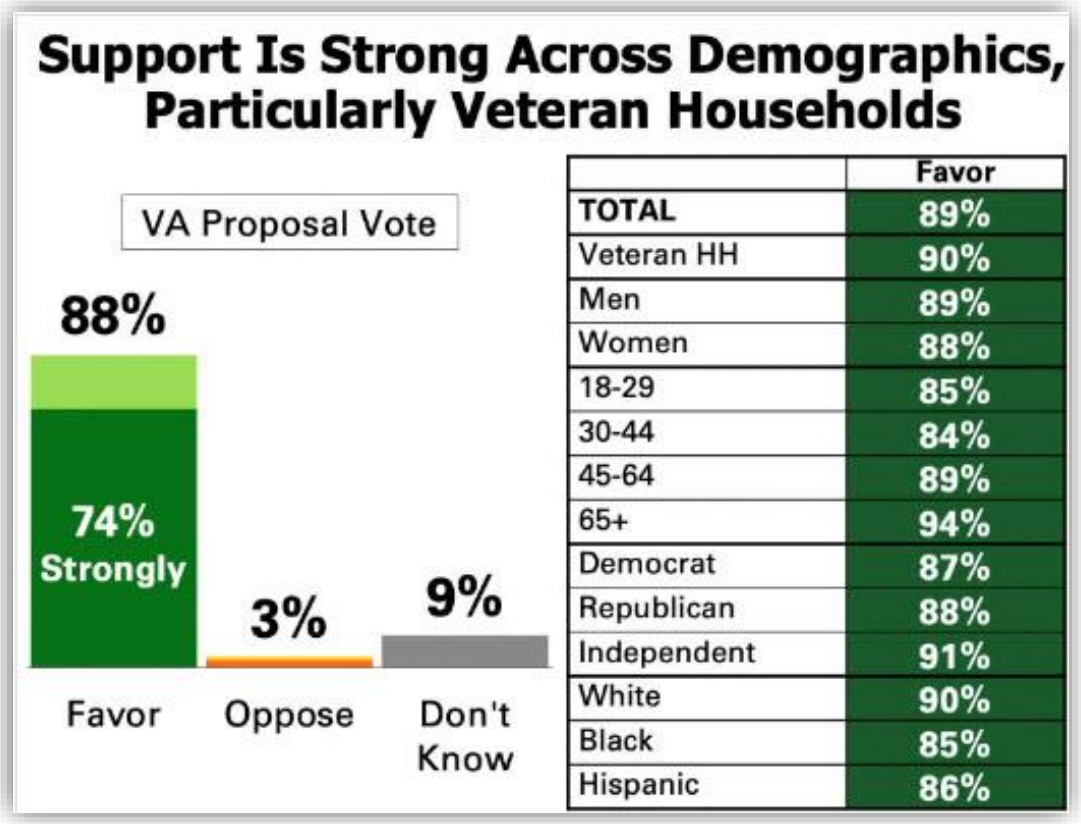
[9] Department of Veterans Affairs, op. cit.

full practice authority for CRNAs. This is typical of the hostage taking that we see from both the AMA and ASA in order to protect their pay checks and turf. They are willing to put our veterans second if it means they can put themselves first. 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.

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.

Outside of the sphere of healthcare providers, there are numerous independent groups who have weighed in supporting the removal of restrictions on CRNAs and other APRNs. Most critically, veterans themselves overwhelmingly 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.



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

Conclusion

The VA has the ability to remedy delays resulting from anesthesia staffing shortages today, either by extending full practice authority to CRNAs as they promised to consider if such shortages were proven to exist, or by working within current guidelines which allow for non-anesthesiologist supervision. By continuing down the path, we are on today, we will continue to fail those who have risked their lives to ensure that we can live ours freely. As a veteran myself, I urge the VA to do right by us and allow us to receive the healthcare that we deserve and were promised.