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

ONE HUNDRED EIGHTEENTH CONGRESS

FIRST SESSION

TUESDAY, SEPTEMBER 19, 2023

Serial No. 118–30

Printed for the use of the Committee on Veterans' Affairs

Available via http://govinfo.gov

U.S. GOVERNMENT PUBLISHING OFFICE

53–767 WASHINGTON : 2024

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VA'S FEDERAL SUPREMACY INITIATIVE: PUTTING VETERANS FIRST?

TUESDAY, SEPTEMBER 19, 2023

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:16 a.m., in room 360, Cannon House Office Building, Hon. Mariannette Miller-Meeks [chairwoman of the subcommittee] presiding.

Present: Representatives Miller-Meeks, Radewagen, Bergman, Murphy, Van Orden, Luttrell, Kiggans, Brownley, Levin, Deluzio, Budzinski, and Landsman.

Also present: Representative Davis.

OPENING STATEMENT OF MARIANNETTE MILLER-MEEKS, CHAIRWOMAN

Ms. MILLER-MEEKS. Good morning. I now call the hearing of the Subcommittee on Health Oversight to order.

I would like to start out by asking that Representative Scott be allowed to join our Subcommittee and be allowed to sit at the dais in order to participate in today's hearing proceedings.

Hearing no objection, so ordered.

You may sit.

I never had an opportunity to do that, so.

As a 24-year Army veteran physician and a former nurse, I strongly believe that veterans deserve the utmost quality in care. I actually met my husband Kurt, who was an Licensed Practical Nurse (LPN) at the time, while we were both serving at Walter Reed.

Having served in these positions both as a student nurse married to an LPN who became a Bachelor of Science Nursing (BSN) nurse and a nurse and a doctor, and then the former director of the Iowa Department of Public Health which had a lot to do with licensure and scope of practice, I believe I have a deep understanding of providing safe and effective care and it remains one of my top priorities in Congress and to ensure that veterans receive the same quality of care as those seeking care in private hospitals.

The VA issued an interim final rule known as the Federal Supremacy initiative in 2020. Through this initiative, VA is working on establishing national standards for over 50 healthcare occupations regardless of state scope of practice laws. VA has stated standardizing a set of practices that healthcare providers can perform within the Federal VA system would help when needing to

transfer care workers between different VA medical centers depending on where care is needed most.

Well, I do not argue that this might provide some greater uniformity within the VA, VA clinicians of all types were able to move quickly throughout the VA system during the pandemic when critical needs arose in certain localities.

Although this interim rule was published approximately 2 years ago, VA has not yet considered or opened up a comment period for majority of healthcare occupations. It remains a concern to me and many other members on this Committee that the VA has not been clear and as engaged about some clinical specialties, specifically specialties that require a significant investment in training and practice to ensure patient safety and board certification.

It is imperative that the VA is transparent about this process and standards to avoid confusion among providers and patients, especially when there are wide variations in state licensure laws.

During today's hearing, I look forward to examining the process and development of these standards. Additionally, I am eager to better understand how these standards will affect patient care in the future.

I want to be clear. I am not here to play one profession against the other. I have the utmost respect for every clinician who devotes their life to the care of patients and especially of veterans.

With that I yield to the Ranking Member Brownley for her opening statement.

OPENING STATEMENT OF JULIA BROWNLEY, RANKING MEMBER

Ms. BROWNLEY. Thank you, Chairwoman Miller-Meeks. Thank you for holding today's hearing to examine VA's ongoing National Standards of Practice (NSP) initiative.

As the chairwoman just said, let me also say, because I want to be clear as well at the outset of this hearing, that I hold the utmost respect for all of the dedicated healthcare professionals who work at VA medical facilities nationwide including all the physicians, nurse practitioners, physician assistants (PA), Certified Registered Nurse Anesthetists (CRNAs), optometrists, and other healthcare providers. They show unwavering commitment day in and day out to caring for veterans, and their contributions to VA healthcare systems are invaluable.

However, as we embark on this examination of VA's National Standards of Practice initiative, it is imperative that we consider the unique needs of veterans, many of whom have extreme and complex needs and unique medical conditions resulting from their service. Ensuring that veterans receive the highest level of care demands a thorough evaluation of the roles, responsibilities, and training of all healthcare providers within the VA system.

I firmly believe that physicians with their extensive medical training and clinical experience play a pivotal role in providing comprehensive care for veterans, particularly when it comes to complex medical conditions, surgical procedures, and advanced treatments.

My own son is a physician, so I have observed firsthand the tens of thousands of hours of intense study and training it takes to be-

come a physician. Veterans like all Americans deserve access to the full spectrum of medical expertise available to address their healthcare needs.

Throughout this hearing I look forward to engaging in a constructive and fact-based dialog to better understand the implications of VA's National Standards of Practice initiative on the quality of care provided to veterans. Together we must ensure that veterans receive the highest standard of care and that their healthcare needs are met by providers with the appropriate qualifications and expertise. I look forward to continuing the discussion we began at a closed-door roundtable this past April where we heard from each of the organizations represented on our first panel of witnesses today. At that time, stakeholders representing physician groups expressed frustration about what they viewed as a lack of transparency and engagement by VA. They said they had sent letters that had gone unanswered and that they had not had meaningful opportunities to engage with Veterans Health Administration (VHA) officials involved in the National Standards of Practice initiative. I have heard that the VA has made a greater effort to engage these groups in the ensuing months and that is something I hope to hear more about today.

One thing I brought up at the roundtable which I still do not feel has been thoroughly addressed by VA is why, given all of the other priorities competing for the attention of senior leadership, the department has chosen to undertake this initiative. We are already approaching 3 years since the start of the National Standards of Practice initiative without VA having finalized standards for any of the 51 occupations yet. If there was truly an urgent need to undertake this process one would think more progress would have been made by now. I hope today's hearing will shed more light on VA's justification for undertaking this long, drawn out process to develop a National Standards of Practice.

I thank all of our witnesses and colleagues for their participation and candor in this crucial discussion.

With that, Madam Chair, I yield back.

Ms. MILLER-MEEKS. Thank you, Ranking Member Brownley.

I would now like to introduce the witnesses.

On our first panel we have Dr. Jesse Ehrenfeld, president of the American Medical Association (AMA); Dr. Paul Barney with the American Optometric Association; Ms. Janet Setnor, president elect of the American Association of Nurse Anesthesiology (AANA); Dr. Stephen McLeod, chief executive officer of the American Academy of Ophthalmology; and Dr. Ron Harter, president elect of the American Society of Anesthesiologists (ASA).

Dr. Ehrenfeld, you are now recognized for 5 minutes to deliver your opening statement.

STATEMENT OF JESSE EHRENFELD

Dr. EHRENFELD. Good morning, Chairwoman Meeks, Ranking Member Brownley, members of the Subcommittee. Thank you for having me here today.

My name is Dr. Jesse Ehrenfeld. I am a practicing physician and president of the American Medical Association. I am a former Navy commander. I have a background in military medicine. I am on the

faculty of the Uniformed Services University deployed to Kandahar, Afghanistan during OBF.

I can choose to get my own healthcare pretty much anywhere. For the past 7 years I have chosen to get all of my medical care at the VA because I believe in the VA, its people, and what it can offer.

The implementation of these National Standards of Practice is a very personal issue. This project concerns me because I believe that our Nation's veterans, my shipmates, will receive lower quality of care of this project is implemented. In medicine, our goal is to match the expertise of the person delivering the care to the needs of the patient receiving the care. It is why their busiest down reach facilities which handle the most complex injuries in battle the Department of Defense (DOD) sends physicians to lead care teams. It is why today when a patient having cardiothoracic surgery at the VA, they receive their care from physicians who lead the care team.

However, the Supremacy Project will make it next to impossible for the VA to match the most qualified clinician with the needs of the veterans, potentially allowing nonphysicians to perform procedures that are beyond their scope of knowledge and state licensure.

This is concerning because expanding the scope of practice for nonphysician practitioners increases costs and jeopardizes patient safety.

The VA Evidence Based Synthesis Program found that there was no evidence to support the safe implementation of nurse-only models of anesthesia care. A study in the National Bureau of Economic Research compared the productivity of independently practicing nurse practitioners and physicians in a VA emergency department. The study found that nurse practitioners use more resources and result in worse health outcomes than physicians.

For this reason, physician-led teams are the gold standard in medicine, which is further illustrated by the fact that 45 states do not allow nurse anesthetists to practice independent, and 42 states do not allow optometrists to perform eye laser surgery.

If this project moves forward, models of care that are rarely used in the private sector will be formalized across the VA. This will make the VA an outlier in the medical community, erode public trust in the system, and lead to worse health outcomes for our veterans. The nonphysicians, such as nurse anesthetists, pharmacists, optometrists, physician assistants are integral members of the care team. The skills acumen obtained by physicians throughout their extensive education and training makes them uniquely qualified to oversee and supervise veterans care.

To ensure our veterans receive the care that they have earned, physicians need to remain as leaders of the care team. If there are universal standards for each profession then the most vigorous state scope requirements should be implemented.

In closing, I want to recognize and thank all those who have served, especially practitioners who brought their skills and their training to the battlefield. As the administration and Congress consider the implementation of this project, it is imperative to remember four points. There are important distinctions between care provided in battle and that of routine planned care provided to veterans that typically have comorbidities due to age and service-con-

nected disabilities. Though I choose to get my care at the VA, there are many veterans that must receive their care at the VA because they have no other option. We must ensure that they receive the best care possible, that of physician-led team-based care. As leaders of a care team, physician representation on all the VA workers, not just the physician workers, should be mandatory.

Finally, it is unclear why this project is needed. The VA originally rationalized that they needed this project because of privileging issues with the new EHR. In follow-up meetings the VA then stated the project was needed to move personnel around the system. These shifting rationales do not make sense and do not align with how good medicine is practiced.

As we all work together to ensure that the VA is the best healthcare system it can be, let us truly consider the implications of the Federal Supremacy Project and the negative impact it will have on our veterans.

Thank you so much for having me here and I look forward to your questions.

[THE PREPARED STATEMENT OF JESSE EHRENFELD APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you, Dr. Ehrenfeld.

Dr. Barney, you are now recognized for 5 minutes to deliver your opening statement.

STATEMENT OF PAUL BARNEY

Dr. BARNEY. Thank you and good morning.

My name is Dr. Paul Barney, and I am here today representing the American Optometric Association.

I live and practice in Anchorage, Alaska, where I have served as a center director for the Pacific Cataract and Laser Institute for nearly 25 years. I believe that I bring a valuable perspective to today's discussions as I am a practicing Doctor of Optometry who routinely provides laser and other surgical care to my patients.

I did part of my training at an Army hospital and at a VA outpatient clinic. As an adjunct professor at two U.S. optometry schools, I am involved in training the next generation of frontline eye doctors. As a lecturer, I help keep my colleagues on the cutting edge of patient care.

I also understand what it is like to live in a community faced with a shortage of medical doctors and other providers. Roughly 40 percent of counties or county equivalents in the U.S. have access to a Doctor of Optometry but not an ophthalmologist. That number is expected to grow.

America's Doctor of Optometry are stepping up to fill that gap. Optometry's training and abilities have continued to advance alongside the evolution of technology. Today's rigorous 4-year optometry school curricula focuses exclusively on the study of ocular health and vision care. Laser and surgical education, both didactic and hands on is embedded and is a key part of optometric education at both the optometry school level and the post-doctoral level. In fact, contrary to what detractors say, laser and surgical care has been and continues to be taught at each and every school and college of optometry in the country.

Doctors of Optometry are licensed to practice by their state and their scope of practice is set by the state's laws and regulations. The trend for the past 50 years has been for states to increase optometric scope of practice. In no case has their scope of practice been reduced.

In 10 states, doctors of optometry are authorized to use lasers to treat ocular conditions. In one state, Oklahoma, optometrists have been providing laser eye care for nearly 30 years. State regulators cite that this authority has led to an increase in access to care particularly in the states underserved in rural areas. Those state officials also report little or no patient complaints have resulted from this increase in scope of care.

Further, malpractice rates for doctors of optometry in states with the authority to provide laser eye care and other contemporary procedures are roughly identical to rates in states without that authority which highlights the safety and efficacy of this care provided by optometrists.

Aside from in-house care at VA, all Federal health programs recognize, cover, and pay for doctors of optometry to provide laser and other surgical procedures covered under the state's scope of practice. Medicare, Medicaid, and the Indian Health Service all cover and pay for the full range of services authorized under an optometrist's state scope of practice.

Similarly, all major private payers cover and pay for laser eye care and other surgical procedures included in an optometrist's state's scope of practice. The VA's own Community Care program recognizes that injections, lasers, and eye surgery can be provided by an optometrist based on the licensure of the provider.

Eye and vision care ranks as the third most requested service by veterans. Doctors of optometry provide roughly three-quarters of all eye and vision care in the VA. With optometrists often being the only eye care provider at many VA facilities what the department decides to include or exclude from the Optometry National Standards of Practice will have an outsized impact on access and timeliness of care, which will affect patient outcomes and veteran quality of life for years to come.

The veteran service organization, American Veterans (AMVETS) has repeatedly urged the VA to ensure that any VA policy ensure veteran access to the full range of care that both ophthalmologists and optometrists are authorized to perform, including lasers and other surgical procedures. AMVETS has shared concerns that if the VA does not get it right, its members may not have the same access or choices that other citizens in their states enjoy.

At a time when the VA is struggling to meet veteran demand for eye care, it is important that the VA cut through the noise and do what is right for veterans by advancing an optometry NSP that recognizes and ensures veteran access to the full range of care including laser eye care and other surgical procedures that doctors of optometry are trained, licensed, and fully capable of providing. Thank you.

[THE PREPARED STATEMENT OF PAUL BARNEY APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you, Dr. Barney.

Ms. Setnor, you are now recognized for 5 minutes to deliver your opening statement.

STATEMENT OF JANET SETNOR

Ms. SETNOR. Good morning, Chairwoman Miller-Meeks, Ranking Member Brownley, and members of the Subcommittee. Thank you for the invitation today to speak on veterans' care.

I am Jan Setnor. I am a colonel retired from the United States Air Force Reserves with 26 years of service as a CRNA, a flight nurse, and a senior staff member for the Air Force Surgeon General.

As a CRNA who has served as both the anesthesia element team lead over both physician anesthesiologists and CRNAs in the largest in-country medical facility in Afghanistan and a sole anesthesia provider for the Special Forces Operating Base, I know firsthand that unrivaled anesthesia care is provided by CRNAs without duplicative or unnecessary supervision. I have practiced independently in the most difficult circumstances while serving in the military.

CRNAs work without supervision in the Army, the Navy, the Air Force, and in countless facilities across the country. If CRNAs are called upon to competently and safely deliver anesthesia in the battlefield without supervision, it is reprehensible to restrict that care to our veterans here at home.

As a practicing CRNA, I am frustrated that my profession is constantly having to defend its value purely for political and self-serving financial reasons when many peer reviewed studies have proven CRNA care is safe, effective, and par with other providers. In fact, the VA in its 2016 final rules stated that CRNAs provide high quality care. Additionally, 90 percent of veteran households in a survey stated that they support allowing access to CRNAs within the VA.

CRNAs also grow weary of hearing the physician anesthesiologists' false narrative that the VA is planning to replace all anesthesiologists with CRNAs or that CRNA education is inadequate. These are outright falsehoods. The AANA maintains that both anesthesiologists and CRNAs should be available to provide direct patient services and that VA facilities should be allowed to choose their most suitable anesthesia delivery model.

There has been too much political influence on nonphysician scope of practice decisions. The AMA and physician groups have a vested financial interest in limiting the scope of practice for other providers. According to their own website, the AMA has spent over $3.5 million to impede Advanced Practice Registered Nurses (APRNs) from practicing to the top of their education and training.

I would be remiss if I did not address the Hattiesburg article currently being shared with Congress by our medical colleagues.

This study (1) Reviews only nurse practitioners and physician assistants in emergency room settings; (2) Does not include or even apply to CRNAs; (3) Does not look at CRNA or optometrist practice and has no relevance to the national standards for our profession.

Yet, our medical colleagues dishonestly tried to extrapolate from this deeply flawed study and draw fallacious conclusions regarding supervision.

However, the VA's strategic plan released last year highlighted in a study showing full practice authority for other APRNs has had a very positive effect on wait times for the veterans.

Removing barriers to care, including removal of wasteful and financially motivated supervision requirements is not controversial and is supported by many organizations that do not have a vested or self-serving financial interest in maintaining this antiquated status quo. These include two past administrations, the Bipartisan Policy Center, the AARP, the National Rural Association, the Brookings Institute, and the Americans for Prosperity among others.

The men and women who have selflessly served our Nation deserve timely and quality care. All scientific evidence and multiple independent groups have concluded that that is CRNA care.

In conclusion, I would like to commend Chairwoman Miller-Meeks' Iowa VA facilities for setting the standard of what a great collaborative, full practice CRNA physician anesthesiologist practice looks like. It is noteworthy that Iowa was the first state in the Nation to opt out of physician supervision for anesthesia care. In both Iowa City and Des Moines facilities, all CRNAs practice independently to the full extent of their education and training; thus, enabling the physician anesthesiologist to do their own cases. This decreases wait times, increases access to quality care, and improves patient safety and satisfaction. All providers do high acuity, complex cases and all take call independent of each other. Both facilities consistently rank amongst the most highly rated of VA facilities and they invite you to come and shadow them at any time you wish to see this in progress.

Thank you very much for your time. I appreciate it.

[THE PREPARED STATEMENT OF JANET SETNOR APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you, Ms. Setnor.

Dr. McLeod, you are now recognized for 5 minutes to deliver your opening statement.

STATEMENT OF STEPHEN MCLEOD

Dr. MCLEOD. Good morning, Chairwoman Miller-Meeks, Ranking Member Brownley, and members of the Subcommittee.

My name is Dr. Stephen McLeod. I am the chief executive officer of the American Academy of Ophthalmology. I have served in this role since 2022. Prior to that I was chair of the Department of Ophthalmology at the University of California San Francisco, 17 years, and served as a staff ophthalmologist at the San Francisco VA Medical Center.

I am here today on behalf of the American Academy of Ophthalmology to voice our deep concern that veterans will be put at risk if the VA adopts national standards that allow optometrists to perform surgery.

First let me say that we strongly believe that optometrists are vital members of the eye care team. During my tenure at University of California San Francisco (UCSF) I actively developed these collaborative team-based models and continue to support them as a national model of care. However, our efforts recognize the different training, skill, and expertise of each team member. I must

emphasize that as medical doctors with extensive surgical training, indeed many thousands of hours devoted specifically to eye surgery, only ophthalmologists possess the expertise and the experience required to perform eye surgery and to address the potential complications that might arise.

The VA must exercise extraordinary caution when it comes to setting standards for allowing eye surgery. Eye tissue is extremely delicate and unforgiving. The surgery is considered amongst the most technically challenging and damage is simply impossible in cases to repair.

Currently, the vast majority of states, 41, do not allow optometrists to perform laser surgery. There are a handful of states representing a small fraction of the U.S. population that allow other surgical procedures but even within these states, optometrists scopes of practice vary considerably.

Optometrists are restricted from performing surgery in most states in the VA system for a reason. Optometrists are not trained to safely perform surgical procedures. Optometry training primarily focuses on the correction of refractive error, glasses and contact lenses, and on primary eye care. While the curriculum includes some didactic education on surgical topics, meaningful hands-on surgical training is not included.

In states where optometrists have been granted limited surgical privileges, training often consists of a condensed 32-hour certification course conducted at a hotel venue, not a clinical facility. There is no hands-on patient surgical experience which is obviously a crucial component for competent, safe, and successful eye surgery. An optometrist trained under these circumstances may, in fact, attempt their first, unsupervised laser cases having never used the equipment on a human eye.

There is also evidence that suggests that patients who receive surgical procedures from optometrists experience poor outcomes. A 2016 study published in the Journal of the American Medical Association of Ophthalmology, found that there was nearly triple the likelihood of repeat laser treatment in the same eye when the surgery was performed by optometrists compared to same surgery done by ophthalmologists.

Now, the stated goal of the VA Supremacy initiative is to develop national standards that ensure that our veterans receive the same high quality care regardless of where they enter the system. Extending surgical privileges to a subset of providers with vastly inferior training based only on location violates both fundamental principles—quality and consistency regardless of entry point.

To compound this further, it is possible that the VA would grant optometrists licensed in one state the privilege to perform surgery nationwide, potentially overriding state specific laws and expanding risks to patients across the VA. For example, an optometrist licensed in Oklahoma could be allowed to perform laser surgery in Iowa even though Iowa, like 40 other states, for safety reasons prohibits optometrists from performing laser surgery.

As I conclude, I will share my own state's experience. Nearly a year ago, California Governor Newsom vetoed Assembly Bill 2236 which would have allowed optometrists to perform surgical procedures. In his message the Governor stated, and I quote, "I am not

convinced that the education and training required is sufficient to prepare optometrists to perform the surgical procedures identified. This bill would allow optometrists to perform advanced surgical procedures with less than 1 year of training."

We cannot allow our Nation's veterans to receive complex surgical procedures from those who simply do not have the training and expertise to perform them. All of our Nation's veterans need and deserve the highest level of care, and that means regardless of site, only surgeons should perform surgeries."

Thank you again for the invitation today. I look forward to your questions.

[THE PREPARED STATEMENT OF STEPHEN MCLEOD APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you, Dr. McLeod.

Dr. Harter, you are now recognized for 5 minutes to deliver your opening statement.

STATEMENT OF RON HARTER

Dr. HARTER. Good morning. Thank you, Chairwoman Miller-Meeks and Ranking Member Brownley. I am here on behalf of the 56,000 members of the American Society of Anesthesiologists.

We strongly believe that VA's proposed move to a nurse-only model of anesthesia care is a solution in search of a problem. A solution that could risk veterans lives, especially toxic exposed veterans.

There is no shortage of anesthesiologists in VA. As of yesterday there were only 22 position vacancies for anesthesiologists in VA out of 1,000 total positions. The average vacancy rate for anesthesiologists this year is just 2 percent, well below the national average.

VA has the right anesthesia policy in place right now. It is consistent with what every top-rated civilian hospital provides, what 45 states requires, and what VA reaffirmed in 2016 after years of thorough review.

VA is going to tell you that there is no evidence from impartial, independent studies to indicate the full practice authority for CRNAs leads to either improved or adverse outcomes.

A lack of evidence is not the same as a demonstration of safety. VA has not met the burden of proof to show evidence that CRNA-only care is safe. Congressional action is required. VA addressed this burden of proof question in 2014 when VA's own researchers conducted the Quality Enhancement Research Initiative (QUERI) study that specifically questioned whether more complex surgeries can be safely managed by CRNAs providing anesthesia alone.

Without meeting this burden of proof, VA is risking the health and lives of veterans with its proposed policy. VA has an ethical obligation to meet its burden of proof that it will not harm veterans before putting in place a new policy that not one top-rated civilian hospital allows.

This issue cannot be fully addressed without consideration of The Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act Veterans. It makes no sense for VA to spend billions of dollars to treat PACT Act veterans with respiratory disease and then fail to provide them with the

same level of anesthesia care delivered at all leading civilian hospitals.

This Committee and its members were instrumental in the passage of the PACT Act. Toxic-exposed PACT Act veterans have acquired lung disease that typically increases the risk of anesthesia.

These veterans have the right to ask this question. Since the passage of the PACT Act, has VA conducted an independent study of the increased risks of anesthesia on toxic-exposed veterans.

Anesthesiologists and CRNAs are not interchangeable. Using basic common sense, there are 100 anesthesiologist members of ASA who were CRNAs before they made the decision to go to medical school for 4 years, and then 4 years of residency. Why would they spend years of their life doing that if there was nothing more for them to learn. They decided to pursue those additional years of rigorous medical education and training to prepare them to make the split second decisions that can mean the difference between life and death.

I have spent most of my career teaching and training medical students and residents in the medical specialty of anesthesiology. Although nurse anesthetists are truly outstanding advanced practice nurses, they are not anesthesiologists. CRNAs are educated and trained to work with anesthesiologists as a member of a team, not to practice medicine.

In fact, with one exception, every CRNA training program is located in a state that requires a CRNA to work with a physician in the delivery of anesthesia care. Any claim that CRNAs are trained to practice without physician supervision is not accurate.

Despite various nursing organizations suggesting the CRNA-only model is commonplace. The CRNA-only model is rare. Only 5 states permit the CRNA-only model of care, and even in those states it is used infrequently. All other states require physician involvement with CRNAs, whether it be supervision, direction, collaboration, or other state-specific terms. Whatever the terminology, CRNAs in 45 states must work with a physician.

Finally, I was pleased to read the American Legion's statement and respect them for seeking veterans' thoughts about this important issue. They found that 91 percent of respondents support the physician-delivered and physician-led anesthesia care team model. Nearly three-quarters believe that dismantling or altering this model will subject veterans to a lower standard of care than civilians receive.

Chairwoman Miller-Meeks, Ranking Member Brownley, and members of the Subcommittee, thank you for your time and attention to this issue which is critical to our veterans.

I welcome your questions.

[THE PREPARED STATEMENT OF RON HARTER IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you, Mr. Harter. We will now proceed to questioning.

As has been my custom, I will delay my question to the end.

Before I go to the first questioner, the first member, I just want to say to all of our witnesses, for those who have served, thank you for your service. To those who serve our veterans at a VA facility, thank you for serving our veterans.

With that, the chair now recognizes Representative Bergman.

Mr. BERGMAN. I am recognized?

Ms. MILLER-MEEKS. Yes, sir.

Mr. BERGMAN. Okay. Thank you, Madam Chairwoman.

Members of the military do not get to excited about a lot of things, but what we do get excited about negatively is we use the term in the Pentagon, "protecting rice bowls." You all know what that means. You have got your little rice bowl of appropriations and all those things that you do. That is human nature. You all are not alone in that.

When I started as a Marine, I started in rice paddies. If you get the drift in the late '60's, early '70's. I really was not concerned about rice bowls, and I would suggest there are veterans of today who served in places like Iraq and Afghanistan, they are not interested in rice bowls. They are interested in what they observed in the desert and experienced in the mountains and all of that in different ways.

One of the challenges we have as a Committee is to separate what is a rice bowl that is being protected for the right reasons or not. I thank both sides of the aisle on this Subcommittee especially to make sure that we are doing the right thing for the right reason, for the veterans in all cases regardless of which rice bowl it may fall in.

Having said that, Dr. Barney, am I correct to understand that under Medicare, Medicaid, and Indian Health Service, all cover and pay for the full range of services authorized under an optometrist state scope of practice, and in addition, all major private payers cover and pay for those services including laser eye care and other contemporary procedures included in an optometrist's state scope of practice?

Dr. BARNEY. Yes. That is correct.

Mr. BERGMAN. Okay. With all of that being true, would it be correct to say that VA is currently an outlier among all private payers and other Federal programs? Could you speak to the impact that this could have on our veterans' access to, in this particular case, eye care?

Dr. BARNEY. Yes. I think that would be a correct statement, especially if you consider VA's Community Care Program. The Community Care Program does pay for laser procedures provided by an optometrist outside the VA facility itself. If there is a restrictive optometry NSP, I would foresee a scenario where a veteran would not be able to get access to laser eye care by an optometrist within the facility but it could go outside the facility and receive that care. To me that seems like not a very wise use of VA funds and resources.

Mr. BERGMAN. Thank you.

Ms. Setnor, can you discuss the role that nurse anesthetists play in rural and remote areas, in this case like Michigan's 1st District, which is not only rural, it is really, really remote?

Ms. SETNOR. CRNA's cover almost 100 percent of the rural health medicine in most of the states. Several facilities are now closing down because of an inability for access to have these care models delivered. I could say that with certainty that CRNAs practice independently in these settings.

Mr. BERGMAN. Okay. Thank you.

Finally, Dr. Harter, can you point to any evidence that shows VA is trying to replace anesthesiologists as you say the ASA has claimed?

Dr. HARTER. The move to remove physician supervision simply would have that opportunity arise. That there could be VA facilities that might for various reasons opt to not have physician anesthesiologists if they are no longer required to be present.

Mr. BERGMAN. Okay. We think that might be an outcome at this point but nothing has occurred to this point to point to the fact of a lower standard of care?

Dr. HARTER. Well, we would be, I think, speculating as to what might happen one way or another.

Mr. BERGMAN. Well, that is okay, because we have to, in all cases now—I see I have got about 20 seconds left—we need to make sure as best we can as Members of Congress that what is being done at all bureaucratic levels within the Federal Government, in this case especially Veterans Administration, that it is being done for the right reasons with outcomes for veterans in mind, not outcomes for the bureaucracy.

With that I yield back.

Ms. MILLER-MEEKS. Thank you, Representative.

The chair wants to issue a sincere apology to Ranking Member Brownley for going out of order.

I now recognize Ranking Member Brownley for any questions she may have.

Ms. BROWNLEY. No worries, Madam Chair. Not at all.

My first question really is to the physician groups that are here testifying because I just want to get some clarity. At our roundtable meeting that Dr. Miller-Meeks and I had back in April, there was testimony there that said that the VA was not really being transparent and/or responsive. I just want to get some clarification. The VA says that they are reaching out so I want to get some clarification from you, where you stand on that issue.

Dr. Ehrenfeld.

Dr. EHRENFELD. Thank you for the question. I really appreciate it.

The VA has not involved the AMA in the development, implementation, or decision-making around the Supremacy Project. Since we became aware of this in 2021, we have made it clear to the VA that we would love to be involved. We would love transparency. I think that is how we separate out whether this is a rice bowl or a rice paddy.

Ms. BROWNLEY. Dr. McLeod.

Dr. MCLEOD. We have been somewhat frustrated by a difficulty in really being able to get clarity. We do think that it is moving in the right direction. You know, from our perspective, an entire process that is looking at delivering eye care within the VA where the eye care is going to be delivered by optometrists and by ophthalmologists, that does not bring both groups into the room at the same time to come up with the most rational way of dealing with the patients' needs is not in the best interest of the patients and that has not happened.

Ms. BROWNLEY. Thank you.

Dr. Harter.

Dr. HARTER. Much the same. We have requested to have opportunity to have discussions about this specific to nurse anesthesia practice under the proposed National Standards of Practice and to this point have not had the opportunity to provide that.

Ms. BROWNLEY. Right. Dr. Barney, do you have anything to say with respect to my question?

Dr. BARNEY. They have been communicative with us. We have not been involved with all the details but they have been communicative with us, so.

Ms. BROWNLEY. Thank you.

Ms. Setnor.

Ms. SETNOR. Yes, ma'am. All your physicians have been involved—had an opportunity to participate at various levels.

Ms. BROWNLEY. I apologize on your name.

Ms. SETNOR. No worries.

Ms. BROWNLEY. I will get it right the next time. I promise.

You know, I have been on this Committee for 10 years. I am not a doctor, so let me be clear about that. I will say it has been the VA who convinced me early on that a team-based model is the best model and the gold standard. I think someone mentioned the gold standard in terms of healthcare. You know, the VA has also asserted in its testimony and during recent staff briefings that its National Standards of Practice initiative will not eliminate nor change the department's current team-based model of care. I do not know if everyone is confused. I am a little confused because I hear testimony that this is not the direction the VA is going in. The VA is saying they are going to hold on to the model of care. I guess I want to ask you what is your definition or what does a team-based model of care mean? If we can be brief in the answers because I think most will say it is physician-led. Some may not.

I will start again with Dr. Ehrenfeld.

Dr. EHRENFELD. Thank you for the question. It is really important. The AMA strongly supports physician-led team-based care. Nobody should be practicing in a silo and that means nobody should be practicing by themselves.

Ms. BROWNLEY. Dr. Barney.

Dr. BARNEY. Yes. We support physician-led care. Keep in mind that optometrists are physicians.

Ms. BROWNLEY. Thank you.

Ms. Setnor.

Ms. SETNOR. Team-based care, in the Air Force if you look at our statutes, it actually says that the team-based model is actually the best but it also states that the team lead can also be a CRNA as well as an anesthesiologist. It is the experience and level that you are looking at.

As explained when I was deployed, we worked as a team. Anesthesia is not a one-man sport. It takes a whole team to conduct anesthesia in a facility. You need the surgeon. You need our whole team to make it happen. In essence, it is a team sport and either person can be team lead.

Ms. BROWNLEY. Dr. McLeod.

Dr. MCLEOD. In our space some ambiguity has been lent to the term "physician," and so we will be specific. In our space we believe that it should be an ophthalmologist-led team.

Ms. BROWNLEY. Dr. Harter.

Dr. HARTER. Not surprisingly, we also feel that it should be physician-led care.

I do want to say, to make a distinction, we are not advocating that it must be anesthesiologist-led care. There are certainly settings, both in the private sector as well as within the VA where currently the physician providing that supervision is the operating surgeon. Any thoughts that this will somehow create better access, reduce costs, et cetera, they are able to do that model currently without removing any need for physician oversight of the nurse anesthetist.

Ms. BROWNLEY. Thank you. My time is up but I do have more questions. I am hoping that we may have another opportunity, Madam Chair.

Ms. MILLER-MEEKS. Thank you, Ranking Member Brownley.

The chair now recognizes Dr. Murphy for his questions.

Mr. MURPHY. Thank you, Madam Chair. Thank you to the members. I want to thank you all of you guys for coming out and dedicating your lives to the practice of taking care of people. I do not see any greater cause personally and professionally. I have done one for 35 years and I much prefer the title of doctor rather than Congressman.

Do not take that the wrong way. Sorry, folks.

That said, being a doctor is in my DNA and these scope of practice issues are always coming up. It is like playing whack-a-mole sometimes. I call it scope creep. The term is I want to practice to the highest level of my license. I absolutely understand. I think it is imperative that folks understand where that phrase comes from and what it means. Who gets to determine what your license is, your peers? It is not someone who does a procedure by training and has done it 10,000 times. It is something that your peers say, hey, I think you should be able to do this. When you say I want to practice to the level of my license, it is really a misnomer as to what you are saying. It is really saying I want to practice to the level of what my friends and my colleagues say I can practice. It is not practicing to the level of what people who have actually done specific training in that field say you can do.

That said, there is overlap. There is obviously overlap. I am a urologist and gynecologist. There is plenty of overlap. There is plenty of overlap between differing fields. When it comes to surgery, and it comes to keeping somebody alive under anesthesia, the overlap really hits a wall. I worked with nurse anesthetists. Have for 35 years. Have wonderful relationships with them. Absolutely. When the proverbial hits the fan, I want an anesthesiologist in the room. I have had many, many, many circumstances because I am a cancer surgeon. I have done a lot of cancer surgeries. When someone's like is at stake, I want the person with the highest level of training to be there.

I wear glasses. Thank God for my optometrist or I would be fumbling more than I actually fumble around anyway. That said, I personally do not believe a weekend course, a couple week course, it is fine when you know a narrow band of knowledge and that is fantastic. You may know that. As we all know there are complications that step outside here. There are complications that step out here.

Unless you know the depth and the breadth of what is in that field of pathology, I do not fully feel you know the disease process that you are working with.

The VA, talking with anesthesia, is not having a problem getting anesthesiologists right now. Optometrists and ophthalmologists may be a little bit different things. I understand. I absolutely understand that you are all passionate for wanting to take care of our veterans. Absolutely. There is nobody in this room that is not passionate for wanting to take care of our veterans. In my opinion, in my medical opinion, there is a team concept and there has to be one quarterback. One quarterback for a team. If not it is absolute anarchy. Yes, there are some gray areas and there are some definite partnerships between CRNAs and anesthesiologists without a doubt. There are excellent partnerships between optometrists and ophthalmologists. Absolutely. Some see post-op patients and everything. When we use the scope creep and the term of practicing to the highest ability of my license, it is a little bit, and this may across the wrong way, it is a little bit disingenuous because where you got that license from is really not where the expertise lies.

I do not have any specific questions because I think you guys know where I stand. I want everybody under the same tent because the same tent is that which cares for our veterans. Lessening in my opinion the quality of care because of a perceived access issue really is not what our veterans deserve. They are not what our veterans deserve. I do believe there can be some common ground to help our VA achieve care for all of our veterans but I do not believe in decreasing the quality of care and the expertise of care.

With that, Ms. Chairman, I will yield back.

Ms. MILLER-MEEKS. Thank you, Dr. Murphy.

The chair now recognizes Mr. Van Orden for 5 minutes.

Mr. VAN ORDEN. Thank you, Madam Chair.

Dr. Setnor, I understand that you served in Afghanistan. What years was that or were those?

Ms. SETNOR. 2008.

Mr. VAN ORDEN. Okay.

Ms. SETNOR. I am not a doctor.

Mr. VAN ORDEN. Okay, sorry, ma'am.

Ms. SETNOR. You can call me colonel if you want.

Mr. VAN ORDEN. I think that is what this is all about?

I will, Colonel. I will tell you what. I am going to praise you publicly for the work that you did in secret because if you were in Afghanistan in 2008, there is a 100 percent chance that you are responsible for saving the lives of some of my Navy Seal brothers. I want to thank you for that.

Ms. SETNOR. Thank you.

Mr. VAN ORDEN. Actions speak louder than words. I am from the State of Wisconsin. Behind that door my staff has brought you some cheddar cheese from the State of Wisconsin.

Ms. SETNOR. Yay.

Mr. VAN ORDEN. To quote the president, "That is not a joke."

Doctor Ehrenfeld, do you consider yourself a subject matter expert in the medical field?

Dr. EHRENFELD. Yes, sir.

Mr. VAN ORDEN. Good. Do you consider the American Medical Association the gold standard for medical expertise and advice?

Dr. EHRENFELD. I am very proud of what the AMA is able to represent in serving the needs of our patients and physicians.

Mr. VAN ORDEN. That is not the question I asked you.

Do you consider the AMA the gold standard for medical expertise and advice?

Dr. EHRENFELD. I am not sure I can answer that, sir.

Mr. VAN ORDEN. Okay. Is smoking bad for you?

Dr. EHRENFELD. Yes, sir.

Mr. VAN ORDEN. Is using class 1 narcotics for recreational use bad for you?

Dr. EHRENFELD. Yes, sir.

Mr. VAN ORDEN. If you put an unprotected hand in fire will it be burned?

Dr. EHRENFELD. Yes, sir.

Mr. VAN ORDEN. Can a biological male become a biological female?

Dr. EHRENFELD. I am not sure I understand the question.

Mr. VAN ORDEN. That is the problem, Doctor?

Can a biological male become a biological female?

Dr. EHRENFELD. I am not sure where you are going with that, sir.

Mr. VAN ORDEN. That is even more troubling.

The issue is this. You know the answer to that question. You are just not going to say it because you are playing politics with medicine. So is your organization. That is not just dangerous; it is terrifying. So for my opinion, you are not a subject matter expert in the medical field or you are exercising administrative cowardice because you know the answer to that question, Commander.

Doctor Hartner——

Dr. HARTER. Harter.

Mr. VAN ORDEN. What is it again?

Dr. HARTER. Harter.

Mr. VAN ORDEN. Oh, sorry about that.

You submitted a 17-page biography and CV. You submitted less than a single page of written testimony and yet you spoke for 5 minutes. That is correct. That is all I got, man.

Dr. HARTER. Our written testimony was several pages. I cannot speak to the disconnect.

Mr. VAN ORDEN. Oh, when did you give us the updated one?

Dr. HARTER. I believe it was at the end of last week. I do not know exactly. The 15th.

Mr. VAN ORDEN. Okay.

My concern is this, sir. Can you positively demonstrate a dearth of care for veterans due to a lack of anesthesiologists in the VA?

Dr. HARTER. With respect to wait times, et cetera?

Mr. VAN ORDEN. Yes.

Dr. HARTER. No. We are not aware of that being certainly global. I cannot speak to every VA facility in the country but——

Mr. VAN ORDEN. Okay.

Dr. HARTER. Again, our knowledge is that there are very few vacancies for anesthesiologists within the VA system which would suggest that staffing is appropriate throughout the system.

Mr. VAN ORDEN. Okay. When my colleague General Bergman was asking you about these things you said you were not going to speculate on this and that; correct?

Dr. HARTER. Correct.

Mr. VAN ORDEN. If you cannot positively demonstrate to me that there is a dearth of anesthesiologists or care, high quality timely care for our veterans, if you cannot demonstrate that to me concretely then you are speculating. It is in the dictionary, dude.

Here is the thing. If you cannot demonstrate that our veterans are getting high quality care in a timely manner, what you are saying is meaningless. I would like to see from you on paper a chart that shows me that our veterans are not getting high quality, timely care, because that is the only reason that we are all here. It has nothing to do with your 17 page biography and CV, sir.

Dr. HARTER. To be clear——

Mr. VAN ORDEN. It is not about status. It is not about a badge. It is about high quality, timely care to our veterans.

With that I yield back.

Dr. HARTER. Can I respond?

Ms. MILLER-MEEKS. Thank you.

Mr. VAN ORDEN. If the chair so recognizes you.

Ms. MILLER-MEEKS. Mr. Van Orden, you may respond, Dr. Harter.

Dr. HARTER. Just to be clear, our assertion is the current state is that there is not a shortage of anesthesia providers. Therefore, making significant changes to the scope of practice of the nurse anesthetists, there is no compelling reason to do that.

Is the question to show that there is currently a shortage of anesthesia providers or to show that there is not?

Ms. MILLER-MEEKS. Thank you.

The chair now recognizes Representative Kiggans.

Ms. KIGGANS. Thank you very much, Madam Chair.

I proudly represent Virginia's 2nd congressional district, home to a large veteran population and active duty military as well. I served in the Navy myself, too, for 10 years. I am also a board certified adult geriatric primary care nurse practitioner, and I have had the privilege of taking care of some of greatest generation in many different care settings with many different care teams. I consider myself possibly a subject matter expert in this topic today.

I want to start with the three things that I think that we can all agree with. I think that we can all agree that we have a healthcare provider shortage. There is not enough of us, right, to give the care that we need, especially in the VA setting.

I think that we can all agree that no one practices in a silo. I know you guys talked about that, and Ms. Setnor, you talked about it being a team sport. I certainly think that healthcare is a team sport no matter where you are. Even if you are the only provider in a rural setting there is always somebody you can call. You are going to text somebody or get an answer to your question if you do not have that answer.

The third thing I think that we can agree on is that VA healthcare has much room for improvement. I have been in Congress for 9 months and have sat on this Committee proudly and have listened time after time about veterans that come and dif-

ferent care organizations that come and tell me that VA healthcare is inadequate, 100 percent. We have got to do better for our veterans in a lot of different areas.

I will tell you what is harmful for veterans. A couple of you spoke about harming veterans. What harms veterans is when we cannot give them the healthcare that they deserve.

I will get off my chest just ever so briefly with Dr. Ehrenfeld about some of your comments about nonphysician providers and advanced practice nurses. They were offensive to me personally as someone who has worked with some of the greatest geriatricians in the world to take care of very vulnerable people. To even say that there is worse health outcomes for a nurse practitioner. We practice differently. We just do. I mean, we are educators. We are nurses. We do not want to be doctors. That is where I think a lot of physicians really get confused. We do not want to do open heart surgeries. We do not want to take your place. We want to partner with you. We need that recognition. We fight day in and day out. You talk about that we have higher expenses because we order more tests. Perhaps we are being more thorough. If you want to talk about expenses. We are a cheap form of healthcare. Advanced practice nurses, we have to fight for the pay that we get. We are not compensated in my opinion as much as we need to be.

Be careful with the rhetoric that you use and the companies that you use it in.

You talk about, you know, the VA and why this Committee and why Congress is now weighing in on this issue, this Federal issue. Well, that is our job; right? In Congress, we provide oversight, especially for Federal healthcare which is the VA. I know there are state standards. I sat in the State Senate for 3 years. We argued about autonomous practice for nurse practitioners. During COVID, you know, it was 5 years. We had to practice for 5 years before we could even apply to practice independently. During COVID we switched it to two. After 2 years as a nurse practitioner, 2 years of experience I could practice independently. During one of the most challenging healthcare times in our country where we invited sick people to come visit us, and we took care of them every day and we said come see us if you do not feel good. We will take care of you. With 2 years of experience. Then after COVID they wanted to switch it back to five. How can you even? Why is it different at different times?

I know Ms. Setnor, you talked about on the battlefield when nurse anesthetists could perform the same duties. Why is it different? Either we are going to do it one way or we are going to do it another way.

I wanted to again talk about also kind of the eyes and ears argument. I know we have the optometrists and ophthalmologists. My dad is a Vietnam veteran. He was a Green Beret. He only uses VA healthcare for two things. That is for glasses and for hearing aids and so many of my patients the same. Glasses and hearing aids are expensive.

If we do not expand these care teams, you know, I have been a supporter of even supporting it to pharmacists. Simple things. Now, within scope. I think there is a discussion to be had about what is your scope of practice. We have got to acknowledge that we

need to expand our care teams because we are struggling. Wait times, access to care, patient satisfaction. No, we are not there. If we do not look at some of the obvious answers that are in this room then we are failing our veterans.

I want to yield my last few seconds to Ms. Setnor. If you could please in your own view, how has expansion of full practice authority for APRNs affected availability and quality of care at the VA?

Ms. SETNOR. Thank you for the question.

One thing I would like to clarify that Dr. Murphy kept referring to was licensure. He never referred to our education and training. The education and training of CRNAs is exemplary. We are educated and trained to practice at the highest level. We are airway experts. To take care of the PACT we can do that easily.

As far as expansion of care, as I mentioned to Dr. Miller-Meeks' facility in Iowa, they have the best team care model. They work independently of each other and they take care of very sick patients. They have high acuity and they are very complex cases. They do it seamlessly. They have invited Members of Congress to come and shadow them so that they can see the work in progress.

Ms. KIGGANS. Thank you. My time has expired. I will yield back.

Ms. MILLER-MEEKS. Thank you, Representative Kiggans.

Maybe we can silence some phones, although I like the song.

The chair now recognizes Representative Scott for 5 minutes.

Mr. SCOTT. Well, thank you. Let me get the mic on. Thank you very much.

First, I want to thank Chairwoman Miller-Meeks and Ranking Member Brownley for allowing me to participate in this incredibly important hearing. And for your support for our fantastic veterans.

Let me just start by saying that for over a decade, expanding three different administrations, I have called for the VA to reject any proposal that removes the medical expertise of physicians during intricate surgical procedures with our veterans. I was very pleased that after years of extensive review and study and at the urging of myself and other Members of Congress, medical organizations, veterans, and the veterans' family members that then-VA Secretary McDonald put our veterans first.

Unfortunately, this current administration has put forth this proposal yet again that would replace the current method of anesthesia administration, meaning that complex surgeries could be performed without the presence of trained anesthesiologists. Ladies and gentlemen, we are talking about these surgeries being applied to our precious veterans. Of all groups it is our veterans that have battlefield wounds, that have intricate problems. If there is anybody that needs to have the best and most reliable anesthesiology care it is our precious veterans who volunteer to put their lives on the line on the battlefield for us. They need physicians that are trained with the latest information, the best talent possible.

Now, I have great respect for our nurses. My daughter is a nurse at Grady Hospital in Atlanta, Georgia. I love nurses. They are not qualified to give the level of expertise when it comes to anesthesiology. That is the most important part of having surgery, putting our veterans to sleep so the surgery can be performed with the best of care. Very importantly, waking them up after a successful surgery. There is no more important thing. Don't our veterans deserve

the best? All of our American citizens do. It would be a mockery and a hypocrisy if we do not perform this for our veterans. Each of you, and each of you on the panel, if we have to have surgery would not we want to make sure we have a trained physician conducting that basic talent that they have?

If I may, I would like to ask a question of Dr. Harter. If the administration, Dr. Harter, allows this proposal, the Atlanta VA in my home state will move to a nurse-only care model while other world-class hospitals in Georgia continue to use the anesthesia team model. Why, Dr. Harter, should veterans in Georgia, or anywhere in our Nation, have a lower quality of care and safety than any other member of our Nation or citizen of our state? Dr. Harter.

Dr. HARTER. Thank you, Mr. Scott.

Clearly we feel that there should not be a different standard within the VA system than for what is in the civilian setting for 45 states in the Nation and is used even in the other five states it is a very frequently used model to still have the anesthesiologist or physician-led anesthesia care team. We feel that the standard should be at least as high within the VA system as it is in the civilian setting.

Mr. SCOTT. Well, thank you very much for that response.

Is my time? All right. Thank you all very much.

Ms. MILLER-MEEKS. Thank you, Representative Scott.

The chair now recognizes herself for 5 minutes. Again, thank you all for your testimony, for being here. For those who served, thank you for your service, and for those who care for our veterans, thank you all so very much.

Ms. Setnor, thank you for your comments about Iowa and Iowa VA. It is a physician-led team. The surgeon who is a physician is, in fact, in care in the operating room for all care. As a practicing physician who worked with CRNAs and have deep respect for them, I was, in fact, the supervising physician during those care and those procedures.

I also would like to say that in my time as a faculty member at the University of Iowa, we had optometrists that were on our faculty. In my private practice in Ottumwa, Iowa, we had a local optometrist join us who had done an internship at the VA in St. Louis, and that person was a full partner in our practice. Not an employee and not subservient to me. However, I do feel that there is a difference in care. The concern that I have is that you will see behind me a poster.

Dr. Barney, can you tell me what that is? Maybe we can raise it up.

Dr. BARNEY. It is a multifocal Intraocular Lenses (IOL). It looks like we might have some capsular opacification. From this distance it is hard to tell but it looks like a multifocal IOL.

Ms. MILLER-MEEKS. It is a multifocal IOL that underwent a Yttrium Aluminum Garnet (YAG) capsulotomy by an optometrist who was trained by another optometrist. The veteran was sent out of state to go to a state where it is under the state's licensure laws that optometrists can do YAG laser capsulotomies. I will fully admit that I have pitted an intraocular lens before. I am not pure. This is a multifocal intraocular lens that was severely pitted. It cost $20,000 to have this removed from that veteran in another

State when they went back to their practicing state after they had been sent out of state by an optometrist. That is why this is a concern to me.

Dr. McLeod, in your written testimony you referenced the team approach to eye care helps ensure patients receive the most appropriate treatment in a timely manner. Can you elaborate on the benefits of this team approach that it has for patients as well as for the healthcare system itself?

Dr. MCLEOD. Absolutely. As we look at the healthcare systems, we recognize there is a full range of care that is required whether you are out in the community or in the VA. It has been referenced that, you know, that access to patient care is really important. When we look at the volume of cases coming in, having a system in place that you can adequately deal with eye care, adequately deal with the need for glasses and contact lenses, and meet those basic needs is really important. That is actually a huge volume.

Beyond that we have glaucoma. We have macular degeneration. We have diabetic retinopathy. There is a whole series of things that need to be taken care of. Different people need to do different things. Making sure that there is an adequate optometric supply in order to deal with the primary eye care, the glasses, contact lenses actually is one of the things that would really help getting patients through. Once patients get into a disease state, having physicians that have the expertise to manage those diseases appropriately, to then get them to surgical care when necessary, to do that surgical care working with the optometric group allows for a system of care that is able to manage a given patient and a population of patients through the system in a timely manner with high quality safe care. We have to work together for this.

Ms. MILLER-MEEKS. In its written statement, the American Optometric Association states that state regulators have made it clear that little or no patient complaints have resulted from the expansion of state optometric scope of practice laws. Let me also say that the physician who removed that intraocular lens and brought this case to me, there was no complaint reported, nor any lawsuit filed.

What have you heard from ophthalmologists or other providers that are practicing in these states?

Dr. MCLEOD. The first thing to address is there is sort of the misconception that it is a norm out in the community for optometrists to be doing laser surgery. It is not the norm. There are approximately 33,000 optometrists in the country. If you look at the total percentage that are doing the YAG laser capsulotomy that you reference, it is a half of 1 percent of the total. If you look at laser cases it is 0.1 percent of the total. Bringing optometric surgery into the VA with any degree of scale is actually a far outlier from what happens in the community. Then when you look at the relatively small percentage that we do see, unfortunately what we see is an overrepresentation of outcomes that we would be concerned about.

Now, what you will hear is we do not have a lot of data for poor outcomes. Much of that is that we actually as systems of care do not have good systems for capturing and reporting poor outcomes unless it is volunteered by practitioners.

The last point that I will make is that malpractice rates are not a good way of looking at whether care is good or bad. People do not typically get sued because they have got a bad outcome. They get sued because they have a poor relationship with an unhappy patient. You can smooth over a lot of poor outcomes with your relationship and that is not what we want for our veterans or for the American population.

Ms. MILLER-MEEKS. Thank you very much. I am sure we would all have more questions that we would want to ask. On behalf of the Committee I thank you all for your thoughtful testimony and for joining us today.

You are now excused, and we will wait for a moment as the second panel comes to the witness table.

[Recess]

Ms. MILLER-MEEKS. Welcome everyone. Thank you for your participation today.

Joining us today from the Department of Veterans Affairs are Dr. Erica Scavella, Assistant Under Secretary for Health and Clinical Services and Chief Medical Officer; Dr. Christopher Saslo, Assistant Under Secretary for Health for Patient Care Services and Chief Nursing Officer; and Mr. Ethan Kalett, Executive Director, Office of Regulations Appeals in Policy.

Dr. Scavella, you are now recognized for 5 minutes to deliver your opening statement.

STATEMENT OF ERICA SCAVELLA

Dr. SCAVELLA. Good morning, Chairwoman Miller-Meeks, Ranking Member Brownley, and distinguished members of the Subcommittee. Thank you for the opportunity today to discuss VHA's position regarding National Standards of Practice. Accompanying me today are Dr. Christopher Saslo and Mr. Ethan Kalett.

VA is developing National Standards of Practice for 51 occupations to ensure safe, high quality care our Nation's veterans and to ensure that VA healthcare professionals meet the needs of veterans wherever they are located. National standards are designed to increase veterans' access to healthcare and improve health outcomes.

VA is committed to ensuring that stakeholders are engaged in the process to develop National Standards of Practice in each and every health occupation. VA has not yet finalized National Standards of Practice for any of the occupations. The National Standards of Practice will be designed through extensive internal and external expert consultation.

To further engage with key stakeholders, VA has been hosting listening sessions in August and September 2023 for professional associations that are in-service organizations, the clinical community, the public, and Members of Congress to provide to VA their research, input, comments on variances between state licenses and scopes of practices, as well as their recommendations on what should be included in VA's National Standards of Practice.

VA will consider all feedback received in these listening sessions when drafting the National Standards of Practice for each discipline. When the draft National Standard is ready it will be published in the Federal Register for public comment. Further, VA will

send to every state board for that profession a letter with information on the impact of the proposed National Standards of Practice on the specific state with an opportunity for the state to respond.

The development of National Standards of Practice will not undo the longstanding team-based model of care already established within VA that ensures competent, safe, and appropriate care for veterans. VA encourages a team-based approach to patient care. National Standards of Practice will support and define roles within the team regardless of state.

National Standards of Practice are intended to strengthen the team-based care and thereby generate the best possible access and outcomes for veterans. Patients are familiar with the concept of having a team of caregivers, including nurses, physical and respiratory therapists, and others. The anesthesia care team can be considered a more specialized model of that team. CRNAs provide anesthesia care for surgery, trauma, procedures in nonsurgical and critical care settings, and chronic pain management as part of the patient care team.

VA has a proven team-based model of care involving both anesthesiologists and CRNAs, as well as various additional types of providers, including trainees from both medical and nursing training programs who come to VA for its longstanding tradition of training excellence. The team concept relies on the understanding that no one provider is alone and unsupported.

Team-based care relies on the knowledge and discretion of the facility anesthesia leadership who determine the team composition based on multiple factors. Major procedures performed at complex VA facilities such as cardiothoracic surgery require the expertise of both subspecialty trained anesthesiologists, as well as experienced CRNAs with additional training or experience in cardiac anesthetic management.

More commonly performed procedures, such as screening colonoscopies, are completed much more widely throughout our system. These procedures can require careful preoperative evaluation, and certain patients may safely receive their anesthesia with a CRNA providing their principal care with appropriate collegial support if needed.

In regard to the CRNA National Standards of Practice, VA will only include independent practice if VA determines it is appropriate, safe, and in the best interests of veterans. VA anesthesiologists and CRNAs will continue to work as a team and independently where appropriate to provide vital anesthesia care to veterans throughout the United States.

The Temple University School of Law was contracted to conduct an independent, third-party comprehensive review of each state's licensure requirements for CRNA and analyze the differences in CRNA practice across the country. This data is now being used to develop the CRNA National Standards of Practice by a team of expert CRNAs and other advanced practice nurses and physicians. We intend to release this data in the coming weeks.

In regard to the Optometry National Standards of Practice, VA is currently evaluating whether the National Standards of Practice will authorize optometrists in the 10 states that allow eye surgery to practice and operate within the full scope of their license. VA

does not intend to allow VA optometrists who hold a license in any other State to perform laser eye surgery.

We received great feedback from the listening session held on August 31. VA is using the information presented to determine what should be included in the proposed national standard.

We appreciate the input of the Committee, lawmakers, and all stakeholders on this important issue. We are committed to honoring our Nation's veterans by ensuring a safe environment, to provide exception healthcare.

To close, our next listening session is this Thursday on the 21st and will allow stakeholders invested in VA anesthesia care the opportunity to provide research, input, and comments on the variance between CRNA, State licenses, and also to provide recommendations on what they believe should be included in VA's proposed CRNA National Standards of Practice.

VA will consider all feedback received at the listening session when drafting the National Standards of Practice.

Chairwoman Miller-Meeks and Ranking Member Brownley, we appreciate our continued support and look forward to answering your questions.

[THE PREPARED STATEMENT OF ERICA SCAVELLA APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you, Dr. Scavella.

The chair now recognizes—is Mr. Saslo talking? Excuse me. I am going to defer my questions to the end so the chair now recognizes Ranking Member Brownley for any questions she may have.

Ms. BROWNLEY. Thank you, Madam Chair.

I just wanted to say, I wanted to have a follow-up question on the first panel and was unable to. I just want to make it clear that my concern is the VA have the same kind of standard that hospitals outside of the VA have. I know with physician-led teams even in rural hospitals it was mentioned about the challenges in rural areas.

Let us just take anesthesiology as an example. If there is not an anesthesiologist in the rural area then it will be physician-led or surgeon-led or something. It will be physician-led is my understanding. In looking at that kind of standard, in looking at the VA, I am hopeful that we will hold on to that standard to be in parity with what private hospitals are doing around the country.

Having said that I wanted to ask this question around optometry and the ophthalmologist. The ophthalmology community, and you mentioned this just in your testimony about you do not intend on optometrists to be able to do laser surgery in states where it is not allowed. It sounds to me as though you are planning on having a two-tiered system within the standard.

Dr. SCAVELLA. Thank you for the question.

When it does come to looking at any clinician's ability to perform the services it is based on that person's experience and licensure. With regard to optometrists, we do know that there are only 10 states currently that do train their optometrists to perform laser surgery. Transporting that skill for those individual optometrists to a location theoretically outside of those 10 states allowing them to do that surgery could potentially happen. However, we would not be looking at those who are not trained appropriately who have li-

censes in the other 40 states. Again, this is all under review and consideration based on our listening sessions, based on our engagement with the entities who were here today on the first panel. We are including all of that information as well as review of quality, access, and safety data to make our decision related to that.

Ms. BROWNLEY. You are intending on that judgment call to be made at the medical centers across the country?

Dr. SCAVELLA. The decision to allow a clinician to do a specific type of duty is based on their specific experience. That takes place at each medical center. I, myself, am a physician. My license in Maryland says physician and surgeon. I am not proficient in surgery. My medical center would be required to determine what specific skills I can provide regardless of what my license states. It is an individual decision that is based on that particular clinician. It is based on their skills, their experience, and also their clinical outcomes. We do evaluate our clinicians through a focused and an ongoing professional practice evaluation which allows us to know what we think they can do and we can see what they can safely do and perform for our veterans.

Ms. BROWNLEY. Very good.

This is the second time that the VA has considered adopting a nurse-only anesthesia team. In 2016, veterans spoke out strongly against the proposal and more than 25,000 veterans commented in support of keeping anesthesiologists as the leaders of the team. The American Legion recently conducted a survey of veterans on the issue, the results of which it provided in a statement for the record in this hearing.

Based on the Legion survey, most veterans believe it is important for their anesthesia care to be provided by physician anesthesiologists, and they prefer a physician to administer anesthesia during surgery.

How is VA weighing the views of veterans in the development of the National Standards of Practice for nurse anesthetists? What exact criteria will be used to make the final decision?

Dr. SCAVELLA. Thank you for that question. I will start and then I will hand it to my colleagues.

Related to the American Legion survey, we did speak with the director of American Legion, both during the development of the questions, as the information was coming back, and then we did receive a preview of what the findings were.

We do understand that our veterans are committed to having the best care possible. We would like to continue to work with them to explore what that means in all different care settings.

Regarding the ability to make a determination related to the type of care that they are receiving, we want to make sure that we are providing care that is equitable, that is accessible, and that is safe.

Dr. Saslo, would you like to add anything?

Mr. SASLO. Thank you, Dr. Scavella.

I think it is important to also recognize that we are not looking, and we have said it before, we are not looking at a nurse-only model. We continue in looking at the team-based models.

As an adult nurse practitioner, even as an independent practitioner in VA, my goal is to make sure that I work as part of a team.

Ms. MILLER-MEEKS. Excuse me. Your time is up. Thank you.

Mr. SASLO. Oh, I apologize.

Ms. MILLER-MEEKS. It was up when she yielded to you so, which was inappropriate. Thank you.

The chair now recognizes Representative Bergman for his questions.

Mr. BERGMAN. Thank you, Madam Chairwoman.

Just out of curiosity, those of you sitting on this panel who work at the VA. Yes?

Dr. SCAVELLA. Yes.

Mr. BERGMAN. Then you have got the members of the first panel who basically do not work at the VA. They represent their, if you will, constituencies. Do you guys ever get together and just, you know, whether it be a quarterly meeting? Let us focus on just the AMA, because the overarching institution with all the subspecialties underneath it and you as the VA are the overarching umbrella, if you will, of all things veteran and veteran healthcare. Do you guys ever, I mean, do you have routine meetings? Could you describe one?

Dr. SCAVELLA. Sure. Thank you for that question, Congressman Bergman.

We have been engaged with several organizations, including the AMA since 2021. We have dates of the over 200 engagements we have had with several different stakeholders.

Mr. BERGMAN. Did it not occur before 2021?

Dr. SCAVELLA. We do but I can tell you that we have got dates in our files today——

Mr. BERGMAN. Okay.

Dr. SCAVELLA [continuing]. that indicate that for this particular purpose that we have been engaging with the groups, including the AMA, since 2021.

We do meet with these entities and I think what we are hearing from them is they are interested in being a part of the——

Mr. BERGMAN. Let me ask the question. Since you do have gatherings has the question ever come up since 2021 that care in the community for veterans, has that ever been the subject of one of your gatherings? It is one thing to work in the urban suburban setting where you have the big VA medical centers and you have big civilian, you know, hospitals and surgery centers and whatever. I mean, has there ever been any focus of a meeting on what it means to provide rural and remote healthcare for veterans in this 21st century?

Dr. SCAVELLA. Thank you for that question.

Yes. We have explained that in some locations, due to the acuity of the facility, the types of care that is provided.

Mr. BERGMAN. Explaining is not dialoguing.

Dr. SCAVELLA. Okay. I will say during dialogs, during meetings with these different entities we have explained that we do have some concerns related to our ability to provide care in all locations where VA facilities or care——

Mr. BERGMAN. Okay. I am just kind of curious because when you have stakeholders in anything, and again, I think everybody here in the room believes why we are here is to provide better outcomes for veterans in healthcare.

Are you aware, and this is for any one of the three of you, are any of you aware that in the 2016 APRN final rule that VA stated that CRNAs provide quality care and are able to practice independently without added risk to patient safety?

Mr. SASLO. Yes, we are aware of that. During that period of time the decision was made by the administration at that time not to move forward with the full practice authority for CRNAs only while the remainder of the advanced practice rolls were given the full practice authority at that time.

Mr. BERGMAN. Okay. Well, since we are facing an ongoing shortage, workforce shortage across both VA and the private healthcare industry, especially in the rural and remote areas, how will it restrict the services that certain health professionals can provide instead of allowing them to provide the full scope of services under their license do anything to help the problem? Are we unnecessarily restricting?

Dr. SCAVELLA. I will start and then I will turn it over to my colleague, Mr. Kalett.

I think we want to make sure any provision of services that we provide that we are providing safe care. That needs to be evaluated closely to make sure that we are not providing anything that we think is going to be potentially a poor outcome for our veterans. It is not an easy answer. It is not just a linear answer. It is based on lots of factors.

Mr. Kalett.

Mr. KALETT. Thanks for the question.

The idea here for the National Standards of Practice is to remove barriers. If there are professions who, for example, require a referral before they can see a patient, like PT, eliminating that within the VA system would be our goal. The goal is not to limit top of license practice. If you have a license that allows you to do more than what a national standard can do, there could still be the way to do that. We are not looking to strict care if I understood your question.

Mr. BERGMAN. Okay. Thank you.

With that, Madam Chairwoman, I yield back.

Ms. MILLER-MEEKS. Thank you, Representative Bergman.

The chair now recognizes Representative Budzinski for 5 minutes.

Ms. BUDZINSKI. Thank you, Madam Chairwoman.

I appreciate the input from all stakeholders on this important issue. My team and I have met with numerous stakeholders on both sides of this issue, and I am particularly interested in how much of this effort will impact our rural veterans in particular.

As we all know and have consistently heard, we are facing severe shortages of healthcare workers. Overall, and particularly in rural areas like those in my district, veterans in these areas most often travel lengthy distances for care, especially when seeking more specialized care. Professions such as CRNAs and optometrists often fill

these gaps in most rural areas which leads me to my first question to Dr. Scavella.

Can you elaborate on the VA's process for these standards and to what extent the agency is factoring rural access challenges into your analysis of whether health professions such as CRNAs and optometrists' scope of practice should be broadened?

Dr. SCAVELLA. Thank you for that question.

Yes, making sure that all of our veterans have access at all the locations where we provide services is extremely important to us. If you cannot get the care then it does not matter if it is great or not. We want to make sure we are providing that care.

In rural locations we may have different challenges. Even in some urban locations we may have different challenges with being able to provide the services that we need to provide. We are keeping that at the forefront of everything that we are doing.

Dr. Saslo or Mr. Kalett, would you like to add anything?

Mr. SASLO. I think it is really important, and I appreciate the question about the rurality because we recognize that every state has rural areas to it. Our goal really is to try to provide the best and the safest care. NorthStar is always at our forefront when we are looking at the national standards for all 51 professions. I think the best take home message is, yes, we are looking at exploring all of the opportunities as long as it is the national standard, not the minority of what we deliver in healthcare. For those states that may be a smaller number providing greater access, we are not looking to restrict those particular states but we do not necessarily want to see that care broadened across because it is not the norm for the rest of the country.

Mr. Kalett.

Ms. BUDZINSKI. Okay. I wanted to mention another one of my top priorities since joining the House Veterans' Affairs Committee (HVAC) has been working to ensure veterans have access to comprehensive behavioral health treatment as well. That VA is keeping this as a focus in the development of these national standards. With that in mind I noted the mental health and suicide prevention professions that would be included in the list of 51 occupations for national standards.

My question, again, I will start with Dr. Scavella, how do you see these national standards improving behavioral health access and suicide prevention efforts for our veterans?

Dr. SCAVELLA. Thank you for that question.

There are several professions represented that do extend and perform care in our mental health or behavioral health settings and that are able to both extend the team that is providing that care and also sometimes provide that care specifically. We know that there are ways to expand the team by giving them more autonomy and ability to provide that care directly to veterans when it comes to suicide prevention and mental healthcare.

Mr. SASLO. If I could just add to that. I think it is really important as Dr. Scavella pointed out that several of the team members we already use and we want to maximize that delivery such as those social workers, psychologists, and some of our advanced practice nurses and delivering that mental health that is so very vital for our suicide prevention.

Ms. BUDZINSKI. Would you like to add anything? Okay. I think I have time for one other point and question.

I wanted to turn to quality of care. We heard during the first panel that quality of care may diminish under these new standards and both sides have cited studies that I think are important to factor into these proposed standards.

I believe we do need some form of standardization but I also want to ensure it is done in a way that does not harm the quality of care for our veterans, of course.

Can I start again with you, Dr. Scavella? In addition to seeking public comments through the Federal Register, what other steps does the VA plan on taking to ensure veterans see improved health outcomes with these standards?

Dr. SCAVELLA. Thank you for that question.

One of the very nice things about the Department of Veterans Affairs is that we have lots of data. We can look at healthcare outcomes and compare and contrast the care that our veterans are receiving. We obviously can look at the quality of the care being provided by different clinicians by focusing on the work that they are doing, work they have done in the past, and make sure that we are rightsizing and only allowing those with the skills, education, and training to perform those duties.

Mr. SASLO. I would like to also add that one of the things that we recognize as part of the National Standards of Practice is that we have an obligation to look at the future state. As we roll out those National Standards of Practice as they are finalized, one of our goals in VHA is to look at the quality of the data, the outcomes to make sure that what we are doing continues to have ongoing oversight. The national standards have to be reviewed and renewed or updated every 5 years at a minimum. One of our goals is that should those standards need to be changed sooner because we identify opportunities or changes in practice across multiple states, we want to be able to have that ability to look at them up front and be able to address them sooner rather than later.

Ms. BUDZINSKI. Thank you. I yield back.

Ms. MILLER-MEEKS. Thank you.

The chair now recognizes Dr. Murphy for 5 minutes.

Mr. MURPHY. Thank you, Madam Chair. Thank you guys all for coming. I just want to say from the bottom of my heart as a physician and a Member of Congress, I have a very, very large contingent of veterans in our district. I deeply appreciate your compassion and care for those who have severed our country so well.

Just a few questions. I gave kind of my thoughts about the scope of practice and the creep of the scope of practice because everybody wants to do what everybody did before and vice versa. It just gets in this absolute maelstrom of what is happening.

Just a side note, Dr. Scavella, do you have anything to do with the electronic medical record (EMR)? We had a hearing last week and it did not go well. Everybody was very disappointed in the EMR that is going on with the VA system.

Dr. SCAVELLA. No, sir. That is not in my portfolio.

Mr. MURPHY. Bless you. I think you are very lucky for that. It spoke to me when you said we have data that confirms this, that, and the other stuff. That was one of the purposes of the EMR is

to cull data. If you do not have a functional one I do not know how you cull data really.

I just want to kind of ask a question. Dr. Scavella, you noted that the VA has a plan not to move away from the team-based model. If that is the case then tell me how you plan the role of the physician in that if it is team based? How does that work?

Dr. SCAVELLA. Thank you for that question.

In VA at times there may be different members of the team who may be the lead of the team. We believe that the team-based model is important. The majority of the time it is a physician-led team but there could be times where the physician may not be part of that team. We are being broad with that terminology to make sure that we are able to be agile with the care we are providing.

Mr. MURPHY. Yes.

Dr. SCAVELLA. If there is something that requires a physician, a physician. We want to make sure that we leave ourselves some room for that.

Mr. MURPHY. Sure. All right. Well, thank you.

I agree with you completely. A physician does not have to be at everything all the time. The bottom line is we want to take good care of our veterans. I mean, I think that is, absolutely everybody agrees in the room. I said this before, and I will say it again. That is the bottom line.

Can you describe to me what the problem is that is trying to be solved?

Dr. SCAVELLA. Yes, sir. Thank you for that question as well.

We want to make sure that if we have veterans who are entering our system in locations where we may not have the full complement of a team, that those people who are trained and competent in the needs of that patient, that they are able to provide that care.

Mr. MURPHY. Okay.

Dr. SCAVELLA. That is the ultimate.

Mr. MURPHY. Sure. Sure. I understand that completely.

Where does Community Care fit in with that? I take care of VA patients. When I was running a practice we were part of the Community Care system. You know, I have a VA clinic that is literally 800 yards from the main medical center.

Where does Community Care fit in that model? My question really centers around are you going to send somebody out in the community that already has established scope of practice, residency physician that has a fully recognized, fully established expertise in that field? Or are we going to just try to keep them within the VA where their expertise and their scope of practice is not uniform satisfied within the country?

Dr. SCAVELLA. To answer the question related to how we are going to use Community Care, if we place a referral, our intent is always to see what our availability is within our system. We need to look at both the time length for the appointment between the time desired and the time necessary for the patient to be seen, as well as how far they may need to travel for that care.

There are two different decision points when it comes to looking at how we get patients seen within our system or within the com-

munity. Those have to be evaluated each time to make sure that we are providing that care.

We also use the technology that we have existing currently to determine if we are able to provide that care face to face or virtual if appropriate. Those are also factored into our decisions related to making referrals, and we want to make sure that we are doing what is best for the veteran.

Mr. MURPHY. Okay. Again, we want the best care for the veteran regardless of really what that looks like. In the world of telehealth, in the world of Community Care, I do not think we need to degrade the care of our veterans in the term of "access." I live in a very rural area, very rural. We do not need to do that.

I get concerned, and I will just kind of say this for the record. Actually, I probably will not. Thank you. I will be quiet. Thank you all.

Ms. MILLER-MEEKS. Thank you, Dr. Murphy.

The chair now recognizes Representative Landsman for 5 minutes.

Mr. LANDSMAN. Thank you, Madam Chair.

I want to thank Dr. Murphy for his comments about the commitment and what you all do for veterans. Oftentimes, we overlook that in hearings where we want to get into the work, which is obviously really important, but I really appreciated the fact that that is something we all believe which is how hard you all work and why that matters so much.

Just two questions and then I will let you all answer them as you see fit. One is on the listening sessions. Just sort of next steps, what to expect, what we should be looking out for. Will there be more? What do you hope to achieve and really just what are the next steps there?

The second question has to do with this larger point about making sure veterans get the best care possible, which is obviously the goal that we all share. We have competing thoughts; right? Folks from different communities are weighing in. Bringing them together to think through this seems pretty important to me. I know that has been brought up, but you know, thoughts on that. How that works? How has that not worked? You know, getting them in a room to say, okay, you know, we all share the same goal of trying to provide the best possible care. How do we do this together?

Dr. SCAVELLA. Thank you for those questions.

For the first one I will start and then I will share with Mr. Kalett.

We have held four listening sessions for the National Standards of Practice. We have broken up the groups of which entities were included. Over the past 4 weeks, all on Thursdays, the last one that is currently scheduled we scheduled for this Thursday. They have been really impactful. I think eye-opening to all of us on this panel. We think the information gathered, because people have brought data, presentations and other things to us, I think that has been really important and impactful to us.

I will turn it over to Mr. Kalett for some more details on how we have done.

Mr. KALETT. Thank you. Am I on now? There we go. Sorry about that.

After the listening sessions, the final one is scheduled for Thursday. That will the CRNA one. We expect to get a lot of information as a result of that listening session. We are going to need time to digest that information. We will then publish something in the Federal Register. Notices to all the states. We have provided your staff with a detailed high level version of the process.

After we get information from the proposals where people tell us what they think we got. Hopefully, something we got right and what we did not get right. We will then have to finalize the standard, publish it, and that is not where it ends. Right?

Once we do that we are going to move to implementation. We are going to have a live link where we are hoping states will make sue of it if they notice for what ever reason during the process that they are unable to get the information to us that they felt we needed, they will do that.

I did want to also just address very quickly the why behind this because several of you have asked about that. Most professions are not going to experience a change as a result of the National Standards of Practice. That sort of leads you to ask, well, then why are you doing it? The reason we are doing it is because those professions where there are slight variances, administrative headaches that were noted as far back as the 1990's by the National Academy of Science. That is a problem for us. Things like requiring referrals. Or not allowing people to order studies. Like chiropractors cannot order imaging studies. These are the types of things. Or audiologists to dispense hearing aids. This is really the target of the NSPs. The bigger picture issues exist but they are not the prime driver for why we are doing this.

Dr. SCAVELLA. To continue to answer your second question which is related to how we can better bring together the groups, especially the opposing groups, I think our challenge has been internally within our groups, especially the two corollaries that are represented here. Between our ophthalmologist and our optometrist, internally they both align under me. I brought them together from day one. They have been part of this process. They may or may not be members of these organizations and may or not be representing the organizations in their thought processes but they have been together developing these standards from day one. Within our organization, anesthesia care, the anesthesiologists sit under me. The CRNAs sit under Dr. Saslo. From day one they have worked together to put this together. Whether they represent an internal VA professional group or one of these external entities represented today, they have been part of this process. I think our challenge remains and the fact that we are not necessarily as agile and as able to engage the presidents of organizations and to embed them in this work. We will need to work on how better to do that.

Mr. LANDSMAN. Thank you very much, all three of you. I yield back.

Ms. MILLER-MEEKS. The chair now recognizes Representative Van Orden for 5 minutes.

Mr. VAN ORDEN. Thank you, Madam Chair.

Apparently, discretion is not the better part of valor so I would like to yield to my colleague, Mr. Murphy, as much time as he requires to say something that he will later regret.

Ms. MILLER-MEEKS. The chair now recognizes Mr. Murphy.

Mr. MURPHY. Not at all. I only open my mouth to change feet.

I will just say this very quickly. Right now in the state of California, three nurse practitioners are suing the state so that when they interview their patients they can be called doctor. It is very confusing, and this is one of my major concerns about scope creep as it is. I do not think that is fair. I do not think it is right. I think it is inaccurate and I honestly do not think most nurse practitioners would agree with them. That said, it is just something that I think we have to be wary about of marching up the stream when there is so much of this scope creep. This really concerns me. I do not think that is accurate. I do not think it is fair. There is a difference between being a doctor and having a doctorate. Thank you.

With that I will yield back.

Ms. MILLER-MEEKS. The chair now recognizes Representative Van Orden for the remainder of his time.

Mr. VAN ORDEN. Thank you, ma'am.

Mr., it is Kalett; is that correct?

Mr. KALETT. Yes, sir.

Mr. VAN ORDEN. First of all, thank you very much for coming. Dr. Saslo and Scavella. It is interesting that Dr. Murphy and I are both struggling to read your names and we are talking about optometrists.

Are there plans in place, and this is across the board, are there plans in place for in extremis situations? Some of us are from the Midwest, including the chairwoman. Suppose there is a snowstorm or a blizzard and the anesthesiologist cannot get to the hospital. Is that veteran going to be able to get medical care promptly?

Dr. SCAVELLA. Thank you for that question.

Our goal is to make sure that we are there to provide the care wherever a veteran may come into the system. Whether there is a snowstorm or not. Perhaps I misunderstood your question.

Mr. VAN ORDEN. Well, ma'am, I live in a very rural area. We may only have one of the healthcare providers that are going to meet your national standard of care. I am just going to say that right now. It is going to happen. If we have one anesthesiologist who gets snowed into their house or drive off the road and in a ditch in a blizzard—it happens every winter—will the veteran that is at the hospital waiting for surgery be able to get that care in a timely manner?

Dr. SCAVELLA. I will yield to Dr. Saslo.

Mr. SASLO. I think it is important to recognize that whether it is a snowstorm, or a hurricane, or an earthquake, one of the things that we try to make sure facilities recognize is how they prepare their staffing models in order to be able to meet the demands of the veterans when they are coming in. Should those types of events occur, how do we make sure that we are maximizing the care delivery to that veteran. It really will be dependent upon the facility to prepare the right model in order to make sure that they are meeting the needs regardless of the issues that arise.

Mr. VAN ORDEN. Well, I understand that, sir. You know, rocks are heavy, trees are made of wood, and gravity is real. We have got one anesthesiologist. If there is a qualified nurse anesthetist who is on station and the anesthesiologist is in a ditch, will he or

she be able to give the appropriate medical care to that veteran in a timely manner? It is a very, very simple questions.

Dr. SCAVELLA. Yes. It depends. Unfortunately, it does depend. If the one sole anesthesia provider that is available is not capable of providing the care that is provided it would not be something that we would want to see. We would want to make sure that that veteran is receiving the appropriate care from a clinician that can provide it. In those instances it may be a matter of delaying the procedure. If it is elective, it may be a matter of sending him to another facility where there is the appropriate care that could be provided. It could be a matter of waiting if it is elective. If it is an emergency there is a different situation.

Mr. VAN ORDEN. Doctor.

Dr. SCAVELLA. Yes.

Mr. VAN ORDEN. Ma'am, may I ask where you are from?

Dr. SCAVELLA. I grew up in Chicago, Illinois.

Mr. VAN ORDEN. Okay. You have been in a blizzard.

Dr. SCAVELLA. Correct.

Mr. VAN ORDEN. Okay. I want my hair to grow back. It is not happening.

I am asking you a real simple question. We have a qualified nurse anesthetist on station. You cannot send somebody to another facility because there is not one where I live. Or it is 60 miles away and it is 35 degrees below zero and you are in a snowstorm. You physically cannot move. You have got a patient and a qualified nurse anesthetist on station. The anesthesiologist is in a ditch. Will that man or woman who is qualified as a nurse anesthetist be able to provide adequate healthcare, excuse me, timely healthcare to that veteran, yes or no?

Dr. SCAVELLA. Congressman Van Orden, your key word is "qualified." If that entity is qualified——

Mr. VAN ORDEN. Back it up. Sorry, go ahead?

Dr. SCAVELLA. If that person is qualified to provide the care that is being requested and needed then that person would be able to provide that.

Mr. VAN ORDEN. A qualified nurse anesthetist will be able to administer anesthesia to a veteran in extremis without direct supervision, or supervision, even a phone call because someone is still at work, in extremis?

Dr. SCAVELLA. Again it depends on the care that is being provided and it would be a case by case basis. Sorry that I do not have a better answer but to give a blanket authorization to provide care just because you have a body does not necessarily mean that you can. The same thing for an anesthesiologist or a physician.

Mr. VAN ORDEN. Yes, ma'am. I understand that.

My time is expired. I want to say one more thing. I believe that this model may be too rigid and there must be things written in here to provide for that exact scenario, because it is going to happen in Dr. Miller-Meeks' district just as mine.

Thank you. I yield back.

Ms. MILLER-MEEKS. Thank you, Representative Van Orden.

The chair now recognizes Representative Scott if he wishes to have questions for 5 minutes.

Mr. SCOTT. Yes, I would. Thank you very much once again, Chairwoman Miller-Meeks and Ranking Member Brownley for your kindness in allowing me to be a part of this.

Ladies and gentlemen, we are at a very critical moment in time in our Nation's history. The way we care and express publicly about our thoughts, our feelings, for two groups. One group is our veterans. No other group is having the massive suicide rates as our veterans. A large percentage of those suicides come from inadequate healthcare in our VA system. Now with this movement to try to now turn over the basic element of medical treatment away from the doctors of anesthesiology to the nurses. Think about that.

The other group are our law enforcement who put their lives on the line. Both groups out there willing to pay the ultimate sacrifice for our protection and our growth. They are worried about what we are discussing here today, their healthcare.

Now, I want to direct my questions this time to both Dr. Scavella. I hope I got that right. Dr. Saslo. If you could answer these questions.

The VA's previous process was transparent and it included all stakeholders. It resulted in the right decisions for our veterans. However, this current process lacks any transparency. A small work group has been tasked with working on this proposal all behind closed doors.

My question to you is this. Why is this process so secretive?

Dr. SCAVELLA. Thank you for the question, Congressman Scott.

We have been including our individual specialists in the area of each of the 51 occupations on the working group. We have been engaged with stakeholders since 2021 related to this specific work.

Mr. SCOTT. Well, let me ask you this. What assurances do we have that the work group includes subject matter expertise from all key stakeholders, including front line VA anesthesiologists?

Dr. SCAVELLA. Thank you for that question as well.

We have included our frontline anesthesiologists and CRNAs as well as other advanced practice nurses and physicians specifically for the work that is beginning for the National Standards of Practice related to anesthesia care.

Mr. SCOTT. Well, let me ask you this. Can you and Dr. Scavella I believe. Did I get that right?

Mr. SASLO. I am Dr. Saslo but that is all right.

Mr. SCOTT. I do not, okay, I do not want your colleague to have to be by herself in answering these. This is important. The eyes of the Nation are on us and finally we are dealing with this issue of veterans.

Answer me. Can you list, either of you, who currently serves on the work group?

Mr. SASLO. Thank you for the questions.

I think it is really important to recognize that with each of the different 51 professions that we are working with we have multiple professions within that group that are sitting on those workgroups. We also go back to those workgroups as they are developing because the concept of it as a small workgroup is not necessarily as accurate as it might sound. The larger workgroups of those particular professions are the ones responsible to come in and work with us to identify what opportunities for standardization exist

amongst each of the professions. We hope that it is a much bigger participation than what you may have already been alluding to. Thank you.

Mr. SCOTT. Well, my time is up. Once again, thank you very much. I appreciate this.

We have a bill going forward to make sure we keep our anesthesiologists as the primary source for treatment in this area. I appreciate you all having me as a guest. Thank you very much. Thanks to the panel.

Ms. MILLER-MEEKS. Thank you, Representative Scott.

The chair now recognizes herself for 5 minutes.

The reason we are having this hearing is actually because of comments that you have made, Dr. Scavella. We are having this hearing because multiple groups approached members of HVAC with complaints that National Practice Standards were being developed and they did not have access, nor were they communicated. Not in email, not in phone calls, not in meetings. We had a roundtable in April as Ranking Member Brownley mentioned and we found further at that roundtable that Allied Health professionals are nonphysician health professionals. To be clear, I do not consider an optometrist a physician. I will ask a question about that in a moment. However, we found that nonphysician groups had great access to the VA but physician groups did not. You specifically defended yourself by saying "within our organization."

Let me just say, when you are an employee of an organization, which I have been, both in my 24 years in the military and as a physician-employee of a hospital, and as a nurse of a hospital, you are sometimes muted in your responses because you are talking to your employer. If you feel your employer wants to go down a certain track or pathway, you may not relay your true concerns or feelings.

The other thing that I would like to mention is something I think that gets confused. It is often brought up in scope of practice issues within states and state government, is that often the rationale for expanding scope of practice is so individuals get care in rural areas.

As we found when Oklahoma passed their laser law for optometrists, looking at Centers for Medicare and Medicaid Services (CMS) data, the majority of laser procedures were guess what? They were not performed in rural areas. They were performed in the metropolitan areas of Tulsa and Oklahoma City. That exists to this day.

Can you tell me how many VA hospitals are located in rural areas? How many are in rural areas?

Dr. SCAVELLA. Chairwoman Miller-Meeks. Thank you for the question. I would actually have to look at a map and count. I do not have a breakdown of those that are specifically in those locations.

Ms. MILLER-MEEKS. They may be in rural states but in a rural areas of a state. In Iowa, our two VA hospitals are in Iowa City, where the University of Iowa is located, and in Des Moines. There are not any facilities in a rural area. There may be clinics. If, as you alluded, if you were to allow an optometrist licensed in Alaska as Dr. Barney said he is licensed in Alaska and can perform laser

procedures to then come and be located to the VA Hospital in Iowa, even though there are ophthalmologists, that optometrist would then be allowed to perform a procedure for which he is not licensed to do in Iowa. Is that correct? I think that is what you stated.

Dr. SCAVELLA. Theoretically, just like my license is transportable across the country, I can operate in any Federal location, potentially, if we were to make that decision that would be something that we would look at for quality reasons, potentially.

Ms. MILLER-MEEKS. Which is why it is tremendously concerning.

Dr. Scavella, are nonphysician providers required to identify themselves as such to veteran patients? How does the VA educate veterans as to the qualifications? When a veteran, or for that matter the public hears doctor or physician, they think that this is someone that has gone to medical school. Are you going to inform veterans that the person treating you has not gone to medical school, has not done a residency, is not board certified? In fact, to get on the insurance of most health insurance providers and Medicare, you have to be board certified or board eligible. Are CRNAs, are optometrists, are other Allied Health professionals that you may increase their scope of practice to practice in a state for which they are not licensed to do that, are they board certified and board eligible?

How is it that you intend to, number one, address what the American Legion said when they would prefer to have a physician; and how are you going to use lower educated, lower trained providers in lieu of having someone go out into a community for care when there is a provider that is a physician provider in that community?

Dr. SCAVELLA. Thank you for that question.

We would always want to make sure we were providing the highest quality care for the veteran and the needs the veteran was having at that time.

Related to how clinicians identify themselves to veterans, it is our understanding that they introduce themselves, explain where they are as part of the care team.

Ms. MILLER-MEEKS. Which is exactly why we are having this hearing and exactly why as a nurse married to a nurse, as a doctor, as a veteran, I am concerned about the secrecy. Thank you, Representative Scott. The secrecy of the VA in going through this procedure. Their lack of engagement with other groups and other providers until you have an open comment.

I know that you are having listening sessions. I thank you for doing that but I would say that my concerns have not been allayed that we will be providing our veterans the highest quality care by care teams led by physicians, and that patients know whether or not a physician is delivering care or another individual of other education and training as knowledgeable as those individuals may be. I have great respect for everyone in the healthcare profession but I am very concerned about what is going on.

The chair would recognize Ranking Member Brownley for any closing remarks.

Ms. BROWNLEY. Thank you, Madam Chair.

I will say I served in the California legislature and whenever there was a Committee hearing on scope of practice and licensing

you always knew it because there were crowds of people outside of the hearing room that could not get into the hearing room. There was a lot of debate going on outside of the hearing room. I know that these are very, very difficult. Very, very difficult issues to settle on.

I will say that based on this hearing I feel as though we are getting closer to better clarity from the VA on whether a team-based model of care means a physician-led team-based model of care.

I think the answer from the VA was most of the time. Most of the time it will be a physician-led model of care.

I will say in regards to that when we compare the VA to those hospitals outside of the VA that is not their model of care. I do not want to give up quality under any circumstance. I think we heard also today that even in rural hospitals, and I think Dr. Miller makes his point of there are no hospitals in rural areas is a very good one. Even in those rural hospitals, if they are there we have been told that it is always a physician-led care team. It might not be the anesthesiologist. It might not be the ophthalmologist. It is a physician-led team.

I do not want to give up quality, and I do not want to be less than what other hospitals are doing outside of the VA.

I will say again what I said in my opening comments and that is to why the VA is doing this initiative when at the end of the day the medical professionals at each medical centers will ultimately make these decisions.

Now, the VA said we still have to settle some of these discrepancies between different practices. At the end of the day it is still going to be the medical centers and the professionals they are in who will ultimately make final decisions on who will be performing what and scope of practice.

The VA has also said we need more agility. I understand that. Even when the VA provided more flexibility of scope of practice during COVID, the VA has told me unequivocally that the practices and protocols never changed regardless of the emergency. Even when they were given that ability to be more agile it was not utilized. I have to assume that those decisions were based on the quality of care.

I will just end by saying I think what other members have said on the Committee is the VA should never give up, ever give up on delivering the highest quality of health care. Our veterans have complex health issues and they should receive the highest quality of care. They should deserve no less. This is what we owe our veterans. I hope as we proceed in the process of this that we will keep the highest standard of care.

I yield back.

Ms. MILLER-MEEKS. Thank you, Ranking Member Brownley.

I would like to thank everyone for their participation in today's hearing and for the productive conversation.

I know this is a challenging topic. I have been involved in it at the state level, as well as here at the Federal level. The passion for your work and your care for veterans is evident to us in both of our panels.

I appreciate everyone's willingness to come here today and to focus on what should be our utmost priority of putting veterans first.

It is important to me and to my colleagues on both sides of the aisle that all veterans seeking care in the VA are ensured quality care that is safe and effective. I look forward to continued work on this effort to create equitable standards of practice across the VA, within the department, stakeholders and my colleagues on this Subcommittee.

I will echo again that the nature of care in rural areas when it comes to a VA hospital facility needing providers is very different than what it is within a state or a district. I would also like to say that the workforce shortage that has been mentioned, last year we passed a bill to increase the pay for nurses, nurse practitioners, PAs, and Allied professionals because there was a shortage of those. I think to proffer an idea that there is a physician shortage so we need to replace them with others would be inaccurate.

I am also going to echo a statement often made by VA officials, that the veteran population is unique. They tend to have more complex health issues with multiple comorbidities resulting in a higher risk of complications. Let us not forget that when considering policies that may have a significant impact on the care they receive. Let us also remember that we have a mission act and Community Care to address some of the issues in where veterans can receive care and in a timely fashion.

The complete written statements of today's witnesses will be entered into the hearing record.

I ask unanimous consent that all members have 5 legislative days to revise and extend their remarks and include extraneous material.

Hearing no objection, so ordered.

I thank the members and the witnesses for their attendance and participation today. This hearing is now adjourned.

[Whereupon, at 12:28 p.m., the subcommittee was adjourned.]

A P P E N D I X

PREPARED STATEMENTS OF WITNESSES

Prepared Statement of Jesse Ehrenfeld

The American Medical Association (AMA) appreciates the opportunity to submit the following statement to the U.S. House of Representatives Committee on Veterans Affairs Subcommittee on Health as part of a hearing concerning the "VA's Federal Supremacy Initiative: Putting Veterans First?" The AMA commends the Committee for focusing on this critically important issue since it is imperative that our Nation's veterans receive the best health care possible.

"The Veterans Health Administration (VHA) is the largest integrated health care system in the United States, providing care at 1,298 health care facilities, including 171 VA Medical Centers and 1,113 outpatient sites of care of varying complexity (VHA outpatient clinics) to over 9 million Veterans enrolled in the VA health care program."[1] Since the VHA is such a large health care system, the actions it takes, especially in terms of the scope of practice of its non-physician providers, could have an immense impact on health care in its entirety. National Standards of Practice developed by the VA Federal Supremacy Project would override long-established state laws governing scope of practice and health-professional licensure, and, as such, the quality of care provided to our veterans, and potentially patients across the nation, will decline if the Project is fully implemented. We therefore oppose the implementation of the Federal Supremacy Project. At the very least, we urge Congress to ensure that physician-led team-based care is maintained and that physician representation on all the Work Groups, not just the Physician Work Group, be mandatory.

The VA Federal Supremacy Project: Physician representation is necessary across all stages and Work Groups.

In November 2020, the VA published an interim final rule entitled "Authority of VA Professionals to Practice Health Care."[2] The interim final rule was issued to expand health care professionals' scope of practice "notwithstanding any State license, registration, certification, or other requirements . . . This rulemaking also confirm[ed] VA's authority to establish national standards of practice for health care professionals which will standardize a health care professional's practice in all VA medical facilities."[3] By invoking the Supremacy Clause of the Constitution to preempt state laws to develop National Standards of Practice, the VA is making it harder to oversee the practice of medicine and is potentially allowing non-physicians to perform procedures that are outside the scope of their knowledge and state licensure.

Based upon this interim final rule, the VA has begun the process of implementing National Standards of Practice for 48 health care occupations through the "Federal Supremacy Project." As noted in the rule, this Project preempts state scope of practice laws and creates a single set of practice standards for all VA-employed physicians, and separate standards for 47 other non-physician health care professionals. The VA has already closed the comment period for Blind Rehabilitation Specialists, Ophthalmology Technicians, Kinesiotherapists, Therapeutic Medical Physicists, Registered Dietitian Nutritionists, Orthotists, Prosthetists, and Prosthetist-Orthotists, Histopathology Technologists, and Cytotechnologists.[4] Moreover, comment periods are currently open for Art Therapists, Dance/Movement Therapists, Drama Therapists, Music Therapists, and Recreation Therapists and close on September 26, 2023. Finally, the VA is currently hosting five listening sessions to allow individuals to provide input on state variances for health care occupations for the occupations

[1] https://www.va.gov/health/aboutvha.asp#:~:textThe%20Veterans%20Health%20Administration %20(VHA,Veterans %20enrolled %20in %20the %20VA.

[2] https://www.federalregister.gov/documents/2020/11/12/2020–24817/authority-of-va-professionals-to-practice-health-care#p–65.

[3] *Id*.

[4] https://www.va.gov/STANDARDSOFPRACTICE/providing-feedback.asp.

that have not yet had their feedback period closed, including Optometrists, Nurse Practitioners, Physician Assistants, and Pharmacists.[5]

Physician-led, team-based care is the gold standard of health care and the predominant model of care for many, if not most, of these occupations across the country. As such, due to the physician's unique role as head of the care team, it is important that physician input is received and implemented within the Project as early as possible. Importantly, physician representation on all the Work Groups, not just the Physician Work Group, should be mandatory since it could help to counter internal and external resistance when National Standards of Practice are published in the Federal Register for comment and help to ensure that these standards are accurate and built to help enforce team-based care. Therefore, if the VA persists in moving forward with the Federal Supremacy Project, we urge the VA to require physician representation on all Work Groups and consultation with relevant physician specialty societies and other internal and external stakeholders.

Scope of Practice: Physicians should be the head of the care team to ensure the highest quality care for our nation's veterans.

Should the VA move forward with the Federal Supremacy Project, the AMA is concerned that the National Standards of Practice for non-physician providers developed by the Project may not accurately reflect the skills acquired through the education and training of such occupations and may allow non-physicians to provide services and perform procedures that are outside the scope of their knowledge and licensure. The AMA strongly supports the team approach to patient care, with each member of the team playing a clearly defined role as determined by his or her education and training. While we greatly value the contribution of all non-physicians, no other health care professionals come close to the education and training that physicians receive.

With more than 12,000 hours of clinical experience, physicians are uniquely qualified to lead health care teams. Non-physicians such as physician assistants, nurse anesthetists, pharmacists, and optometrists do not have the same rigorous and comprehensive education as physicians. For example, physician assistant programs are two years in length, require 2,000 hours of clinical care, and have no residency requirement.[6] Similarly, nurse anesthetists complete only two-to-three years of graduate level education and have no residency requirement. Pharmacists are trained as experts in medication management but have very limited direct patient care experience and are not trained to independently diagnose and treat patients. Students of optometry rarely complete postgraduate education and are trained in primary eye care. They are not exposed to standard surgical procedure, aseptic surgical technique, or medical response to adverse surgical events. In short, the educational programs undergone by non-physicians do not prepare them to develop clinical judgment or skills similar to a physician. For this reason, physicians and non-physicians are not interchangeable on a care team.

But it is more than just the vast difference in hours of education and training, it is also the difference in rigor, standardization, and comprehensiveness of medical school and residency programs, compared to other non-physician programs. To be recognized as a physician with an unlimited medical license, medical students' education must prepare them to enter any field of graduate medical education. During medical school, students receive a comprehensive education in the classroom and in laboratories, where they study the biological, chemical, pharmacological, physiological, and behavioral aspects of the human condition. This period of intense study is supplemented by two years of patient care rotations through different specialties, during which medical students assist licensed physicians in the care of patients. During clinical rotations, medical students continue to develop their clinical judgment and medical decision-making skills through direct experience managing patients in all aspects of medicine. Following graduation, students must then pass a series of examinations to assess a physician's readiness for licensure. At this point, medical students "match" into a three-to-seven-year residency program during which they provide care in a select surgical or medical specialty under the supervision of experienced physician faculty. As resident physicians gain experience and demonstrate growth in their ability to care for patients, they are given greater responsibility and independence. This level of education and training is necessary to develop the acumen required for the independent practice of medicine, including di-

[5] https://www.federalregister.gov/documents/2023/08/14/2023–17309/announcement-of-public-listening-sessions-to-inform-vas-standards-of-practice.

[6] https://www.ama-assn.org/system/files?file=corp/media-browser/premium/arc/ama-issue-brief-independentnursingpractice.pdf.

agnosing and treating patients, performing eye surgery and administering anesthesia.

There is deep concern that the VA removing scope of practice safeguards will allow for non-physician practitioners who have not been adequately trained to provide medical care or perform procedures that are outside the scope of their expertise and licensure, ultimately leading to a lower standard of care for veterans. Veterans are an extremely complex patient population. Consequently, our veterans deserve better—they deserve and have a right to have physicians leading their health care team.

Increased Cost and Decreased Quality: Increasing non-physician practitioners' scope of practice within the VHA increases cost and decreases the quality of health care.

There is strong evidence that increasing the scope of practice of non-physicians in the VA results in higher costs and worse outcomes for veterans' health care. For example, a high-quality study published as a working paper by the *National Bureau of Economic Research* in 2022 compared the productivity of nurse practitioners and physicians (MDs/DOs) practicing in the emergency department using Veterans Health Administration data. The study found that nurse practitioners use more resources and achieve worse health outcomes than physicians. Nurse practitioners ordered more tests and formal consults than physicians and were more likely than physicians to seek information from external sources such as X-rays and CT scans.[7] They also saw worse health outcomes, raising 30-day preventable hospitalizations by 20 percent, and increasing length of stay in the emergency department. Altogether, nurse practitioners practicing independently increased health care costs by $66 per emergency department visit.[8] The study found that these productivity differences make nurse practitioners more costly than physicians to employ, even accounting for differences in salary.[9] The authors estimate that continuing to use the current staffing allocation of nurse practitioners in the emergency department results in a **net cost of $74 million per year**, compared to staffing the emergency department with only physicians. Not only does the increased resource use by nurse practitioners result in increased costs and longer lengths of stay, but it also means patients undergo unnecessary tests, procedures, and hospital admissions.

This study is a uniquely high-quality study within this body of literature because it measures nurse practitioners working within the VHA system during a time when nurse practitioners were authorized to practice without physician supervision. It also uses a high-quality causal analysis. While the VA national standards of practice do not include nurse practitioners, this study is informative as the VA considers expanding the scope of practice of other non-physician practitioners, including physician assistants. In short, education and training matters. The authors note that these findings may reflect poorer decision-making by nurse practitioners based on their lower level of skill compared to physicians—causing them to seek additional sources of information. While it is appropriate for nurse practitioners to seek additional information when they are unsure or unable to make a differential diagnosis and determine the appropriate course of treatment, this path results in increased costs to the system and worse patient outcomes, ultimately a lower quality of care for veterans.

These findings are consistent with other studies as well, including a recent study from the Hattiesburg Clinic in Mississippi which found that allowing physician assistants and nurse practitioners to function with independent patient panels in the primary care setting resulted in higher costs, higher utilization of services, and lower quality of care compared to panels of patients with a primary care physician. Specifically, the study found that non-nursing home Medicare ACO patient spend was $43 higher per member, per month for patients on a nurse practitioner/physician assistant panel compared to those with a primary care physician. Similarly, patients with a nurse practitioner/physician assistant as their primary care provider were 1.8 percent more likely to visit the ER and had an eight-percent higher referral rate to specialists despite being younger and healthier than the cohort of patients in the primary care physician panel. On quality of care, the researchers examined 10 quality measures and found that physicians performed better on nine of the 10 measures compared to the non-physicians.

Other studies further suggest that physician assistants and nurse practitioners tend to overprescribe and overutilize diagnostic imaging and other services, contrib-

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[7] *Productivity of Professions: Lessons from the Emergency Department*, Chan, David C. and Chen, Yiqun, NBER, Oct. 2022.

[8] *Id.*

[9] *Id.*

uting to higher health care costs. For example, a 2020 study published in the *Journal of General Internal Medicine* found 3.8 percent of physicians (MDs/DOs), compared to 8 percent of nurse practitioners and 9.8 percent of physician assistants met at least one definition of overprescribing opioids and 1.3 percent of physicians compared to 8.4 percent of physician assistants and 6.3 percent of nurse practitioners prescribed an opioid to at least 50 percent of patients.[10] The study further found that, in states that allow independent prescribing, nurse practitioners and physician assistants were 20 times more likely to overprescribe opioids than those in prescription-restricted states.[11]

Multiple studies have also found that physician assistants and nurse practitioners tend to prescribe unnecessary antibiotics.[12] A study in *Infection Control & Hospital Epidemiology* which examined prescribing data for patients with common upper respiratory infection that should not require antibiotics and found that adults seen by nurse practitioners or physician assistants were 15 percent more likely to receive an antibiotic compared to those patients seen by a physician. Similar rates were found for pediatric patients.[13] Unnecessary antibiotic prescribing leads to antibiotic resistance which can have negative impact on a patient's future ability to fight infection.

Multiple studies have also shown that physician assistants and nurse practitioners order more diagnostic imaging than physicians, which increases health care costs and threatens patient safety by exposing patients to unnecessary radiation. For example, a study in the *Journal of the American College of Radiology*, which analyzed skeletal X-ray utilization for Medicare beneficiaries from 2003 to 2015, found ordering increased substantially—more than 400 percent—by non-physicians, primarily nurse practitioners and physician assistants, during this timeframe.[14] A separate study published in *JAMA Internal Medicine* found that physician assistants and nurse practitioners ordered more diagnostic imaging than primary care physicians following an outpatient visit. The study controlled for imaging claims that occurred after a referral to a specialist.[15] The authors opined this increased utilization may have important ramifications on costs, safety, and quality of care. They further found greater coordination in health care teams may produce better outcomes than merely expanding physician assistant or nurse practitioner scope of practice.

The findings are clear: nurse practitioners and physician assistants tend to prescribe more opioids than physicians, order more diagnostic imaging than physicians, and overprescribe antibiotics[16]—all which increase health care costs and threaten patient safety.

Finally, it is important to ensure that certified registered nurse anesthetists are properly overseen. There is no literature to support the safety of eliminating physician clinical oversight of anesthesia. To the contrary, independent literature points to the risk to patients of anesthesia without appropriate physician clinical oversight. For example, a study from *Anesthesiology*, found that patients having general or orthopedic surgery were eight percent more likely to die if anesthesia was not provided by a physician anesthesiologist.[17] An additional study from the *Journal of Clinical Anesthesia* found that patients that had their anesthesia solely provided by a nurse anesthetist rather than a physician anesthesiologist were 80 percent more

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[10] MJ Lozada, MA Raji, JS Goodwin, YF Kuo, "Opioid Prescribing by Primary Care Providers: A Cross-Sectional Analysis of Nurse Practitioner, Physician Assistant, and Physician Prescribing Patterns." Journal General Internal Medicine. 2020; 35(9):2584–2592.

[11] *Id*.

[12] Sanchez GV, Hersh AL, Shapiro DJ, et al. Brief Report: Outpatient Antibiotic Prescribing Among United States Nurse Practitioners and Physician Assistants. *Open Forum Infectious Diseases*. 2016:1–4. Grijalva CG, Nuorti JP, Griffin MR. Antibiotic prescription rates for acute respiratory tract infections in US ambulatory settings. *JAMA* 2009; 302:758–66.

[13] Schmidt ML, Spencer MD, Davidson LE. Patient, Provider, and Practice Characteristics Associated with Inappropriate Antimicrobial Prescribing in Ambulatory Practices. *Infection Control & Hospital Epidemiology*. 2018:1–9.

[14] D.J. Mizrahi, et.al. "National Trends in the Utilization of Skeletal Radiography," Journal of the American College of Radiology 2018; 1408–1414.

[15] D.R. Hughes, et al., A Comparison of Diagnostic Imaging Ordering Patterns Between Advanced Practice Clinicians and Primary Care Physicians Following Office-Based Evaluation and Management Visits. JAMA Internal Med. 2014;175(1):101–07.

[16] Sanchez GV, Hersh AL, Shapiro DJ, et al. Brief Report: Outpatient Antibiotic Prescribing Among United States Nurse Practitioners and Physician Assistants. Open Forum Infectious Diseases. 2016:1–4. Schmidt ML, Spencer MD, Davidson LE. Patient, Provider, and Practice Characteristics Associated with Inappropriate Antimicrobial Prescribing in Ambulatory Practices. Infection Control & Hospital Epidemiology. 2018:1–9.

[17] Silber JH, Kennedy SK, Even-Shoshan O, et al. Anesthesiologist direction and patient outcomes. *Anesthesiology*. 2000;93(1):152–163. doi:10.1097/00000542–200007000–00026.

likely to have an unexpected disposition (admission to the hospital or death).[18] Furthermore, a study from *VA Evidence Synthesis Program Evidence Briefs*, found that after the VA reviewed its own research resources, the VA's Quality Enhancement Research Initiative concluded that there was no evidence to support the safe implementation of nurse-only models of anesthesia for the VA especially for complex surgeries and in small or isolated VA hospitals.[19] Last, multiple studies have found that when states choose to remove the Medicare physician supervision requirement for nurse anesthetists there is no evidence that access to care increases.[20]

Nurse practitioners, nurse anesthetists, and physician assistants are integral members of the care team, but the skills and acumen obtained by physicians throughout their extensive education and training make them uniquely qualified to oversee and supervise patients' care. Physician-led team-based care has a proven track record of success in improving the quality of patient care, reducing costs, and allowing all health care professionals to spend more time with their patients. We urge Congress to invest in the proven track record of physician-led team-based care.

Patients Want Physicians: Patients have consistently stated that they want a physician as the head of their care team.

In developing National Standards of Practice, patient sentiment should be considered and support for physician-led teams should be enhanced. Based on a series of nationwide surveys, patients overwhelmingly want physicians to lead their health care team. Four out of five patients want a physician leading their health care team and 95 percent believe it is important for physicians to be involved in their medical diagnoses and treatment decisions (68 percent said it is very important). Moreover, only 3 percent of U.S. voters said it was not important to have physicians involved in specific treatments such as anesthesia, surgery, and other invasive procedures.[21] Patients understand the value that physicians bring to the health care team and expect to have access to a physician to ensure that their care is of the highest quality. As such, developing National Standards of Practice that will potentially remove physicians from many veterans' health care teams goes against what patients want, which will decrease the quality of care received, patient confidence, and the effectiveness of the VHA.

State Based Licensure: The Federal Supremacy Project undermines state licensing boards and will further encourage inadequate oversight of non-physician practitioners within the VA.

State licensing boards play an important role in ensuring that medical care is properly administered and that providers are disciplined when malpractice is committed. Such laws are often the result of extensive debate by state legislatures, sometimes spanning several years and involving negotiations among all stakeholders. However, the VA's decision to circumvent state scope of practice laws and regulations through the Federal Supremacy Project will make it impossible for state boards to oversee physicians and non-physician practitioners employed by the VA, leading to unintended consequences.[22]

Unlike physicians who are supposed to have their licenses reviewed every two years by the VA, registered nurses and other non-physician practitioners within the VA are appointed for an indefinite time, meaning that their credentials are reviewed

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[18] Memtsoudis SG, Ma Y, Swamidoss CP, Edwards AM, Mazumdar M, Liguori GA. Factors influencing unexpected disposition after orthopedic ambulatory surgery. *J Clin Anesth*. 2012;24(2):89–95. doi:10.1016/j.jclinane.2011.10.002.

[19] McCleery E, Christensen V, Peterson K, Humphrey L, Helfand M. Evidence Brief: The quality of care provided by advanced practice nurses. In: *VA Evidence Synthesis Program Evidence Briefs*. Washington (DC): Department of Veterans Affairs (US); September 2014.

[20] Schneider JE, Ohsfeldt R, Li P, Miller TR, Scheibling C. Assessing the impact of state "opt-out" policy on access to and costs of surgeries and other procedures requiring anesthesia services. *Health Econ Rev*. 2017;7(1):10. doi:10.1186/s13561–017–0146–6; see also, Sun EC, Dexter F, Miller TR, Baker LC. "Opt out" and access to anesthesia care for elective and urgent surgeries among U.S. Medicare beneficiaries. *Anesthesiology*. 2017;126(3):461–471. doi:10.1097/ALN.0000000000001504; Sun E, Dexter F, Miller TR. The effect of "opt-out" regulation on access to surgical care for urgent cases in the United States: evidence from the National Inpatient Sample. *Anesth Analg*. 2016;122(6):1983–1991. doi:10.1213/ANE.0000000000001154.

[21] https://www.ama-assn.org/system/files/ama-scope-of-practice-stand-alone-polling-toplines.pdf. The survey was conducted among 1,000 U.S. voters between January 27th and February 1st, 2021. The margin of error is +/–3.5 at the 95 percent confidence interval.

[22] The vast majority of states support physician-led teams. For example, 38 states plus DC require physician supervision of physician assistants (PAs) and 11 states require PAs to practice pursuant to a collaboration agreement with a physician. Similarly, 20 states require physician involvement for nurse practitioners to diagnose, treat or prescribe and 14 more states require physician involvement for a certain number of hours or years of practice.

before they are hired and may never be reviewed again.[23] As a result, according to multiple Government Accountability Office (GAO) audits, the VA is doing an inadequate job of supervising and disciplining its non-physician practitioners. Over the past few years, the VA Office of Inspector General has reported multiple cases of quality and safety concerns regarding VA providers.[24] The issues reported range from providers lacking appropriate qualifications, to poor performance and provider misconduct.[25] Unfortunately, the VA has been deficient in putting an end to this subpar care in part, due to the fact that VA medical center officials lack the information they need to make decisions about providers' privileges due to poor VA reporting. Owing to the VA's inadequate oversight, VA medical center officials are not reviewing all of the providers for whom clinical care concerns were raised, and the VA is not taking appropriate adverse privileging actions.[26] This includes certain VA medical centers not reporting providers to the National Practitioner Data Bank (NPDB) or to state licensing boards as is required by law.[27] If the National Standards of Practice are implemented the oversight that these non-physician practitioners have will be lowered even more, leading to an increased lack of accountability for Veteran's care. Moreover, it will make it extremely difficult for state boards to oversee the practitioners that they license and will make it all but impossible to discipline VA-employed non-physician practitioners who inadequately care for Veterans. This lack of oversight means that patients' safety could easily be jeopardized, especially if the national standard for a particular provider-type differs from a state's scope of practice and licensing requirements. In these cases, it would be unclear whether the VA provider would have the necessary training, as dictated by the state licensing or medical board, to appropriately treat a patient and could potentially lead to Veterans receiving subpar care with little to no repercussions for the provider.

Since the VA already has numerous problems with quality of care, the VA should not expand its scope of practice parameters and allow non-physician practitioners to perform procedures for which they are not properly licensed or trained. By implementing the Federal Supremacy Project, the VA is making it difficult for state boards to oversee the practitioners that they license and will likely make it tougher to discipline non-physician practitioners who inadequately care for patients due to a lack of clarity about these practitioners' scope of practice. Since it has been shown that the VA is unable to adequately oversee health care providers, it is vital to rescind or restructure the Federal Supremacy Project and ensure that state licensing boards can adequately supervise their non-physician practitioners to ensure the highest quality of care for veterans.[28]

We also believe that the IFR did not meet the standards set out in Executive Order 13132 and, by extension, is in violation of the Administrative Procedure Act (APA). The IFR preempts state law by asserting that state and local scope of practice laws relating to NPPs that are employed by the VA "will have no force or effect," and that state and local governments "have no legal authority to enforce them." However, the requirements to preempt state law, set forth in Executive Order 13132, have not been met.[29] The VA did not "provide all affected state and local officials notice and an opportunity for appropriate participation in the proceedings."[30] This can be seen by the fact that the VA did not provide any time for comments and instead published the IFR on the same day the rule took effect, which gave no opportunity for any stakeholders to meaningfully participate in the proceedings.[31] As such, the VA did not follow the guidelines set out in Executive Order 13132 and "act only with the greatest caution," nor did the VA possess good cause when it bypassed the APA and acted arbitrarily and capriciously by failing to adequately consider the rights of the states and the long-term safety of our nations' Veterans.

Electronic Health Record (EHR): The VA should not be granted uniform practitioner privileging as a result of their inadequate EHR system.

In the Interim Final Rule, the VA argued that non-physician practitioners need to practice independently due to the newly created EHR which purportedly requires

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[23] https://www.gao.gov/assets/700/697173.pdf.
[24] https://www.gao.gov/assets/710/702090.pdf.
[25] *Id.*
[26] *Id.*
[27] *Id.*
[28] https://www.gao.gov/assets/700/697173.pdf.
[29] https://www.govinfo.gov/content/pkg/FR–1999–08–10/pdf/99–20729.pdf.
[30] *Id.*
[31] *Id.*

uniform privileging irrespective of where care is delivered.[32] "An electronic health record (EHR) is a digital version of a patient's paper chart. EHRs are real-time, patient-centered records that make information available instantly and securely to authorized users."[33] EHRs also provide privileging options, meaning that they will provide only a certain amount of access and authority to providers depending on their licensure. Despite multiple EHR systems across the U.S. allowing for differing levels of privileging, the VA argued that it must develop uniform standards of practice because the new EHR system, which it developed in conjunction with the Department of Defense over the course of years, requires all practitioners with the same license to have the same practice privileges. However, the VA recently announced that it will indefinitely delay the implementation of its EHR system due to multiple problems, including increased cost, and significant issues which have led to the death of multiple veterans.[34, 35] With this rationale removed from consideration, the VA should not be rewarded with a universalized privileging system for building a $10 billion EHR system that is subpar, defunct, and does not meet state scope of practice laws.[36] Moreover, if there must be uniform privileging in the VA, then instead of setting practice privileges to align with the least restrictive scope provisions, the VA should ensure that veterans are provided with the best care and adhere to the most conservative State scope requirements.

Alternate Solutions to VA Health Care Needs

The AMA understands the importance and need to have an adequately staffed health care facility. As such, we suggest that, instead of implementing the Federal Supremacy Project, additional funding is provided to the VHA to hire and train more physicians. Simultaneously, the VHA needs to accurately count all physicians providing care within its facilities, including trainees, to accurately understand where shortages exist and appropriately adjust hiring accordingly. The GAO has consistently found that the VHA is unable to accurately count the total number of physicians who provide care in its VA medical centers (VAMC) and the VA has disagreed with the recommendation of the GAO to develop and implement a process to accurately count all physicians providing care at each medical center.[37, 38]

The VA is the largest provider of health care training in the United States. "In general, each year approximately 43,000 individual physician residents receive their clinical training by rotating through about 11,000 VA-funded physician FTE residency positions at VA medical facilities."[39] However, approximately 99 percent of the VA's programs are sponsored by outside medical schools or teaching hospitals. Functionally, this limits the amount of expansion that can occur in the VA system as those who train at VA locations must still be housed under a third-party graduate medical education (GME) program with full accreditation and administrative functioning. Therefore, the VA should work to create more of its own GME residency positions as well as continue to work with medical schools to expand existing partnerships and shared training slots. A few of the ways this could be accomplished include expanding the VA Pilot Program on Graduate Medical Education and Residency[40] and expanding the number of positions available via the VA MISSION Act of 2018[41] and the Veterans Access, Choice and Accountability Act.[42] Expansions could be made through the Department of Veterans Affairs Office of Academic Affiliations to help preserve and expand GME within the VHA. The expansion of GME within the VHA has already proven to be successful in retaining physicians. For example, the annual Trainee Satisfaction Survey administered by the VA Office of Academic Affiliations to physician residents consistently finds that residents have a more positive opinion regarding a career at the VA after completing their rotations, with over half (55 percent) responding they would consider a career at a VA

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[32] https://www.federalregister.gov/documents/2020/11/12/2020–24817/authority-of-va-professionals-to-practice-health-care#p–65.

[33] https://www.healthit.gov/faq/what-electronic-health-record-ehr.

[34] https://digital.va.gov/ehr-modernization/resources/ehr-deployment-schedule/; https://subscriber.politicopro.com/article/2023/04/vas-new-health-records-system-contributed-to–4-deaths–00090830?source=email.

[35] https://digital.va.gov/ehr-modernization/resources/ehr-deployment-schedule/.

[36] https://www.gao.gov/assets/710/700478.pdf.

[37] https://www.gao.gov/products/gao–18–124#summary__recommend.

[38] https://www.gao.gov/assets/gao–22–105630.pdf.

[39] https://sgp.fas.org/crs/misc/R44376.pdf.

[40] https://www.federalregister.gov/documents/2022/02/04/2022–02292/va-pilot-program-on-graduate-medical-education-and-residency.

[41] https://www.govinfo.gov/content/pkg/COMPS–15905/pdf/COMPS–15905.pdf.

[42] https://www.govinfo.gov/content/pkg/COMPS–15905/pdf/COMPS–15905.pdf.

medical center.[43] If the full funding for the direct and indirect costs of GME positions was expanded within the VA more physicians would be able to work within the VA, which would decrease existing shortages while providing high quality care for veterans.

For the first time in years the staffing shortages within the VHA have intensified, resulting in a 22 percent increase in occupational staffing shortages in 2022 compared to 2021.[44] Some of the professions with the severest shortages within the VHA include psychiatrists, primary care physicians, and gastroenterologists.[45] As such, another potential solution to the physician shortage is to hire more physicians and provide additional benefits to physicians working within the VA to help with retention.

Within the VHA, physician salaries are determined according to a combination of base pay, market pay, and performance pay. Moreover, under 38 U.S.C. 7431(e)(1)(A),[46] every two years the Secretary must prescribe for Department-wide applicability the minimum and maximum amounts of VHA physicians annual pay.[47] Therefore, under this statue, it would be possible to increase the pay offered to physicians within the VHA which would help with recruitment and retention. Furthermore, the VA should enhance its loan forgiveness and scholarship efforts to further incentivize physician recruiting and retention and improve patient access in the Veterans Administration facilities.

Additionally, ensuring that all physician specialties are direct hires and streamlining the hiring process in general will help with the efficient and timely staffing of physicians. The hiring process for international medical graduates (IMG) should also be streamlined, including providing/expanding the exception to the two-year home country return requirement if an IMG works for the VHA for a designated period of time. The VA states for all its jobs that the hiring process "may take a while." In line with this, 94 percent of respondents to a survey about VA hiring stated that they had lost an interested candidate due to delays in the HR hiring process.[48] As such, changes need to be made to the hiring and onboarding process so that good candidates are not lost to other jobs.

Finally, increasing access to the Community Care program when physician employment gaps cannot be filled will help to ensure that veterans continue to receive the care they need and increase access to physician services. However, the implementation of this program must be improved, including resolving delays in payment to participating providers. For example, a 225-bed health care system in South Carolina had $22.7 million in outstanding VA claims at the beginning of FY 2022 with $16.7M (83 percent) over 90 days due. On top of this, the health care system had to write off approximately $12.7M during FY 22 because the VA claims were over 300 days old. As such, increasing reliability of payment for services rendered as part of the Community Care program and increasing the number of physicians and other health care professionals who are part of the program could help to fill workforce gaps.

In line with this, the VHA should pay private physicians a minimum of 100 percent of Medicare rates for visits and approved procedures to ensure adequate access to care and choice of physician and ensure that clean claims submitted electronically to the VA are paid within 14 days and that clean paper claims are paid within 30 days. This would increase the willingness and variety of providers who would care for our veterans.

Conclusion

Our nation's veterans should be provided with physician-led health care teams that consider important scope of practice limitations and make the most of the respective education and training of physicians and non-physician practitioners. Therefore, we oppose the implementation of the VA Federal Supremacy Project. Instead, additional investments in physicians and physician-led team-based care should be made to ensure that veterans receive the care they deserve. At the very least, we urge Congress to ensure that physician-led team-based care is maintained and that physician representation on all the Work Groups, not just the Physician Work Group, be mandatory.

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[43] https://journals.lww.com/academicmedicine/Fulltext/2022/08000/Veterans__Affairs__Graduate__Medical__Eduction.37.aspx.

[44] https://www.va.gov/oig/pubs/VAOIG–22–00722–187.pdf.

[45] https://www.va.gov/oig/pubs/VAOIG–22–00722–187.pdf.

[46] https://www.govinfo.gov/content/pkg/USCODE–2018-title38/html/USCODE–2018-title38-partV-chap74-subchapIII-sec7431.htm.

[47] https://www.federalregister.gov/documents/2019/12/09/2019–26435/annual-pay-ranges-for-physicians-dentists-and-podiatrists-of-the-veterans-health-administration-vha.

[48] https://www.afge.org/globalassets/documents/generalreports/2023/03/vhpireport__v2.pdf.

Prepared Statement of Paul Barney

AMERICAN OPTOMETRIC ASSOCIATION

Ronald Benner, O.D.
President, American Optometric Association

September 19, 2023

The Honorable Mariannette Miller-Meeks
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U.S. House Veterans' Affairs Committee
364 Cannon House Office Building
Washington, D.C. 20515

The Honorable Julia Brownley
Ranking Member, Health Subcommittee
U.S. House Veterans' Affairs Committee
550 Cannon House Office Building
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RE: HVAC Health Subcommittee Hearing - VA's Federal Supremacy Initiative: Putting Veterans First

Dear Chair Miller-Meeks, Ranking Member Brownley, and Members of the Subcommittee,

Thank you for the opportunity to submit testimony today regarding the ongoing work of the U.S. Department of Veterans Affairs (VA) to develop an Optometry National Standard of Practice (NSP) and to better ensure that America's Veterans have access to the comprehensive eye and vision care they need and deserve, when and where they need it.

As President of the American Optometric Association (AOA), I am proud to submit AOA's testimony to you today and reaffirm our commitment to working with you and your colleagues as well as VA, Veteran Service Organizations (VSOs), and others to implement solutions aimed at better meeting the eye and vision care needs of our Veterans. Eye and vision care ranks as the third-most requested service by Veterans, and doctors of optometry provide roughly three-quarters of all eye and vision care within the VA. What the Department decides to include in or exclude from the forthcoming Optometry NSP will have an outsized impact on access and timeliness of care, patient outcomes, and Veteran quality of life for years to come.

The AOA represents more than 44,000 doctors of optometry, optometric professionals, and optometry students, including a large share of the more than 1,000 VA doctors of optometry on the frontlines providing primary and medical eye care services to millions of Veterans across the country. We also represent thousands of private practice community care optometrists proudly serving as an access to care force multiplier to help VA fulfill its mission to care for those that have borne the battle.

Right now, VA Doctors of optometry care for more than 70 percent of the total unique Veteran visits involving eye care services, including 73 percent of the 2.5 million selected ophthalmic procedures and nearly 99 percent of services in low vision clinics and blind rehabilitation centers. VA Doctors of optometry currently practice at 95 percent of the VA sites where eye care is offered and, in many facilities, they are the only licensed independent eye care practitioner available.

Despite the key role doctors of optometry play in the delivery of VA health care, the Department continues to face difficulties meeting Veteran demand for eye and vision care services. While wait times vary from facility to facility, it is undeniable that veteran access to needed eye and vision care is lacking – a situation that has been publicly recognized by VA. Recruiting and retaining doctors of optometry are both concerns. AOA, VA, and leaders in Congress are right now working to boost optometry recruitment and retention by including doctors of optometry in the same market-based pay scale as medical doctors and others. This is a partial fix, but we can and must do more.

VA also recognizes that recruitment and retention is only one part of the solution, and that the existing optometry workforce must be better utilized. In April 2020 VA issued Directive 1899 which encouraged its medical facilities to use doctors of optometry and others at the full scope of their licensure. To help VA better fulfil its mission, the AOA believes that VA must fully utilize the training and abilities of doctors of optometry by issuing forthcoming Optometry National Standard of Practice that recognize and ensure Veteran access to the full scope of care, including laser eye care and other contemporary procedures, that doctors of optometry are trained and licensed to provide.

The Importance of Timely Access to Eye and Vision Care

Undiagnosed and untreated vision problems can negatively impact Veteran quality of life. Too often undiagnosed and untreated vision problems can be signs of larger health concerns. Regular eye care can help address vision-related quality of life issues and better ensure early diagnosis and treatment for underlying concerns, including a wide range of systemic conditions.

Eye and vision disorders have broad implications for Veterans because of their potential for negatively impacting activities of daily living, resulting in decreased quality of life. They are associated with loss of mobility, independence, employment, and can lead to reduced social interaction and depression. It is estimated that at least 40 percent of vision loss in the United States is either preventable or treatable with timely intervention, yet many Americans remain undiagnosed and untreated. Changes in visual function can affect an individual's ability to perform activities of daily living. Since these changes can develop gradually and occur without symptoms, their effect on visual function and performance may not be readily apparent – making regular eye care so important.

The leading causes of vision impairment and blindness in the United States, other than refractive errors, are primarily age-related diseases such as cataracts, glaucoma, and age-related macular degeneration. In addition, diabetic retinopathy, the most common microvascular complication of diabetes, can occur in adults of any age. Refractive errors, cataracts, age-related macular degeneration, and diabetic retinopathy usually reduce central vision, especially for reading and other near activities. Glaucoma characteristically

affects peripheral vision, which may alter balance and walking. Untreated, these conditions lead to problems with taking medications, keeping track of personal information, walking, watching television, driving, and reading, and often create social isolation. Early detection and treatment of these conditions are central to improved quality of life.

The eye is the only part of the human body where blood vessels and nerve tissue can be viewed directly in their natural state. Alterations in retinal blood vessels allow the eye doctor to draw conclusions about the status of blood vessels in the entire body. Changes in the eye often precede or occur concurrently with various systemic conditions and can represent important prognostic indications of disease progression. Regular eye care presents a unique opportunity to observe and evaluate the impact that systemic health problems such as diabetes, hypertension, and hyperlipidemia have on the body and the eyes. For some individuals, signs of an undetected systemic disease may initially be found during an eye examination. Detection of systemic diseases through a comprehensive eye and vision examination can lead to earlier treatment resulting in better patient care, avoidance of complications, and reduced health care costs.

Education and Accessibility of Doctors of optometry

Doctors of optometry, America's primary eye health care providers, are the frontline of eye and vision care and are recognized as physicians under Medicare. Doctors of optometry examine, diagnose, treat, and manage diseases and disorders of the eye. In addition to providing eye and vision care, they play a major role in an individual's overall health and well-being by detecting systemic diseases, and diagnosing, treating, and managing ocular manifestations of those diseases, and providing vaccinations.

Doctors of optometry prescribe medications – both orally and via injection, low vision rehabilitation, vision therapy, spectacle lenses, contact lenses, perform certain surgical procedures, and counsel patients regarding surgical and non-surgical options that meet their visual needs related to their occupations and lifestyle. A doctor of optometry degree is awarded after a rigorous, extensive, clinically oriented, four-year postgraduate program at an accredited school or college of optometry.

Optometry students begin clinical training almost immediately in their doctoral degree curriculum. The program includes doctoral level study concentrating on the eye, vision, and associated systemic disease and also includes courses on systemic health conditions that focus on the patient's overall health and medical conditions. Optometric education has evolved and advanced over the past few decades, in large part due to the evolution of technology.

Laser and surgical education, both didactic and hands-on, is embedded and is a key part of optometric education at both the optometry school level and the post-doctoral level. In fact, contrary to what detractors may say, laser eye care and other contemporary procedures are taught in each and every school and college of optometry in the country. Today's rigorous four-year optometry school curricula focuses exclusively on the study of ocular health and vision care – including education and training in performing laser procedures on the eye. The National Board of Examiners in Optometry (NBEO) now also has a "Laser and Surgical Procedures Examination" as part of the national board exam series.

In addition, many doctors of optometry complete a residency in a specific area of practice. In fact, the VA hosts the largest optometric clinical training program in the United States. Nationwide, there are over 215 accredited post-graduate residency and more than 1,500 externship positions available annually for clinical training.

A key access point, doctors of optometry serve as frontline providers for the vast majority of patients in the United States. Optometrists provide more than 70 percent of comprehensive eye care in our country. Research conducted by the AOA shows doctors of optometry practice in more than 10,000 communities and counties that account for 99 percent of the U.S. population. Thirty-nine percent of U.S. counties or county-equivalents have access to a doctor of optometry but not an ophthalmologist. According to the Health Resources and Services Administration, by 2025 there will be a shortage of about 6,000 ophthalmologists. With a steadily increasing supply of patients needing care and a dwindling number of ophthalmologists to care for them, doctors of optometry are uniquely positioned to serve as the solution to this growing lack of timely access to essential care.

Licensure and Scope of Practice Trends

Doctors of optometry are licensed to practice by their state and their scope of practice is set by that state's laws and regulations. The trend for the past 50 years has been to increase the scope of services that doctors of optometry can provide. In no case has their scope of practice been reduced. Today optometrists are authorized to prescribe oral medication and treat glaucoma in all states. In most states, optometrists can order diagnostic testing and conduct in-office blood testing. Doctors of optometry are authorized to provide injections in most states. In many states, optometrists are authorized to perform minor surgical procedures, including removal of foreign bodies.

In ten states (Alaska, Arkansas, Colorado, Indiana, Kentucky, Louisiana, Mississippi, Oklahoma, Wyoming, and Virginia) doctors of optometry are authorized to use lasers to treat ocular conditions. In one state – Oklahoma – optometrists have been providing laser eye care for nearly 40 years. State regulators cite that this authority has led to an increase in access to care that patients need, particularly in their state's underserved and rural areas. Those state officials also make clear that little or no patient complaints have resulted from this increase in services offered. Further, malpractice rates for doctors of optometry in states with the authority to provide laser eye care and other contemporary procedures are roughly identical to rates in states without that increased authority, highlighting the safety and efficacy of this care provided by doctors of optometry.

All federal health programs recognize, cover, and pay for doctors of optometry to provide laser and other surgical procedures, as well as all other contemporary procedures covered under their state scope of practice. Medicare, Medicaid, the Indian Health Service – which is a similar federal supremacy system – all cover and pay for the full range of services authorized under an optometrist's state scope of practice. Similarly, all major private payers cover and pay for those services, including laser eye care and other contemporary procedures, included in an optometrist's state scope of practice. As such, VA is currently the outlier among other federal programs and all private payers. Advancing an Optometry NPS that recognizes all care within an optometrist's scope of practice would bring VA into alignment with all other major systems and national payers.

VA Actions and VSO Engagement

For nearly 15 years, VA relied on a policy (Directive 1132) that prevented its doctors of optometry from providing therapeutic laser eye care to Veterans. When the policy was adopted, VA made clear in official correspondence that the policy was not created for safety concerns. Then in May 2020, VA reissued Directive 1132, with new language asserting that the policy had been created in response to safety concerns. After outreach from concerned members of Congress, VA rescinded the policy in August 2020. In its place, VA included language in the VA's Eye Care Handbook (Directive 1121) saying that "currently" only ophthalmologists can perform laser eye procedures. This set up a pathway for doctors of optometry to obtain the necessary credentialing and privileging to provide this needed care.

Then in September 2022, after again hearing from concerned members of Congress, VA dropped restrictive language within two Eye Care Comprehensive Standardized Episode of Care (SEOC) guidelines that had prevented Veterans from accessing community care doctors of optometry for so called "invasive" eye procedures. The original SEOC language had said "only ophthalmologists can perform invasive procedures, including injections, lasers, and eye surgery." After hearing from concerned Veteran advocates and leading Members of Congress angry that their state's Veterans were not afforded the same access that all other citizens of their state enjoyed, VA changed the language to allow these services to be provided by "an ophthalmologist or optometrist based on the state licensure of the provider."

In a March 2023 letter to VA Secretary Denis McDonough, a leading VSO, AMVETS, thanked the Department for its work and urged VA to "continue working to ensure that all Veterans have access - when and where they need it - to the full range of care that eye doctors within VA and in the community are trained and licensed to provide."

> "AMVETS is appreciative for and supports recent amendments made by VA to its Eye Care Comprehensive Standard Episodes of Care (SEOC) – a change which aims to better ensure Veterans access to a wide range of medical eye care services provided by both optometrists and ophthalmologists, based on the state licensure of the provider. We agree with VA that "this change will improve access by allowing providers to render services for which they are legally licensed, reduce the need for multiple Community Care encounters and allow Veterans to choose their preferred provider within the care network." This move also helps ensure that Veterans are treated fairly and have the same access to care now enjoyed by pretty much every other citizen in their states, including those covered by Medicare, Medicaid, the Indian Health Service, and all major private health insurers. If VA is considering any further changes to these policies, we would ask for a full briefing beforehand.
>
> Additionally, as VA works to finalize optometry national standards of practice, we would urge the Department to follow the aforementioned Eye Care SEOC approach by ensuring that Veterans within VA – as they now do through the community – have access to the full range of care that both ophthalmologists and optometrists are trained and licensed to provide. While optimistic that the new standards will help boost access to needed care, we are concerned that they may not include some eye care services provided by optometrists simply because these types of eye

> doctors are authorized to provide those services in less than a majority of states. Should VA take the approach of only including health care services in the standards which are authorized in a significant number of states, AMVETS is worried that Veterans in some states may needlessly be denied access to essential health care services solely because states other than their own have failed to act. AMVETS urges VA to ensure that through these practice standards Veterans, at the very least, have the same access to the same services that every other citizen of their state now enjoys."

AMVETS highlights a concern shared by the AOA that the Optometry NSP not solely include services that are allowed under an optometrist's scope of practice in a large majority of the states. Right now, Medicare, Medicaid, IHS, and all privately covered citizens in many states have access to doctors of optometry for a wide range of care that they need and deserve – but America's Veterans do not, at least through the VA itself. Through Optometry NSP, VA must continue its work to ensure that Veterans at least have the same access that every other citizen of their state now enjoys.

Lots of Noise, But What Does the Evidence Say?

Detractors often claim that they have evidence of the dangers of optometrists providing laser eye care and other contemporary care, but each one has been shot down. The Journal of the American Medical Association (JAMA) released a study, which was paid for by the American Academy of Ophthalmology, on Selective Laser Trabeculoplasty (SLT) from Medicare data out of Oklahoma. Based on this study, the JAMA authors claim that optometrists are performing this procedure 2.5x more (repeat procedures) than ophthalmologists.

However, the reality is that the FDA clinical trial protocol for SLT laser dictated that the surgeon was to perform a treatment on only half of the eye to reduce laser exposure and to prevent post-operative inflammation. Optometrists were trained using the conservative methodology used in the FDA clinical study, which was determined to be safe. Some eye doctors decided to double the radiation exposure (treating the entire eye) to reduce the number of visits. The 2016 JAMA study found that ophthalmologists doubled the radiation exposure more often than optometrists. This paper is not proof that ophthalmologists are safer. If anything, it shows that optometrists are more conservative than their ophthalmologist colleagues by following more closely to the approved FDA protocol. Further, the paper admits that it is not a safety study nor a study of the efficacy of the procedure despite how it is often misquoted.

Another claim is that a patient from Texas, Charlotte, reports that a laser procedure performed in Louisiana caused irreparable harm to her vision and now prohibits her from doing the things she loves, such as sewing and knitting. The reality is that while Charlotte has never released her medical records related to this issue, based on the information provided, we believe the procedure she received was vitreolysis. This is a procedure that doctors of optometry in most states utilizing in-office laser procedures do not and cannot perform by law. Despite Charlotte's claims of significant vision impairment, she did not seek private legal action against these doctors and did not file a formal complaint in either Texas or Louisiana.

Similarly, those opposed to doctors of optometry providing laser eye care and other procedures continue to highlight rare instances of poor health outcomes at VA, including a decade-old occurrence at the Palo Alto facility. The AOA made a promise nearly 10 years ago, to both VA and to VSOs, that we would not retaliate to such attacks and point out instances where negligent VA ophthalmologists harmed Veteran patients (and there are specific examples that we could cite), because it undermines VA's ability to care for Veterans and undermines Veteran's faith in their health care providers, which can ultimately undermine their health and wellness. It has not been easy to keep from responding to these ongoing attacks, but we plan to keep our promise to VA and the Veteran community.

While detractors continue with their campaign of fear, the reality is that doctors of optometry have been and continue to provide this care safely and effectively. Each state that has authorized these services makes clear that this move has boosted access to care and has not created safety concerns and never in the five decades of optometry scope expansion has any state every repealed scope advancement. If there were serious patient concerns, oversight officials would have taken notice and our detractors would have made any sincere concern into a large-scale public relations campaign.

There are studies highlighting the safety and efficacy of doctors of optometry providing this care. A study published in August of 2023 in the journal *Optometry & Vision Science* formally assessed the efficacy and safety of YAG laser capsulotomy procedures performed by optometrists with 99 percent of patients reporting subjective improvement in visual acuity post-procedure and 95 percent of patients showing objective visual improvement that allowed for a better quality of life. Importantly, no significant adverse events were noted in any subject.

Considerations for Optometry National Standard of Practice

With eye and vision care ranking as the third-most requested service by Veterans, and doctors of optometry – often the only eye care provider available – right now providing roughly three-quarters of all eye and vision care within the VA, what the Department ultimately decides to include in or exclude from the forthcoming Optometry NSP will have an outsized impact on timeliness, access, outcomes, and Veteran quality of life for many years to come.

It is clear that VA has a need to better meet the eye and vision care needs of the Veteran population. And it is clear that better utilization of the training and licensure of doctors of optometry will help VA achieve that goal. Doctors of optometry have been and continue to provide a wide range of care, including laser eye care and other contemporary procedures, safely and effectively for many years. That is why all other federal programs, including VA Community Care, and all private payers cover and pay for this care provided by optometrists – and no state, health program, or payer has ever reversed course.

It is now time for VA to listen to the VSO calls for VA to ensure that Veterans have the same level of access to the care that everyone else in their state now enjoys. It is time for VA to cut through the noise and do what is right for Veterans by advancing an Optometry NSP that recognizes and ensures Veteran access to the full scope of care, including laser eye care and other contemporary procedures, that doctors of optometry are trained, licensed, and fully able to provide. Thank you for the opportunity to provide this testimony today and please know that we are committed to working with you and your colleagues as well

as VA, Veteran Service Organizations (VSOs), and others to better meet the eye and vision care needs of our Veterans and better ensure that America's Veterans have access to the comprehensive eye and vision care they need and deserve, when and where they need it. Please do not hesitate to contact me or AOA staffer Matt Willette (703-837-1001 / mwillette@aoa.org) if you would like additional information or to discuss this or any other matter.

Sincerely,

Ronald Benner, O.D.

President, AOA

Prepared Statement of Janet Setnor

American Association of
NURSE ANESTHESIOLOGY

Written Statement for the Record by:

Janet Setnor, MSN, CRNA, Col. (Ret), USAFR, NC
President-Elect
American Association of Nurse Anesthesiology

House Veterans' Affairs Committee Subcommittee on Health

360 Cannon House Office Building
Washington, DC 20515

September 19, 2023

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.

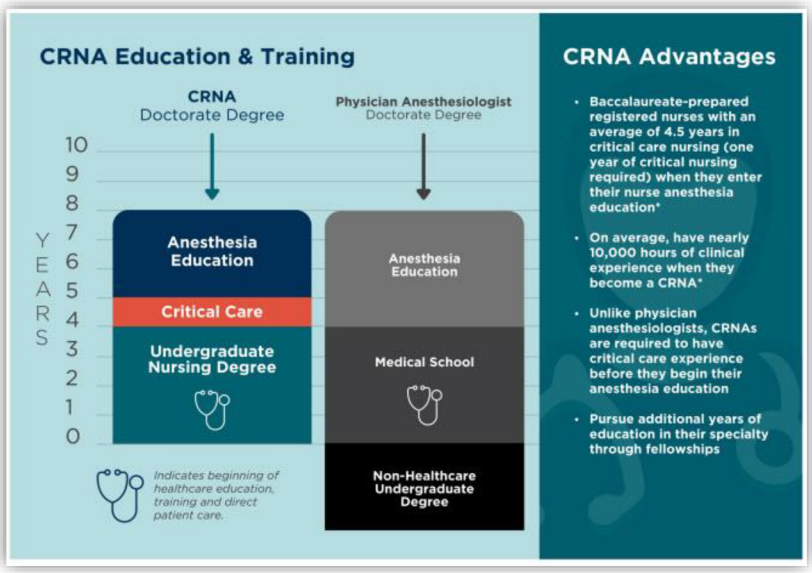
[6] Simonson, Daniel C.; Ahern, Melissa M.; Hendryx, Michael S.. Anesthesia Staffing and Anesthetic Complications During Cesarean Delivery: A Retrospective Analysis. Nursing Research 56(1):p 9-17, January 2007.

[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.

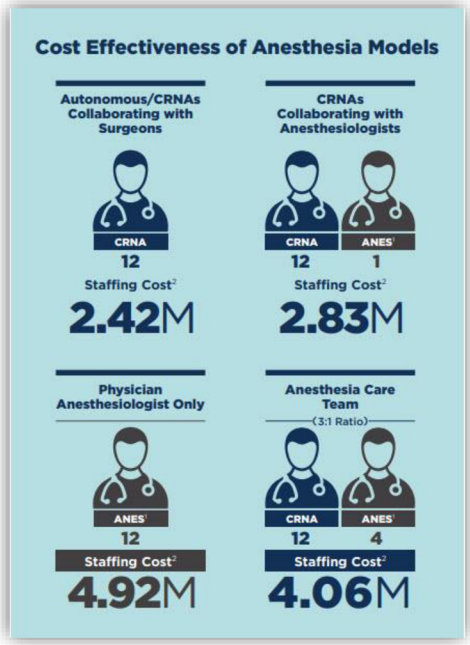


CRNA Education and Training Information

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.

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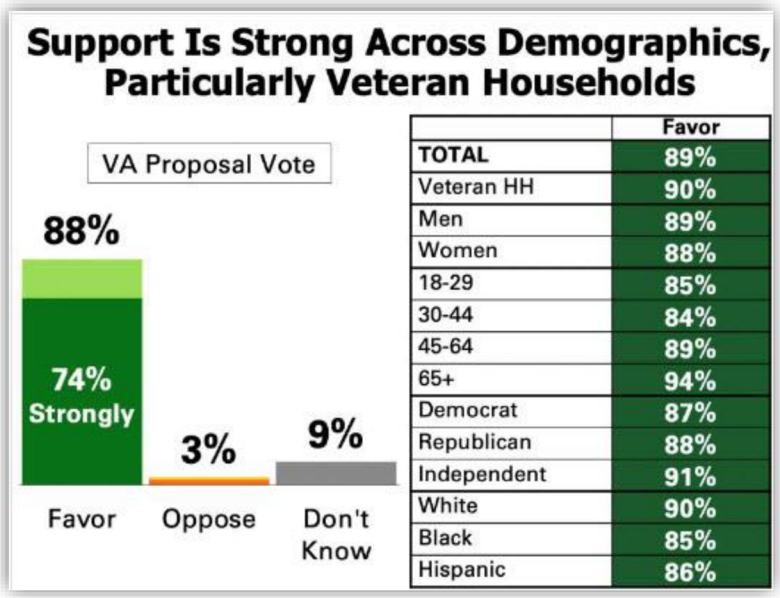
[9] Liao, C.J., Quraishi, J.A., & Jordan, L.M. (2015). Geographical Imbalance of Anesthesia Providers and its Impact On the Uninsured and Vulnerable Populations. *Nursing economic$, 33 5,* 263-70 .

[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

Cc: Chairman Mike Bost
Ranking Member Takano
Rep. Amata Radewagen
Rep. Jack Bergman
Rep. Nancy Mace
Rep. Matt Rosendale

Rep. Greg Murphy
Rep. Scott Franklin
Rep. Derrick Van Orden
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Rep. Cherfilus-McCormick
Rep. Chris Deluzio
Rep. Morgan McGarvey
Rep. Delia Ramirez
Rep. Greg Landsman
Rep. Nikki Budzinski

Prepared Statement of Stephen McLeod

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Statement of Stephen McLeod, MD
Chief Executive Officer
American Academy of Ophthalmology
House Committee on Veterans' Affairs
Health Subcommittee Hearing
September 19, 2023

"VA's Federal Supremacy Initiative: Putting Veterans First?"

Good morning, Chairwoman Miller-Meeks, Ranking Member Brownley and Subcommittee members. My name is Stephen McLeod, and I am the Chief Executive Officer of the American Academy of Ophthalmology. Thank you for the opportunity to present our views on the Department of Veterans Affairs' (VA) Federal Supremacy Initiative and its potential impact on our nation's veterans. The Academy is the largest association of eye physicians and surgeons in the United States that represents a nationwide community of nearly 20,000 medical doctors and surgeons. We protect sight and empower lives by setting the standards for ophthalmic education, supporting research, and advocating for our patients and the public. We innovate to advance our profession and to ensure the delivery of the highest-quality eye care to our patients.

In 2021, the VA initiated efforts to develop national standards of practice for more than 50 health professionals that practice within the Veterans Health Administration. The Academy applauds the VA's efforts to protect and boost veterans' access to health care services and we stand ready to work with the VA to ensure veterans have timely access to all of the health care services that they need. However, it is our firm belief that quality care and patient safety must remain paramount priorities in shaping these VA national standards of practice.

Throughout the United States and the Veterans Health Administration, much of eye-related care is delivered through a collaborative team-based approach, with each team member bringing forth an important skill set. Optometrists are vital members of the team, providing routine eye care services to patients in need. In multidisciplinary settings, Ophthalmologists, due to extensive training

and clinical experience, are customarily the leaders of these clinical teams. This team-based approach enables ready access to basic needs including routine eye checks, glasses and contact lenses, swift detection of eye diseases and ensures timely, skilled and appropriate treatment for patients. Effective communication and rapid care transitions between optometrists and ophthalmologists working as a team enhance access, efficiency and patient outcomes.

Currently, the overwhelming majority of states do not allow optometrists to perform laser and other eye surgeries. This restriction aligns with long-standing VA policy, which also does not permit optometrists to perform laser surgery in veterans' health facilities – regardless of their state licensure. Furthermore, while a very few states permit optometrists to perform some surgical procedures, it is crucial to recognize that the prevailing norm in optometry practice across all 50 states does not encompass performing surgical procedures. The Academy is concerned that in developing the national standard of practice the VA may want to deviate from these practices and policies for VA optometrists by allowing these mid-level providers to perform eye surgery at the VA.

For decades, veterans have benefited and relied upon an established, consistent, and high-quality standard for eye surgery by ophthalmologists. Allowing optometrists to perform eye surgery in the VA would remove important patient safeguards. This decision could substantially elevate risks for veterans in need of surgical eye care without offering discernible benefits. Public surveys indicate that there is a lack of public support for eye surgery performed by optometrists, and it is reasonable to assume that veterans share these concerns and preferences.

Procedures that May be Included in the VA National Standard of Practice for Optometrists:

It's challenging to determine the specific surgical procedures the VA may include in the national standard of practice for optometrists. Some optometrists claim they can safely perform the following surgeries.

> **YAG Laser Capsulotomy:** This procedure addresses post-cataract surgery vision issues by using a laser to rupture a membrane holding the lens implant in place that can become cloudy and reduce vision. Complications include inflammation, high ocular pressure, macular edema, lens implant dislocation, lens implant damage, and retinal detachment.

Argon and Selective Laser Trabeculoplasty: This procedure applies laser energy to the trabecular meshwork (a narrow zone around the base of the cornea that regulates eye pressure) in patients with elevated eye pressures or glaucoma. Often, these patients have failed other treatments. Energy spots are precisely applied. Overtreatment can damage the meshwork, exacerbating pressure issues. Misdirected energy can harm surrounding structures, causing no pressure reduction and potential damage. Complications include inflammation, scar tissue leading to angle closure glaucoma, corneal issues, and cataracts.

Laser Peripheral Iridotomy: This procedure uses a laser to create a hole in the iris to promote the flow of aqueous fluid (a thin, watery fluid located in the eye), preventing angle closure glaucoma (a form of glaucoma that occurs when the iris bulges). Precise placement and size are crucial to avoid issues like double vision, a "second" pupil, nerve-related pain, bleeding, damage to the cornea or lens, and pupil distortion. Proper energy selection prevents pupil disfigurement. Complications may also include high ocular pressure, and cataracts in addition to those associated with laser trabeculoplasty.

Scalpel surgery to remove eyelid lesions: This procedure involves local anesthesia, lesion excision or biopsy, wound closure and pathologist collaboration. For suspected malignancies, ophthalmologists must ensure clear margins while preserving function and appearance. This may entail cauterization, adjunct treatment, and addressing intraoperative abnormalities. Improper suturing can lead to eyelid dysfunction and chronic issues, potentially resulting in blindness. Complications include scarring, impaired vision, dry eyes, bleeding, infection, blood clots, pain, eyelid disfigurement, anesthesia risks, and vision loss.

These surgical procedures, whether performed with lasers or scalpel, are invasive, yet none are emergent. There is no compelling medical reason for a veteran not to have an ophthalmic surgeon perform these eye surgeries.

All Eye Surgeries Have Potential for Patient Harm:

Eye tissue is exceptionally fragile, and once harmed, full recovery is often impossible. Consequently, eye surgery ranks among the most difficult and delicate surgeries. No eye surgery is entirely safe, easy, or straightforward. While certain procedures carry higher risks, none are without risk, especially when performed by inexperienced providers.

The table below summarizes complications associated with some laser and eyelid surgeries.

PROCEDURE	COMPLICATIONS
Chalazion management	Full-thickness incision, permanent lid deformity, perforated globe leading to blindness, missing the diagnosis of sebaceous cell carcinoma, seeding the orbit with cancerous cells
Selective/Argon Laser Trabeculoplasty (SLT/ALT)	Poor technique requiring more treatment, eye pressure elevation, anterior uveitis, synechiae (scarring) and angle closure glaucoma (ocular emergency)
YAG capsulotomy	Lens pitting/damage, lens implant dislocation, eye pressure elevation, retinal detachment, macular hole, macular swelling, uveitis; often requiring further surgery
Laser Peripheral Iridotomy (LPI)	Uncontrolled glaucoma, damage to cornea, cataract, bleeding inside the eye, double vision, iris scar/deformity, retinal damage with permanent vision loss
Pre- and Post-op care of the above	Acute management that occurs at the time of procedure is almost entirely outside the scope of optometrists
Use of topical and injectable anesthetics	Regional nerve blocks could lead to permanent nerve damage or death. Injectable anesthesia may result in inadvertent injection into the eye for a lid or conjunctival procedure leading to blindness or loss of an eye

Current Standards for Laser and Eye Surgery:

The overwhelming majority of states continue to maintain high standards for eye surgery. These states recognize that a comprehensive medical and surgical education is the best way to ensure patient safety. Only 12 states allow optometrists to perform some non-laser surgery procedures. Of those states, only eight states allow optometrists to perform some laser eye surgeries. One state allows optometrists to perform some laser surgeries but

does not allow optometrists to furnish non-laser surgery procedures. These states also represent a small fraction of the U.S. population.

Within this limited subset of states, optometrists have variable scopes of practice. Some states permit optometrists to perform YAG laser capsulotomy but do not authorize them to perform selective laser trabeculoplasty (SLT), argon laser trabeculoplasty (ALT) or laser peripheral iridotomy (LPI).

STATE	LPI	SLT/ALT	YAG CAPSULOTOMY
AK	YES	YES	YES
AR	NO	YES	YES
CO	YES	YES	YES
KY	YES	YES	YES
LA	YES	YES	YES
MS	NO	NO	YES
OK	YES	YES	YES
VA	YES	YES	YES
WY	YES	YES	YES

The state scopes of practice are even more variable for non-laser surgical procedures. Some state statutes or regulations that authorize optometrists to perform non-laser surgical procedures contain an exclusionary list of surgical procedures. These exclusionary lists are not all the same. Other state statutes have an inclusionary list of procedures that optometrists may perform. Virginia, a state that just last year authorized optometrists to perform laser surgery, does not authorize optometrists to perform non-laser surgical procedures at all. Conversely, some states that authorize optometrists to perform non-laser surgery procedures do not authorize optometrists to perform laser surgery and only authorize a limited list of surgical procedures.

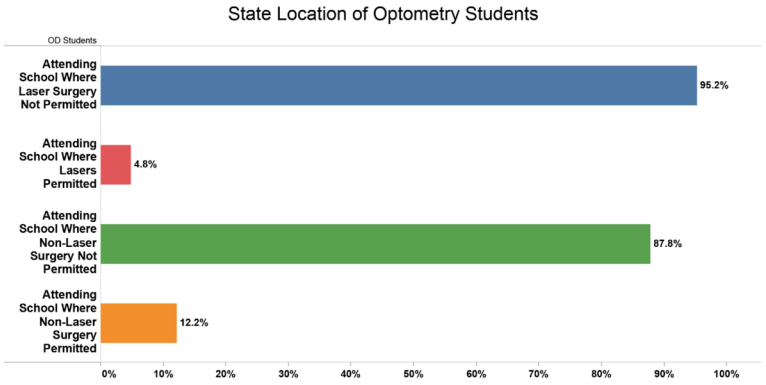
STATE	Authorized List of Non-Laser Surgery Procedures	Authorizes Laser Surgery
AK	Exclusionary List	Yes
AR	Inclusionary List	Yes
CO	Exclusionary List	Yes
IA	Inclusionary List	No
KY	Exclusionary List	Yes
LA	Exclusionary List	Yes
MS	Inclusionary List	Yes
NM	Inclusionary List	No

OK	Exclusionary List	Yes
TN	Inclusionary List	No
VA	No Non-Laser Surgical Procedures Authorized	Yes
WA	Inclusionary & Exclusionary List	No
WY	Exclusionary List	Yes

Variable Education and Training Requirements:

There also is considerable and concerning variation among states in training expectations for optometrists performing laser surgeries. In states that authorize laser eye surgery, Kentucky requires merely one proctored clinical session on a human subject. Colorado, Mississippi, Virginia and Wyoming also require proctored, clinical training but the statute does not specify that the training must include a human subject. Other laser states require no clinical training. In some states, optometrists may perform surgery on a patient without ever practicing on a live human eye under supervision.

Of the 24 US optometry schools, only two schools are located in states permitting laser surgery. That translates to 95.2% of optometry students attending schools where laser surgery is not permitted. This means that the overwhelming majority of optometrists, including those employed in the VA, have no or minimal practical surgical training on human patients. VA optometrists, most of whom are located in non-surgery states and went to optometry school in non-surgery states, have never performed surgery on human patients. To allow them to now perform surgery is inherently unsafe.



Clinical surgical training is not typically part of the curriculum in most optometry programs. In contrast to the estimated 3,000 hours of training time specifically devoted to eye surgery typically undertaken by each ophthalmology resident, the common didactic certification course required by state optometry boards to authorize its licensees to perform laser and non-laser surgery is often conducted in a hotel conference room over 32 hours. This is de facto evidence that substantive clinical training on human subjects is unlikely to be a significant component of this course. For three of the four states that authorize non-laser surgery procedures – Iowa, New Mexico, and Tennessee – there does not appear to be any specific clinical educational requirement.

Thus, it is possible that the first surgery an optometrist performs on a human – whether supervised or unsupervised - could be a veteran.

STATE	DIDACTIC EDUCATION	CLINICAL TRAINING
AK	32 Hours	NO
AR	32 Hours Graduates Since 2019 Waived In	NO
CO	Training Course Approved by the Board OR Graduated from Optometry School Since 2019 where Laser Procedures were Taught + Passage of National Standardized Exam Approved by the Board	One Proctored Clinical Session Before Performing Lasers OR Graduated from Optometry School where Laser Procedures were Taught Since 2019 + Passage of National Standardized Exam Approved by the Board; Repeat Session if Laser not Performed in 2 years
IA	NO	NO
KY	32 Hours	One Proctored Laser on a Living Human Eye
LA	32 Hours	NO
MS	32 Hours Graduates Since 2016 Waived In	8 Hours Working Under a Preceptor Graduates Since 2016 Waived In
NM	NO	NO

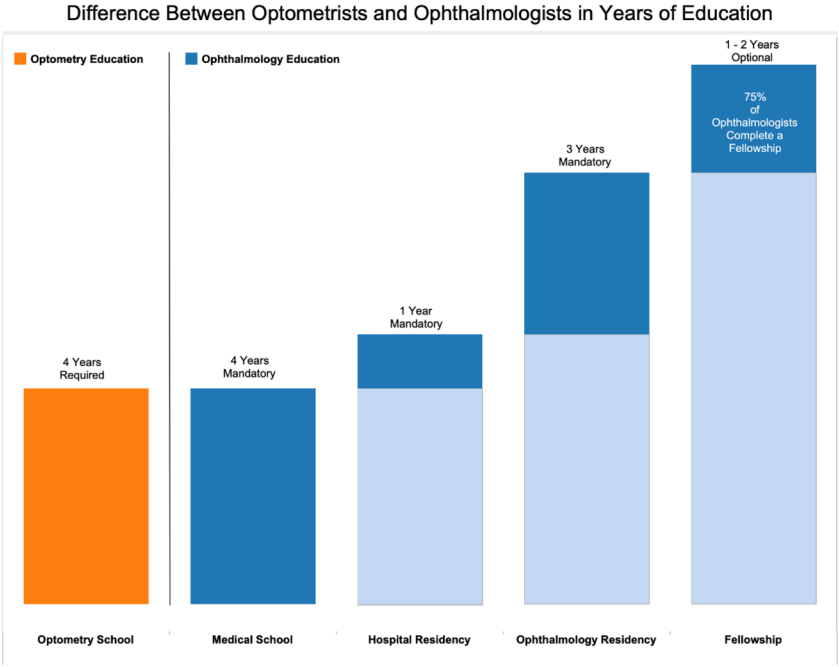
OK	New Graduates Waived in; Other licensees may have taken a didactic course earlier	NO
TN	NO	NO
VA	Training Course Approved by the Board	Clinical Training Program Approved by the Board
WA	Training Course Approved by the Board	Supervised hands-on experience with live patients, or be supplemented by a residency, internship, or other supervised program that offers hands on experience with live patients
WY	Board Approved Course OR Graduated from Optometry School where Laser Procedures were Taught + passage of the NBEO Laser and Surgical Procedure Exam	One Proctored Clinical Session Before Performing Lasers OR Graduated from Optometry School where Laser Procedures were Taught + passage of the NBEO Laser and Surgical Procedure Exam; Repeat Session if Laser not Performed in 2 years

Although optometrists lack sufficient training, ophthalmologists are extensively trained to provide surgery. **It takes thousands of hours of time, training and supervision to become a competent surgeon.** After graduation from medical school and completion of an ophthalmology residency, an ophthalmologist will have performed hundreds of surgeries of varying complexity. The surgeries are mastered over 8+ years, through hours of closely monitored, one-on-one mentored surgical cases taught by board-certified ophthalmologists, themselves experienced surgeons. An ophthalmology resident observes many cases of each type of surgery first, then assists in the surgeries, before becoming the primary surgeon for any one type of procedure, even as supervision continues throughout training. Skills are layered and reinforced throughout the training program.

Becoming a skilled surgeon involves not only technical proficiency but also the development of critical pre- and post-surgical judgment to determine when surgery is necessary and how to approach it safely, and how to recognize postoperative complications and how to treat them. This judgment is honed through broad, mentored experience over years

of training. Accumulating a sufficient number of cases is essential for learning to identify and manage complications that may arise during or after surgery. Trainees do not complete their residency until faculty is confident in their surgical abilities and judgment.

The Accreditation Council for Graduate Medical Education (ACGME), which accredits residencies and fellowships, establishes surgical volume requirements with the prerequisite that these surgeons have completed medical school, an internship, and possess a broad foundation of medical and surgical knowledge and skills. This includes experience in microsurgery and a range of complex procedures. By the time residents are directing lasers towards delicate structures in the eye - which are far thinner than a piece of paper - they have already sutured arteries together in vascular surgery, placed central lines, drained subdural hematomas, delivered babies by cesarean section, delicately carved the gallbladder from the liver, removed tumors from the lung and breast, to name just a few examples. From prior experience, surgeons understand what it means to be operating in a tissue plane where there is no room for error.



The chart below shows in greater detail the significant differences in time, subject matter, and didactic and clinical substance that distinguishes the education of optometrists and ophthalmologists. The result of these different educational pathways is that ophthalmologists are trained to perform surgery, but optometrists are not.

	Ophthalmologist (MD)	Optometrist (OD)
Educational Requirements	12-13 years or more • 4 years of college • 4 years of medical school • 4 years of residency training • 1-2 years of optional • fellowship training	6 years • 2-4 years of college • 4 years of optometry school
Clinical Experience	• 17,000+ hours of clinical experience = 7 years of 40+ hours/week training more than optometrists • 3,000+ patient encounters • Hundreds of surgical cases	• 2,000 hours of clinical experience • No hands-on surgical training in training in 21 of 24 schools • Post-optometry school training to do lasers = weekend course at hotel (1-2 hours of real training)

An intensive and transformative three-year residency program in ophthalmology cannot be compared with a 32-hour optometry mini course over a weekend. A simple comparison of time highlights the substantial contrast in the duration and rigor of education and preparation between these two paths.

In addition, there are inherent limitations to teaching optometrists to perform even a limited set of surgical procedures with lasers and scalpels. As noted above, the overwhelming majority of optometry students (95.2%) attend optometry schools in states where optometrists are prohibited from

performing surgery – meaning they themselves are prohibited from performing live surgery as part of their training. In addition, the number of optometry students is simply too large and patients with eye disease requiring surgical intervention are too few for optometry students to train on live patients.

Even at optometry schools located in states where some surgical procedures are allowed, as opposed to the strict standards that govern ophthalmology resident surgical training, there are multiple unknowns about optometric training. These unknowns include the qualifications of instructors, the number of live patients with disease needing surgery that are evaluated and treated by each optometry student for the different procedures in the state scope of practice, the frequency in which the procedures are performed, and the competency level of the students upon completing training.

Variable Quality Assurance Mechanisms:

Among states that authorize optometrists to perform surgical procedures, quality assurance measures vary widely. Some states that authorize optometrists to perform surgical procedures have no outcome reporting requirements. Others have limited outcome reporting requirements.
For those states that do collect data on outcomes, it is doubtful whether there has been sufficient data collected to draw statistically significant conclusions that could be used to set clear and consistent standards for quality assurance for surgical procedures performed by VA optometrists. Further, we have concerns whether state optometry boards themselves have the expertise to make accurate quality assurance assessments upon which the VA could rely to ensure patient safety amongst the veteran population.

State	Procedures Reported	Outcome Reporting
AK	None	No Reporting
AR	Lasers Only	Outcomes Reporting
CO	Laser Procedures, Ocular Adnexa Treatments	Adverse Outcome Reporting
KY	None	No Reporting
LA	Ophthalmic Surgery	Outcomes Reporting

MS	Ophthalmic Surgery	Outcomes Reporting
OK	None	No
VA	Lasers Only	Adverse treatment outcomes associated with such procedures that required a referral to an ophthalmologist for treatment.
WY	None	No Reporting

The lack of a consistent system of quality assurance was underscored in a 2016 study published in the *Journal of the American Medical Association - Ophthalmology*.[1] The study found that there was a 189% increased hazard of requiring additional laser treatment in the SAME eye compared to the same laser done by ophthalmologists. The study concluded this could be due to multiple reasons, all of which are highly concerning. It could mean that as a group, optometrists are not adequately trained to perform SLTs resulting in ineffective treatment. It could mean that some optometrists are unable to reliably perform gonioscopy, which is a difficult test that evaluates whether a patient is an appropriate candidate for an SLT. It could mean that some optometrists do not recognize that the surgeon must wait 6-8 weeks before they can determine if the laser treatment was efficacious. This study illustrates a real concern for patient safety, raises substantial questions regarding quality of care, and demonstrates that it is NOT cost effective to have optometrists performing surgery.

Access to Care:

Along with quality, access is a priority. Veterans typically have ready access to ophthalmologists in VA facilities, and there is no documented concern over access for laser eye surgery. Moreover, the Community Care Program also provides veterans with timely access to medical services when the VA cannot provide the care needed. Combined, these programs support the VA's core strategy of providing high quality veteran-centered care.

In addition, a study published in JAMA Ophthalmology this year found that expansion of laser privileges to optometrists in Oklahoma, Kentucky, and Louisiana, it has not resulted in a statistically significant increase in access to

laser procedures.[2] Furthermore, while there are regional variations, overall more than 90% of the US Medicare beneficiary population lives within a 30-minute drive of an ophthalmologist.[3]

Therefore, we do not believe that the increased risks to veterans that allowing VA optometrists to perform laser eye surgeries can be justified based access to care rationale.

Conclusion:

The Academy appreciates the opportunity to share our concerns about the VA's Federal Supremacy Initiative and how it could impact the quality of surgical eye care available to our nation's veterans. This initiative gives the opportunity to advance an efficient, reliable, and consistent system of coordinated team-based care.

Optometrists play a critical role on this eye care team. However, allowing optometrists with widely varying scopes of practice, highly variable but consistently inadequate education and training, would necessitate a patchwork of questionably effective quality assurance mechanisms that would not improve efficiency or quality within the veterans' health care system. Furthermore, it would not lead to improvements in access to care.

Rather, it would raise the potential for harm to veterans, contradicting a fundamental principle of the "High Reliability Organization" culture the VA is trying to establish. It would also unacceptably lower the standard of surgical eye care that veterans now rely on and clearly benefit from, putting our nation's veterans at considerable risk.

The Academy looks forward to working with you and the other members of the Health Subcommittee to ensure that our nation's veterans continue to receive the high-quality surgical eye they have become accustomed to receiving, and more importantly, have earned through their service to our nation.

1. Comparison of Outcomes of Laser Trabeculoplasty Performed by Optometrists vs Ophthalmologists in Oklahoma Joshua D. Stein, MD, MS1,2,3; Peter Y. Zhao,MD 4;Chris Andrews, PhD 1;et a lGregory L. Skuta ,MD 5 Author Affiliations, JAMA Ophthalmol.2016;134(10):1095-1101. doi:10.1001/jamaophthalmol.201
2. Shaffer J, Rajesh A, Stewart MW, Lee AY, Miller DD, Lee CS, Francis CE. Evaluating Access to Laser Eye Surgery by Driving Times Using Medicare Data and Geographical Mapping. JAMA Ophthalmol. 2023 Aug 1;141(8):776-783. doi: 10.1001/jamaophthalmol.2023.3061. PMID: 37471084; PMCID: PMC10360006.

3. Lee CS, Morris A, Van Gelder RN, Lee AY. Evaluating Access to Eye Care in the Contiguous United States by Calculated Driving Time in the United States Medicare Population. Ophthalmology. 2016 Dec;123(12):2456-2461. doi: 10.1016/j.ophtha.2016.08.015. Epub 2016 Sep 12. PMID: 27633646; PMCID: PMC5608548.

Disclosure of Federal Grants or Contracts

The American Academy of Ophthalmology has not received any federal grants or contracts pertaining to the Department of Veterans Affairs.

The Academy is a 501c(6) educational membership association.

Prepared Statement of Ron Harter

Good morning. Thank you, Chairwoman Miller-Meeks and Ranking Member Brownley. The American Society of Anesthesiologists (ASA) is an educational, research, scientific, and standard-setting organization for the medical specialty of anesthesiology. On behalf of our more than 56,000 members, I thank the Subcommittee for convening this important hearing on *"VA's Federal Supremacy Initiative: Putting Veterans First?"*.

We are pleased that the Committee has appropriately focused this issue on the prioritization of the best interests of our nation's Veterans. ASA is committed to Veterans and believes the physician-led anesthesia care team model provides the best care to our nation's Veterans. It is what they have earned and deserve. This issue is not about what ASA wants or even what the VA Office of Nursing Services wants. The issue is what is best for the health and well-being of the nation's Veterans, including the new PACT Act Veterans.

The evidence supports that Veterans' health is best served by the VA's existing, proven physician-led anesthesia team-based model of care – a model that recognizes the medical expertise of physicians, and the nursing education and experience of certified registered nurse anesthetists (CRNAs). This model of care assures our nation's Veterans will continue to have access to safe, high quality anesthesia care – the same standard of care used in every top civilian hospital.

We ask the Subcommittee to urge the Department of Veterans Affairs to reject changes proposed by the VA Office of Nursing Services that would lower the standard of care for Veterans by dismantling the team-based model of care and permit a CRNA-only model of anesthesia. The proposal needlessly places the health and lives of Veterans at risk.

We are not here today to challenge the important role that CRNAs play in caring for Veterans. ASA is not trying to change the current practice of VA nurse anesthetists. CRNAs currently practice in VA with our VA anesthesiologists. ASA endorses the existing, **proven** team-based model of care used throughout the VA system, as well as throughout our nation's civilian facilities. This is about whether VA will keep anesthesiologists involved in the teams that provide needed surgical care to Veterans, receiving complex surgical and procedural care.

Key Points

- **Anesthesia is a complex and challenging practice of medicine, posing significant potential patient risks, particularly for the large number of Veterans with underlying health conditions, particularly PACT Act Veterans.**

- **Veterans should have the same standard of care as non-Veterans; they have certainly earned that right.**

- **Anesthesiologists and nurse anesthetists are not interchangeable health care professionals. The education and training of physician anesthesiologists and nurse anesthetists differ dramatically. ASA has many members who formerly trained and practiced as CRNAs before choosing to complete their comprehensive medical education and training to become anesthesiologists.**

- **VA's current anesthesia policy is one of the most thoroughly researched, studied, and reviewed policies existing in VA. The current policy, Anesthesia Services Directive 1123, represents a safe, well-established, and functional compromise approach to anesthesia care delivery. No changes are clinically appropriate or necessary.**

- **There is no demonstrated shortage of anesthesia clinicians necessitating a change in the delivery of anesthesia care within the Department of Veterans Affairs.**

- **VA patients are not the same as Department of Defense patients.**

- **There is no unbiased literature to support the safety of eliminating physician clinical oversight of anesthesia. To the contrary, independent literature points to the risk to patients of anesthesia without appropriate physician clinical oversight.**

Background

VA is leading an initiative known as the Federal Supremacy/National Standards of Practice[1] (NSP) initiative. Under the initiative, VA is seeking to "standardize the practice" of nearly 50 VA health occupations. The standards would apply to all VA facilities, regardless of state law. After the standards are approved, they will be issued as VA Directives.

VA currently has an existing anesthesia standard and directive, VA National Anesthesia Service, VHA Directive 1123[2], which was finalized in October of 2019. The Directive took over 6 years to develop and is one of VA's most thoroughly researched and vetted standards in existence. The process began in 2013 and included two public comment periods generating a department record of 200,000 comments[3]. A final rule was issued in December of 2016[4]. VA got it right in its 2016 rulemaking when it prioritized the needs of Veterans and maintained the physician-led anesthesia care team model; the gold standard that is enjoyed by civilians across the country. Three more years of work were completed before the issuance of the final Anesthesia Directive on October 24, 2019.

The standard affirmed VA's longstanding policy that, "The possible maximum breadth of Certified Registered Nurse Anesthetist (CRNA) practice is controlled by the individual's State license." In 45 states, CRNAs providing anesthesia must have some degree of clinical oversight by a physician. This is frequently referred to as the anesthesiologist/CRNA Anesthesia Team model.

Anesthesia is a complex and challenging practice of medicine, posing significant potential patient risks, particularly for the large number of Veterans with underlying health conditions, particularly PACT Act Veterans.

Physician-led anesthesia care is the essential model of care for Veterans, especially those who have been toxin-exposed and face a higher risk of complications under anesthesia.

The poorer overall health status of the general Veteran population is well-documented in medical literature.[5] Multiple peer-reviewed studies have proven that VA patients have poorer health status, such

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[1] *VA National Standards of Practice:* U.S. Department of Veterans Affairs. www.va.gov/standardsofpractice. Accessed May 10, 2023.

[2] *National Anesthesia Service: VHA Directive 1123,* U.S. Department of Veterans Affairs, Washington, D.C.: October 24, 2019. Amended April 17, 2023.

[3] *VA Grants Full Practice Authority to Advance Practice Registered Nurses: Decision Follows Federal Register Notice That Netted More Than 200,000 Comments*. News Release. U.S. Department of Veterans Affairs, Washington, DC: December 14, 2016.

[4] *Advanced Practice Registered Nurses.* Final Rule, 81 FR 90198. U.S. Department of Veterans Affairs, Washington, D.C.: December 14, 2023. 90198-90207

[5] *Eibner C, Krull H, Brown K, et al. "Current and Projected Characteristics and Unique Health Care Needs of the Patient Population Served by the Department of Veterans Affairs." Santa Monica, CA: RAND Corporation, 2015. Page xxvi*

as diabetes, congestive heart failure, atherosclerotic coronary and peripheral vascular disease, hepatic failure, renal failure, and chronic obstructive pulmonary disease. These comorbidities and underlying chronic conditions, many of which are service-related, put Veterans at significant risk during surgery.[6, 7] Life-threatening situations can occur unpredictably, and a physician's leadership, knowledge, and expertise reduce those risks.

Most noteworthy, with the enactment of the Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act, Congress recognized many of the underlying conditions that can make anesthesia a higher risk for Veterans who have been exposed to Agent Orange, Burn Pits, and other toxic substances: asthma; chronic bronchitis; chronic obstructive pulmonary disease (COPD), and others. Toxic-exposed Veterans require an **even higher** level of care under anesthesia. Agent Orange-related Parkinson's Disease is directly tied to surgery-related risk, including significant interactions between anesthetic medications and Parkinson's Disease medications.[8] Further, general anesthesia is known to cause adverse outcomes in patients with COPD, including those with Burn Pit related COPD.[9][10][11]

It makes no sense for VA to spend billions of dollars to treat the respiratory disease of our PACT Act Veterans only to put those same Veterans at greater risk in the operating room by adopting the nurse-only model of anesthesia.

Veterans should have the same standard of care as non-Veterans; they have certainly earned that right, not a lower standard.

VA is proposing to impose a standard of practice on VA facilities that is inconsistent with the standard applicable to non-VA facilities. Specifically, VA intends to impose the rarely used CRNA-only standard on VA facilities, regardless of state law. Because the CRNA-only model is not permitted in most states, VA would be exercising its discretionary authority to disregard state law. The action will create conflicting standards of care in most states.

Currently, forty-five states require that a nurse anesthetist provide anesthesia with various levels of physician involvement. Many states define the physician's role as "supervision," either in state law or through Medicare's supervision requirement. Other states utilize terminology such as physician "direction," "collaboration," "approval," or "consultation."

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[6] Garshick E, Blanc PD. *Military deployment-related respiratory problems: an update*. Curr Opin Pulm Med. Epub 2023 Jan 4.
[7] Zhao H, Li L, Yang G, Gong J, Ye L, Zhi S, Zhang X, Li J. *Postoperative outcomes of patients with chronic obstructive pulmonary disease undergoing coronary artery bypass grafting surgery: A meta-analysis.* Medicine (Baltimore). 2019 Feb.
[8] *Shaikh, S. I., & Verma, H. "Parkinson's disease and anaesthesia." Indian Journal of Anaesthesia, 55(3), 228–234. May-June 2011.*
[9] *Andrew Lumb, MBBS FRCA, Claire Biercamp, MBChB FRCA, "Chronic obstructive pulmonary disease and anaesthesia." Continuing Education in Anaesthesia Critical Care & Pain, Volume 14, Issue 1, Pages 1–5, February 2014.*

Anesthesiologists and nurse anesthetists are not interchangeable health care professionals. The education and training of physician anesthesiologists and nurse anesthetists differs dramatically. ASA has many members who formerly trained and practiced as CRNAs before choosing to complete their more comprehensive medical education and training to become anesthesiologists.

First and foremost, it is critical to remember that physician anesthesiologists and nurse anesthetists are not interchangeable – physician anesthesiologists bring a unique capacity to safely provide anesthesia care to the full range of patients. These critical capacities are gained through four years of comprehensive medical school training following an undergraduate education, then four additional years of rigorous residency training, during which an authoritative understanding of the human body and its systems is derived not only from didactic sessions but more importantly from hundreds of increasingly complex clinical interactions with patients. I have spent most of my career teaching and training medical students and residents in the medical specialty of anesthesiology. Although nurse anesthetists are truly outstanding nurse practitioners, I can attest that the foundational knowledge of science and medicine gained by physician anesthesiologists yields a depth and breadth of understanding of the intricate complexities of perioperative patient care that is well beyond the training and education provided to nurse anesthetists.

All told, a physician's education and training include 12 to 14 years following high school, including medical school and residency, and 12,000 to 16,000 hours of clinical training. In contrast, a nurse anesthetist's education and training ranges from 4 to 6 years after high school – less than half a physician's training and an average of approximately 2,000 hours of patient care training – less than one-sixth that of physicians. 45 states across the country continue to require some level of physician involvement with nurse anesthetists during surgery – there is simply no replacement for a physician's expertise.[12]

Nurse anesthetists are trained to work within the physician-led care team and with physician involvement. All nurse anesthetists' education programs, except one in Oregon, are in states that require physician clinical oversight of nurse anesthetists. Thus, the vast majority of nurse anesthetists are neither educated nor trained to practice in the nurse-only model. Overall, their nursing-based training, with its limited classroom duration and fewer hours of clinical training, does not allow for detailed, comprehensive medical knowledge.

It is not surprising, then, that 45 states do not permit the nurse-only model of anesthesia that VA has proposed in its Federal Supremacy Initiative. In fact, not one of the top-ranked civilian hospitals in the country employs this untested model. **Not one**. It would be wrong to give Veterans a lower standard of care than what civilians routinely receive across the country, especially because Veterans are a unique population who presents distinct medical challenges.

VA's current anesthesia policy is one of the most thoroughly researched, studied, and reviewed policies existing in VA. The current policy, Anesthesia Services Directive 1123, represents a safe, well-established, and functional compromise approach to anesthesia care delivery. No changes are clinically appropriate or necessary.

The final product for the National Standards of Practice process is a Directive. A national directive for anesthesia already exists in Directive 1123. Directive 1123 is the product of the 2017 APRN final rule which included years of extensive research and two record-breaking Federal Register public comment periods. VA concluded that there was no shortage of anesthesiologists in its system and insufficient data to support the nurse-only model. The findings were not the same for the primary care APRNs -- Nurse Practitioners, Clinical Nurse Specialists and Nurse Midwives. The result of the 2017 APRN final rule was two directives: one for primary care APRNs, Directive 1350; and one for Anesthesia, Directive 1123. VA should recognize Directive

[12] Department of Veterans Affairs, Veterans Health Agency, National Anesthesia program

1123 as the National Standard of Practice for CRNAs, just as VA is recognizing Directive 1350 as the National Standard of Practice for primary care APRNs. To do otherwise is fundamentally inconsistent.

There is no demonstrated shortage of anesthesia clinicians necessitating a change in the delivery of anesthesia care within the Department of Veterans Affairs. Removing anesthesiologists from the care of our Veterans risks creating the very workforce shortage this proposal is claiming to solve.

ASA has closely tracked vacancies for physician anesthesiologists for over 4 years through USAJOBS.gov, the official employment website for the federal government. According to USAJOBS.gov, on September 14, 2023, the number of openings for physician anesthesiologists numbered 31 throughout the entire country, or a job openings rate of 2.9%, which is at or below a typical vacancy rate for such professionals, reflecting normal turnover that occurs in anesthesiologist positions in VA. There is no shortage of physician anesthesiologists in VA, and no evidence of access issues associated with anesthesia care that would necessitate a change in clinical oversight of nurse anesthetists and in the delivery of anesthesia to meet patient demand.

VA patients are not the same as Department of Defense patients. VA has often suggested that it wishes to adopt Department of Defense standards of care. That is not advisable. Active-duty service members have very different health needs than our Nation's Veterans. Naturally, active-duty troops tend to be much younger than Veterans: they are fit, they have fewer comorbidities, they have not yet had concerning occupational exposures, and they are subject to regular fitness tests and rigorous health screenings. Their risks when undergoing anesthesia, therefore, tend to be much lower than a sick Veteran who receives treatment in a VA hospital, oftentimes decades after their service.

Even so, the United States military recruits and retains anesthesiologists. In many cases, the military utilizes the internationally recognized and mandated anesthesia care team (ACT) model within military hospitals and Military Treatment Facilities (MTFs). Every branch of the military employs and counts on physician anesthesiologists.

There is no unbiased literature to support the safety of eliminating physician clinical oversight of anesthesia. To the contrary, independent literature points to the risk to patients of anesthesia without appropriate physician clinical oversight.

VA's current policies promoting team-based models of anesthesia care ensure Veteran access to safe, high-quality anesthesia services. Because these policies are so important to Veteran patient care, any change in policy being considered should be preceded by the collection of extensive and rigorous independent, scientifically valid evidence that supports the safety of anesthesia care outside of the team-based model. As VA's own assessment concluded, such evidence does not exist. Indeed, available independent evidence indicates patients are best served by some level of clinical oversight of anesthesia by a physician. To this point, in the 2022 Burns et al study in *JAMA Surgery,* researchers found that "as **physician anesthesiologist clinical oversight of CRNAs is lessened, patients experience higher rates of injury or death**."[13]

ASA commends VA for utilizing its own research resources to investigate the quality-of-care implication of anesthesia delivered by a nurse anesthetist outside of a team-based model. VA's Quality Enhancement Research Initiative (QUERI), conducted an evidence review of available literature "to assess the strength and relevance of studies comparing autonomous APRNs with physicians in primary care, urgent care and anesthesia settings for 4 important outcomes: health status, quality of life, hospitalizations, and mortality."

With regard to anesthesia, the September 2014 QUERI document, "Evidence Brief: The Quality of Care Provided by Advanced Practice Nurses," found that the evidence to support full practice authority related to nurse anesthetists was "insufficient" and at "high risk of bias."8The paper stated that "[t]he results of these studies do not provide any guidance on how to assign patients for management by a solo CRNA, or whether

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[13] *Burns et al. Association of Anesthesiologist Staffing Ratio with Surgical Patient Morbidity and Mortality. JAMA Surg 2022 (July).*

more complex surgeries can be safely managed by CRNAs, particularly in small or isolated VA hospitals where preoperative and postoperative health system factors may be less than optimal."[14] ASA urges VA to give full consideration to the document's findings, particularly the findings that question whether complex cases can be safely managed by nurse anesthetists outside of the team-based model of care. The VA's review clearly raises questions regarding the ability of the solo nurse anesthetist model to safely manage complex patient cases.

The QUERI assessment references Silber 2000, which remains one of very few independent anesthesia outcomes studies. ASA encourages consideration of this study, titled, "Anesthesiologist Direction and Patient Outcomes," in which the relationship between physician direction and patient outcomes is analyzed. In any study, it is difficult to determine the effect of anesthesia providers on patient outcomes because of the myriad factors that can influence a patient's outcome. However, the authors of this study use robust risk-adjustment techniques that greatly improve the validity of their conclusions. This study should inform responsible policy decision-making in the future when comparing anesthesia providers. The study found the odds of death to be 8 percent higher and the odds of failure-to-rescue to be 10 percent higher in cases where the administration of anesthesia was not directed by a physician anesthesiologist. This corresponds to 2.5 excess deaths per 1,000 patients and 6.9 excess failures-to-rescue per 1,000 patients with complications. The authors employ a wide array of risk adjustment methods and multiple statistical analyses to fortify the validity of their conclusions. Such a statistically sound and conclusive study should be considered when making policy decisions about scope of practice for anesthesia providers.[15]

QUERI notes that Silber's "comparison group does not directly represent care provided by an independent CRNA." That statement is true; however, ASA would point out that QUERI's criticism helps illustrate the strength of the study's results. As indicated, Silber's "undirected" group includes nurse anesthetists practicing independently, plus nurse anesthetists working in non-direction team-based models with physician anesthesiologists and other physicians. Accordingly, it is very likely that the outcomes differences presented by Silber understate the true effect of anesthesiologist involvement on patient outcomes.

QUERI also comments about Silber's risk adjustment methods, noting that "undirected cases were performed in smaller hospitals and hospital size does not adequately explain differences" in outcomes. Much like the comparison group issue, this criticism indicates a likely understatement of the positive impact provided by anesthesiologist care. If undirected cases were performed in smaller hospitals and hospital size does not adequately explain the differences in outcomes, then ideal risk adjustment likely would have resulted in differences even larger than Silber reported. ASA urges review of Silber with these comments in mind as it considers the patient safety implications of the application to nurse anesthetists.

After consideration of the VA QUERI review, a December 14, 2016 final rule did not eliminate the physician oversight requirement of nurse anesthetists from VA's policies. VA eliminated the oversight requirements for all other categories of advanced practice registered nurses (APRN) but explicitly excluded nurse anesthetists. "The final rulemaking establishes professional qualifications an individual must possess to be appointed as an APRN within VA, establishes the criteria under which VA may grant full practice authority to an APRN and defines the scope of full practice authority for each of the three roles of APRN. Certified Registered Nurse Anesthetists will **not** be included in VA's full practice authority under this final rule"[16] [emphasis from original].

Subsequently, the *National Bureau of Economic Research* published in 2022 a study of VA's own emergency department visits between January 2017 and January 2020, the period in which nurse practitioners were first authorized by the VHA to practice in the nurse-only model, without physician supervision. VA's data revealed that emergency care provided by nurse practitioners (NPs) increased costs, utilized more services and lowered the quality of care.[17]

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[14] *U.S. Department of Veterans Affairs, Health Services Research and Development Services, "Evidence Brief: Quality of Care Provided by Advanced Practice Nurses, September 2014*
[15] *Silber JH, et al. Anesthesiologists direction and patient outcomes. Anesthesiology. Jul 2000.*
[16] *U.S. Department of Veteran Affairs, Press Release, VA Grants Full Practice Authority to Advance Practice Registered Nurses, December 14, 2016*
[17] *Chan, D. and Chen, Y. "The Productivity of Professions: Evidence from the Emergency Department," National Bureau of Economic Research (NBER), October 2022.*

ASA also urges consideration of the 2012 study titled "Factors influencing unexpected disposition after orthopedic ambulatory surgery." In the outpatient setting, patients are expected to undergo a relatively low-risk surgery and be discharged to their place of residence on the same day. Any other outcome was considered an "unexpected disposition." In this study of ambulatory surgery by Memtsoudis et al., the researchers found, among other results, that the odds of "unexpected disposition" after ambulatory surgery were 80 percent higher when the anesthesia care was provided by only a nurse anesthetist as opposed to a physician anesthesiologist. Unexpected dispositions may occur due to the patient experiencing an unanticipated adverse outcome from their procedure or anesthesia care, which may also result in additional costs to payers. The Memtsoudis study illustrates that even for low-risk procedures such as ambulatory knee and shoulder surgery, physician anesthesiologists achieve better outcomes than nurse anesthetists practicing outside of the team-based model of care.[18]

Conclusion

The physician-delivered and physician-led anesthesia care team model puts the health and safety of Veterans first. Dismantling or altering this model will subject Veterans to a lower standard of care than civilians receive. Chairwoman Miller-Meeks, Ranking Member Brownley, and members of the Subcommittee, thank you for your time and attention to this issue which is integral to the health and lives of Veterans. I welcome your questions.

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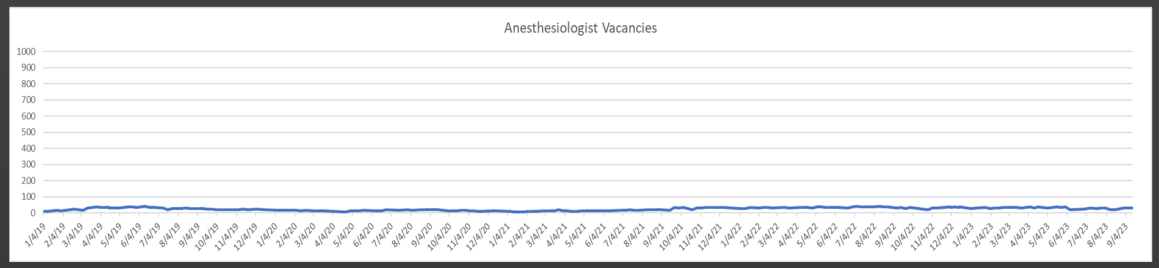
[18] *Memtsoudis SG, et al. Factors influencing unexpected disposition after orthopedic ambulatory surgery. Journal of Clinical Anesth, 2012.*

USAJobs.gov – official public job site of the federal government
Vacancies* as of September 14, 2023

Physician anesthesiologists: 33 of ≈ 1000 positions in the system

*ASA began tracking weekly vacancies in January of 2019 in response to VA officials erroneous claims that there were systemic shortages of anesthesiologists.



Prepared Statement of Erica Scavella

Good morning, Chairman Miller-Meeks, Ranking Member Brownley and distinguished Members of the Subcommittee. Thank you for the opportunity today to discuss VHA's position regarding the National Standards of Practice (NSP). Accompanying me today is M. Christopher Saslo, DNS, APRN-BC, FAANP, Assistant Under Secretary for Health Patient Care Services/Chief Nursing Officer, and Mr. Ethan Kalett, Executive Director, Office of Regulations, Appeals and Policy.

VA remains committed to honoring the Nation's Veterans by ensuring a safe environment to deliver exceptional health care. On November 12, 2020, VA published an interim final rule confirming that VA health care professionals may practice their health care profession consistent with the scope and requirements of their VA employment, notwithstanding any State license, registration, certification, or other requirements that unduly interfere with their practice (38 CFR 17.419; 85 FR 71838). The rulemaking confirmed VA's authority to establish national standards of practice for its health care professionals in all VA medical facilities and explained that a national standard of practice describes the tasks and duties that a VA health care professional may perform and may be permitted to undertake regardless of the state in which the VA medical facility where they are located or the State license, registration, certification, or other State requirement they hold.

VA continues to pursue national standards of practice for 51 occupations (including nursing, dentistry, pharmacy, rehabilitation, diagnostics, social work, mental health) to ensure safe, high-quality care for the Nation's Veterans and to ensure that VA health care professionals can meet the needs of Veterans wherever they are located. National standards are designed to increase Veterans' access to health care and improve health outcomes.

As the Nation's largest integrated health care system, VA must develop national standards of practice that ensure Veterans receive the same high-quality care regardless of where they enter the system. The importance of this initiative has been underscored by the COVID–19 pandemic. The increased need for mobility in our workforce, including through VA's Disaster Emergency Medical Personnel System, exemplifies the necessity of uniform standards of practice in support of those VA health care professionals who practice across State lines. Furthermore, standardizing practice among VA health care occupations to decrease the variances in care by State requirements also creates improved access with VA. The lack of VA national standards can negatively impact the ability of Veterans across all states to have equal access to certain services.

For example, some states, such as Missouri, require a provider's prior referral for Physical Therapy services. Direct access to these services, that is a provider referral is not necessary, is beneficial for increased access to health care, as it decreases wait times to receive care and decreases the burden on the referring provider, thus allowing the referring provider to see more Veteran patients. A VA Physical Therapist NSP could permit all physical therapy services to be initiated without a referral. By removing the additional step of requiring Veterans to first obtain a referral, VA can increase timely access to such services.

A second example involves nursing and the ability to independently follow a protocol. A protocol is a standing order that has been approved by medical and clinical leadership if a certain sequence of health care events occur. For instance, if a patient is exhibiting certain signs of a heart attack, there is a protocol in place to administer potentially life-saving medication. If the nurse is the first person to see the signs, the nurse will follow the approved protocol and immediately administer the medication. However, if the State license does not permit a nurse to follow the protocol and requires a provider co-signature, administration of the medication will be delayed until a provider is able to co-sign the order, which may lead to the deterioration of the patient's condition. Co-signing protocols also increase the provider's workload and decrease the amount of time the provider can spend with patients. Almost all states permit nurses to follow a protocol; however, Texas does not permit nurses to follow a protocol without a provider co-signature. Thus, in Texas, timely delivery of life saving care could be delayed for veterans as compared to other states. The national standards of practice for nursing could permit all VA nurses to follow protocol without provider co-signature.

VA is committed to ensuring that stakeholders are engaged in the process to develop national standards of practice for each and every health care occupation. The national standards of practice are being designed through extensive internal and external expert consultation with a focus on increasing Veterans' access to health care and ensuring health outcomes. There is an already established process for subject-matter expertise inclusion, to include partnering with the Department of Defense

to align national standards, when appropriate, which will apply to the development of all practice standards.

To further engage with key stakeholders, VA hosted five listening sessions in August and September 2023, for professional associations, Veteran Service Organizations, the clinical community, the public, and Members of Congress to provide to VA their research, input and comments on variance between state licenses and scopes of practices, and their recommendations on what should be included in VA's national standards of practice. VA will consider all feedback received at these listening sessions when drafting the national standard of practice. In addition, the draft national standard (once ready) will be published in the Federal Register for public comment; and VA will send every State Board for that profession a letter with information on the impact of the proposed national standard of practice on the specific State, with an opportunity for the State Board to respond.

VA remains committed to providing consistently high-quality patient care by qualified health care providers. The development of national standards of practice will not undo the longstanding team-based model of care already established within VA that ensures competent, safe and appropriate care for Veterans. When developing the national standards of practice, VA encourages a team-based approach to patient care and national standards of practice will support defined roles within the team regardless of State requirements or restrictions. National standards of practice are intended to strengthen team-based care by creating consistent standards nationwide, thereby generating the best possible access and outcomes for Veterans. However, privileges, scopes of practice and functional statements will continue to be specific to individuals based upon their education, training, experience, skill and clinical assignment.

In regard to the certified registered nurse anesthetist (CRNA) national standard of practice, VA will only include independent practice if VA determines that it is appropriate, safe, and in the best interest of Veterans. Work on the CRNA NSPs is currently underway. As delineated in VHA Directive 1123, National Anesthesia Service, VA anesthesiologists and CRNAs will continue to provide team-based care, either under a scope of practice or privileges, where appropriate, to provide vital anesthesia care to Veterans throughout the United States.

Currently, *VHA Directive 1123, National Anesthesia Service*, already includes language for VA CRNAs to practice independently if permitted by the facility bylaws and privileges, and if the CRNA is licensed in a state whose licensing boards have authorized independent practice for CRNAs. There is no evidence from impartial, independent studies, to indicate that full practice authority for CRNAs leads to either improved or adverse outcomes. Internally, VA monitors patient safety and quality of care through the Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) processes. These evaluations are standards required by The Joint Commission. To date, there have been no concerning FPPE/OPPE reports to indicate concerns regarding the safety and quality of independent practice authority either.

VA continues to invest in the team-based model of care, and there is no planned change accompanying these National Standards of Practice development. As noted above, all the team models defined in VHA 1123 are currently employed within the enterprise and already tested. Any local decision to change models of care delivery would be initiated by a need to improve access to care as well as subject to the very same quality standards and reviews already present in VA.

VA engaged the Temple University School of Law to conduct an independent third-party comprehensive review of each State's practice acts for CRNAs and analyze the variance in CRNA practice across states . This data is now being used to develop the CRNA national standard of practice by a team of subject matter experts from within the anesthesia service, comprised of anesthesiologists, CRNAs, and other advanced practice nurses. The national standards of practice will be designed through extensive internal and external expert consultation with a focus on increasing Veterans' access to health care and improving health outcomes. There is an already established process for subject-matter expertise inclusion, which will apply to the development of these practice standards.

In regard to the optometry national standard of practice, VA is currently considering whether the national standard of practice will authorize optometrists in the 10 States that allow laser eye surgery (AK, AR, CO, IN, KY, LA, MS, OK, VA, WY) to practice and operate within the full scope of their license in VA facilities. VA does not intend to allow VA optometrists who hold a license in any other State to perform laser eye surgery, this authority would only be considered for the states that already authorize them to perform laser eye surgery. VA held a listening session on August 31, 2023, and allowed stakeholders invested in VA eye care the opportunity to provide research, input, comments, and recommendations on what they believe should

be included in VA's proposed optometrist national standard of practice. Thirteen organizations presented to VA, including numerous professional societies and VSOs. VA is using the information presented by external stakeholders to determine what should be included in the proposed national standard of practice that will be published in the Federal Register for public comment in the future. The forthcoming proposed national standards of practice will ensure that VA upholds safe, high-quality care for the Nation's Veterans and ensure VA optometrists can meet the needs of Veterans when practicing within the scope of their VA employment.

VHA is sensitive to issues regarding the safety of Veterans in our care. As a High Reliability Organization (HRO), VA continuously monitors the quality and safety of care delivered to Veterans and works to ensure excellence for each Veteran in our care. HROs are organizations that achieve safety, quality and efficiency goals by employing five central principles, including sensitivity to operations; reluctance to simplify; preoccupation with failure; deference to expertise and practicing resilience. VA strives to continuously meet these goals, always holding ourselves and our organization to the highest possible standard. Since the standards of practice are still in the developmental stages and no changes to the model of care have been made, we will continue to monitor for issues and respond should they arise.

Conclusion

We are committed to excellence in clinical care, utilizing our highly skilled workforce in a manner commensurate with their training and expertise. We appreciate the input of Congress and our other stakeholders in ensuring this commitment is always met. We especially appreciate the Committee's efforts in helping VA continue to deliver safe, high-quality care to Veterans.

Chairwoman Miller-Meeks and Ranking Member Brownley, we appreciate your continued support and look forward to answering your questions.

STATEMENTS FOR THE RECORD

Prepared Statement of The American Legion

STATEMENT OF
TIFFANY ELLETT
VETERANS AFFAIRS & REHABILITATION DIVISION DIRECTOR
THE AMERICAN LEGION
BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS,
UNITED STATES HOUSE OF REPRESENTATIVES
ON
"VA's FEDERAL SUPREMACY INITIATIVE: PUTTING VETERANS FIRST?"

SEPTEMBER 19, 2023

Chairwoman Miller-Meeks, Ranking Member Brownley, and distinguished members of the Committee, on behalf of our National Commander Daniel Seehafer and our 1.6 million members, The American Legion thanks you for the opportunity to offer this statement on VA's Federal Supremacy Initiative. The American Legion is directed by active Legionnaires who dedicate their time and resources to serve veterans and their families. As a resolution-based organization, our positions are guided by more than 104 years of advocacy that originates at the grassroots level. Every time The American Legion testifies, we offer a direct voice from the veteran community to Congress.

The Authority of VA Professionals to Practice Health Care rule became effective on November 12, 2020.[1] This rule was issued to "confirm that its [VA] healthcare professionals may practice their healthcare profession consistent with the scope and requirements of their VA employment, notwithstanding any State license, registration, certification, or other requirements that unduly interfere with their practice." This rulemaking also confirmed VA's authority to standardize the scope of practice for healthcare professionals in all VA facilities through a set of national practicing standards. As these national standards of practice (NSP) started to unfold, the veteran advocate community became concerned about how NSP would be researched, developed, approved and implemented. Over the last three years, The American Legion has been in communication with multiple offices within VA in an attempt to understand the NSP and to ensure that quality of care remains at the center of VA's process.

According to the November rule, VA has operated as a national health system that authorizes VA healthcare professionals to practice in any state as long as they have a valid license, registration, certification, or fulfill other state requirements in at least one state. In doing so, VA healthcare professionals have been practicing within the scope of their VA employment regardless of any state requirements that would restrict practice across state lines. The rule highlights VA's acute need to exercise its statutory authority of allowing VA healthcare providers to practice medicine across state lines, move these individuals quickly across the country to care for veterans and other

[1] Authority of VA Professionals To Practice Health Care, 85 Fed. Reg. 71838 (Nov. 12, 2020) (Interim Final Rule). https://www.federalregister.gov/documents/2020/11/12/2020-24817/authority-of-va-professionals-to-practice-health-care

beneficiaries, and not have state licensure, registration, certification, or other requirements prohibit such actions. VA has also shared that NSP would provide additional protection against adverse state actions when healthcare providers practice within the scope of their VA employment, particularly when practicing across state lines.[2] To that end, the following concerns have been brought to our attention by both veterans and medical professionals:

1. The scope of practice for some occupations are only allowed in a minority number of states.
2. VA will arbitrarily set the standards without appropriate input from stakeholders.
3. The lowest common denominator across states will be used to define the standards.

These concerns are specifically focused on the occupations involved in surgical services. Members of the anesthesiology, dentistry, orthodontics, and ophthalmology communities, some of whom are veterans and some who are VA employees, have expressed concerns to us about the scope of practice for health providers, within adjacent occupations, expanding beyond evidence-based best practices in the medical community. As a response to this concern, The American Legion conducted an independent third-party survey of 1,400 veterans between February and April focusing on veteran health care preferences. See Exhibit 1.

Initial findings show that 91 percent of veterans agree that they should receive at least the same quality surgery as at top-rated civilian hospitals. Additional findings identified that 71 percent of veterans believe that VA will have a different standard of care if nurse anesthetists replace physician anesthesiologists. The American Legion, through Resolution No. 3: *The American Legion Policy on Non-Surgeons Performing Invasive Eye Surgery Within The Department of Veterans Affairs,* supports of the concept of "surgery by surgeons" within the VA eye care arena in order to provide veterans with the highest possible quality of surgical eye care available, and for VA to ensure only medically trained surgeons perform invasive eye surgery on America's veterans.[3] Furthermore, through Resolution No. 19: *Physician-led Health-Care Teams,* The American Legion calls for VA to utilize the practice of physician-led medical teams, when appropriate, in VA's delivery of healthcare services to veterans.[4] Both resolutions are focused on support of VA providing the highest quality and safest healthcare services for our nation's veterans.

Given the concerns of medical providers, veterans, and other organizations within the veteran community, The American Legion would be remiss not to state our concern about improper expansion or restriction of a healthcare provider's scope of practice through the establishment of NSP. Through Resolution No. 20: *National Standards of Practice*, The American Legion calls on Congress to provide oversight and accountability efforts, including the Office of the Inspector General and the Government Accountability Office, over the implementation of the NSP process and outcomes.[5]

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[2] "VA National Standards of Practice," Last updated: August 11, 2023, https://www.va.gov/STANDARDSOFPRACTICE/faq.asp

[3] The American Legion Resolution No. 3 (2006): *The American Legion policy on non-surgeons performing invasive eye surgery within the Department of Veterans Affairs*. https://archive.legion.org/node/3032

[4] The American Legion Resolution No. 19 (2022): *Physician-led Health-Care Teams*. https://archive.legion.org/node/14057

[5] The American Legion Resolution No. 20 (2022): *National Standards of Practice*. https://archive.legion.org/node/14058

For The American Legion to fully support VA's NSP initiative, VA must ensure:

1. Healthcare providers are held to the level of licensure and certification requirements that are held by the majority of states.
2. The evaluation and application of NSP is consistent with providing the best care possible to veterans.
3. Necessary stakeholders, including professional medical associations, are able to provide input at all phases of the development and implementation process of NSP.

Chairwoman Miller-Meeks, Ranking Member Brownley, and distinguished members of the Committee, The American Legion thanks you for your leadership and for allowing us the opportunity to share the position. For additional information or questions, please contact John Kamin, Senior Legislative Associate, at (202) 263-5748 or jkamin@legion.org.

EXHIBIT 1

AMERICAN LEGION

American Legion
National Survey on Veterans' Care Preferences

Key Findings
September 18, 2023

DEMOGRAPHICS:

Demographics		Definition of audience	Total (%)
U.S. Veterans (%)		All 2023 Veterans interviewed (n=1400)	100
Branch of Service	Army	Army Veteran	43
	Navy	Navy Veteran	19
	Air Force	Air Force Veteran	18
	Marine Corps	Marine Corps Veteran	11
	National Guard	National Guard Veteran	7
	Coast Guard	Coast Guard Veteran	2
Race/Ethnicity	Wht	Considers self white	73
	Blk	Considers self Black / African American	11
	Hisp	From Hispanic/Latino origin or Latin American background	10
Gender	M	Male	83
	F	Female	17
Age	<35	Age 23-34	10
	35-49	Age 35-49	23
	50-64	Age 50-64	29
	65+	Age 65-74	22

	75+	Age 75+	16
Region	Northeast	Connecticut, Delaware, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, Washington D.C.	16
	Midwest	Illinois, Indiana, Iowa, Kansas, Kentucky, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, West Virginia, Wisconsin	22
	South	Virginia, Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas	41
	West	Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, Wyoming	22

FINDINGS:

The following is a question-by-question analysis of the national veterans' survey findings including key sub-groups.

1. Are you enrolled in VA healthcare?

U.S. Veterans (%)	All	Gender		Age					Race/Ethnicity			Miscellaneous		
		M	F	23-34	35-49	50-64	65-74	75+	Wht	Blk	Hisp	VA Enrolled	Multiple Health Issues	Burn Pit Exposure
Yes	59	58	61	68	71	59	49	50	55	70	72	100	67	83
No	36	37	33	24	25	36	45	47	40	26	25	0	30	16
Not eligible	5	4	7	8	4	5	5	3	5	4	3	0	4	1

AMERICAN LEGION

2. Where do you prefer to receive your care? (**IF RESPONDENT SELECTED "YES" FOR Q1)**

U.S. Veterans (%)	All	Gender		Age					Race/Ethnicity			Miscellaneous		
		M	F	23-34	35-49	50-64	65-74	75+	Wht	Blk	Hisp	VA Enrolled	Multiple Health Issues	Burn Pit Exposure
VA facility	69	68	74	70	74	66	65	72	66	79	73	69	70	74
Community provider	31	32	26	30	26	34	35	28	34	21	27	31	30	26

3. Would you recommend VA to another Veteran?

U.S. Veterans (%)	All	Gender		Age					Race/Ethnicity			Miscellaneous		
		M	F	23-34	35-49	50-64	65-74	75+	Wht	Blk	Hisp	VA Enrolled	Multiple Health Issues	Burn Pit Exposure
Yes	74	74	76	76	78	73	75	70	72	83	82	88	77	84
No	10	9	10	13	10	10	6	9	10	6	8	6	10	8
Don't know/Not sure	16	17	14	11	11	17	19	21	18	11	10	6	13	8

4. Do you have multiple medical conditions or health issues?

U.S. Veterans (%)	All	Gender		Age					Race/Ethnicity			Miscellaneous		
		M	F	23-34	35-49	50-64	65-74	75+	Wht	Blk	Hisp	VA Enrolled	Multiple Health Issues	Burn Pit Exposure
Yes	63	62	68	60	57	67	62	69	63	65	66	72	100	78
No	33	34	28	35	39	29	35	29	34	31	29	25	0	19
Prefer not to say	4	4	4	5	4	4	4	2	3	4	5	4	0	2

AMERICAN LEGION

5. During your time of service in the military, were you exposed to toxins such as those from Agent Orange or burn pits?

U.S. Veterans (%)	All	Gender		Age					Race/Ethnicity			Miscellaneous		
		M	F	23-34	35-49	50-64	65-74	75+	Wht	Blk	Hisp	VA Enrolled	Multiple Health Issues	Burn Pit Exposure
Yes	26	27	20	32	36	18	21	31	26	21	31	37	33	100
No	61	60	64	54	51	68	66	57	61	66	58	49	54	0
Not sure	13	12	16	13	13	14	13	12	13	13	12	14	13	0

6. Do you prefer a physician or a nurse to provide your primary health care services?

U.S. Veterans (%)	All	Gender		Age					Race/Ethnicity			Miscellaneous		
		M	F	23-34	35-49	50-64	65-74	75+	Wht	Blk	Hisp	VA Enrolled	Multiple Health Issues	Burn Pit Exposure
Physician	67	68	65	60	65	68	66	74	67	63	73	68	69	72
Nurse	5	4	7	12	7	3	2	4	5	6	3	5	4	7
First available	28	28	29	29	28	28	32	22	28	31	25	27	28	20

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7. In your opinion, is it important that your anesthesia care during surgery be provided by a physician anesthesiologist?

U.S. Veterans (%)	All	Gender		Age					Race/Ethnicity			Miscellaneous		
		M	F	23-34	35-49	50-64	65-74	75+	Wht	Blk	Hisp	VA Enrolled	Multiple Health Issues	Burn Pit Exposure
Yes, it is important	74	75	72	82	81	74	67	71	72	82	79	75	75	78
No, it is not important	18	17	20	13	12	17	23	23	20	13	13	18	18	17
Don't know	8	8	8	5	7	9	10	6	8	6	8	7	7	5

8. Would you prefer to have a physician or nurse administer anesthesia during surgery?

U.S. Veterans (%)	All	Gender		Age					Race/Ethnicity			Miscellaneous		
		M	F	23-34	35-49	50-64	65-74	75+	Wht	Blk	Hisp	VA Enrolled	Multiple Health Issues	Burn Pit Exposure
Prefer a physician to administer anesthesia during surgery	61	61	61	62	65	58	59	62	60	63	62	61	62	63
Prefer a nurse to administer anesthesia during surgery	5	4	7	14	7	3	2	4	4	8	7	5	5	8
No preference as to who administers anesthesia during surgery	35	35	32	24	29	39	39	34	36	30	31	34	34	29

DISPLAY TEXT: Approximately 95-96 of all major surgical procedures in the United States anesthesia care is overseen by a physician anesthesiologist and often assisted by a nurse anesthetist.

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9. Do you agree or disagree with the following statements?

Surgery and anesthesia are inherently dangerous. Many VA patients have underlying medical conditions such as diabetes, high blood pressure, heart disease, arthritis, or chronic pain that put them at greater risk for surgical complications. Requiring physician involvement is a necessary safeguard.

U.S. Veterans (%)	All	Gender		Age					Race/Ethnicity			Miscellaneous		
		M	F	23-34	35-49	50-64	65-74	75+	Wht	Blk	Hisp	VA Enrolled	Multiple Health Issues	Burn Pit Exposure
Strongly agree	61	61	64	51	63	62	64	61	60	76	58	61	65	63
Somewhat agree	31	32	28	38	31	30	29	34	33	18	33	32	29	31
Somewhat disagree	6	6	5	8	5	7	5	4	6	4	8	5	5	4
Strongly disagree	2	1	2	3	1	2	2	0	1	2	2	1	1	2

10. Do you agree or disagree with the following statements?

Not one top-rated civilian hospital in the U.S. allows nurse-only anesthesia care. Veterans deserve the same level of high-quality care during surgery as non-veterans get at top-rated hospitals.

U.S. Veterans (%)	All	Gender		Age					Race/Ethnicity			Miscellaneous		
		M	F	23-34	35-49	50-64	65-74	75+	Wht	Blk	Hisp	VA Enrolled	Multiple Health Issues	Burn Pit Exposure
Strongly agree	64	63	68	51	65	65	66	67	65	64	59	63	66	65
Somewhat agree	27	27	23	35	26	25	24	28	26	28	27	28	26	28
Somewhat disagree	7	7	6	10	6	8	7	4	7	4	9	7	6	4
Strongly disagree	2	2	3	4	3	2	3	1	2	4	5	2	2	3

AMERICAN LEGION

11. Do you agree or disagree with the following statements?

If the VA replaces physician anesthesiologists with nurse anesthetists there will be two standards of care: one lower standard of care for veterans in VA facilities and the other a higher standard of care for non-veterans in virtually every other hospital in the United States.

U.S. Veterans (%)	All	Gender		Age					Race/Ethnicity			Miscellaneous		
		M	F	23-34	35-49	50-64	65-74	75+	Wht	Blk	Hisp	VA Enrolled	Multiple Health Issues	Burn Pit Exposure
Strongly agree	39	37	47	37	45	42	37	30	39	41	35	41	41	44
Somewhat agree	32	33	29	43	31	30	33	31	32	32	34	32	31	29
Somewhat disagree	20	21	16	15	16	22	20	28	21	18	21	20	20	20
Strongly disagree	8	8	8	4	8	7	10	11	8	9	11	7	8	7

12. If only a nurse anesthetist were available to oversee your anesthesia care at a VA facility, would you opt to instead receive your care from a physician outside a VA facility to ensure you had a physician anesthesiologist during surgery?

U.S. Veterans (%)	All	Gender		Age					Race/Ethnicity			Miscellaneous		
		M	F	23-34	35-49	50-64	65-74	75+	Wht	Blk	Hisp	VA Enrolled	Multiple Health Issues	Burn Pit Exposure
Yes	52	50	62	63	62	48	45	50	49	59	62	54	55	59
No	23	23	19	21	20	26	20	24	24	22	21	24	21	22
Don't know	25	27	19	17	18	26	35	26	28	19	18	22	24	19

AMERICAN LEGION

METHODOLOGY:

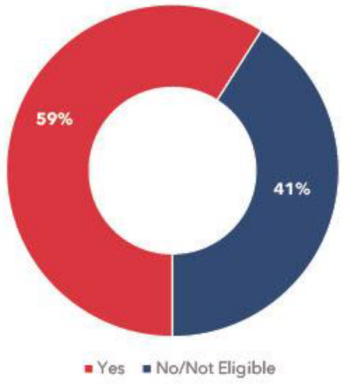
Pierrepont Consulting & Analytics LLC examined care preferences at VA for anesthesia and related health care issues among Veterans of all ages and service branches. Mercury Analytics LLC conducted the fieldwork.

This national survey of U.S. Veterans used a mixed methodology. Most responses (n=1360) were online; the remainder by telephone (n=40). For some elderly Veterans, phone interviews were either the best or only option to secure a response. Our sample size of n=1400 ensures that key learnings reflect statistically sound and trustworthy results. The survey was conducted between February and April, 2023.

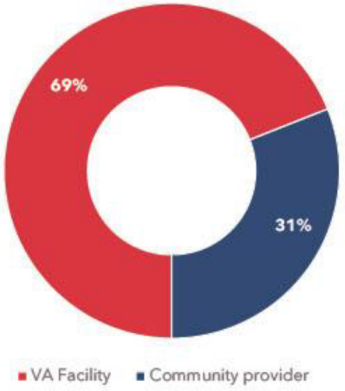
The overall margin of sampling error is +/- 2.62% at the 95% confidence level, meaning the overall results would not vary by more than 2.62% 19 times out of 20. Sampling error is greater for subgroups.

VA care preferences

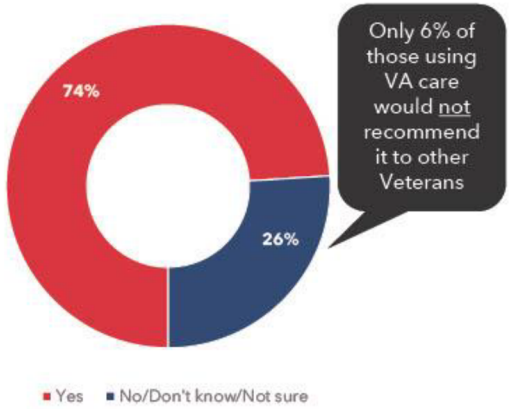
Are you enrolled in VA healthcare?



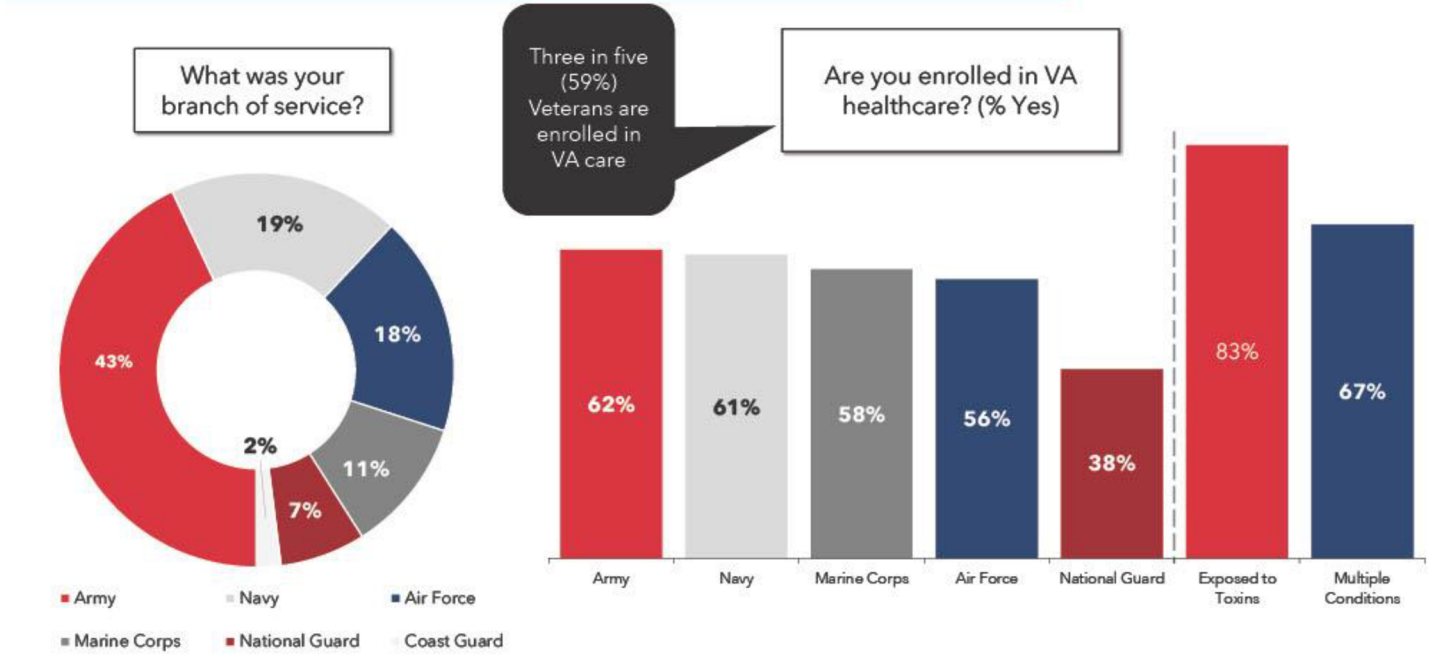
Where do you prefer to receive your care?



Would you recommend VA to another Veteran?



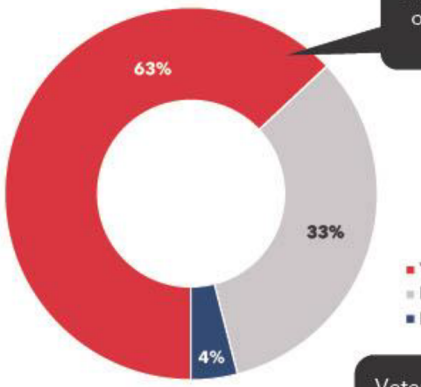
VA enrollment by **service branch and medical condition**



Multiple conditions and toxin exposure

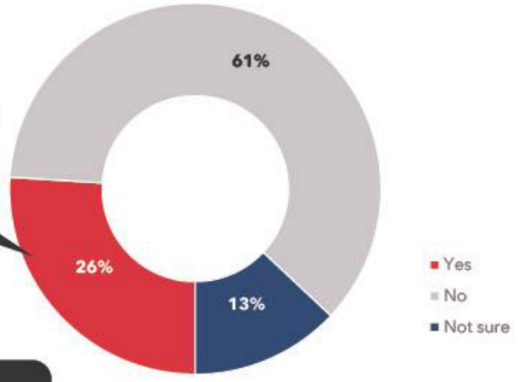
Do you have multiple medical conditions or health issues?

69% of Vets 75+ and 68% of women have multiple health issues



During your time of service in the military, were you exposed to toxins such as those from Agent Orange or burn pits?

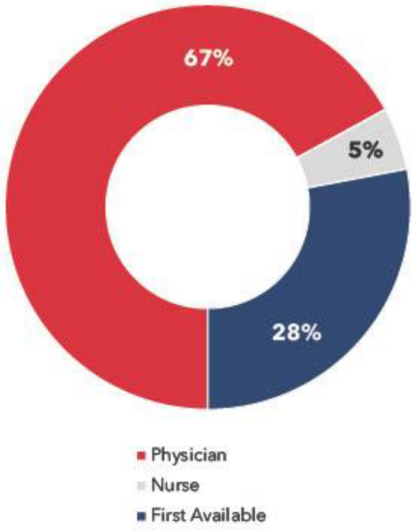
40% of Vets using VA were exposed to toxins

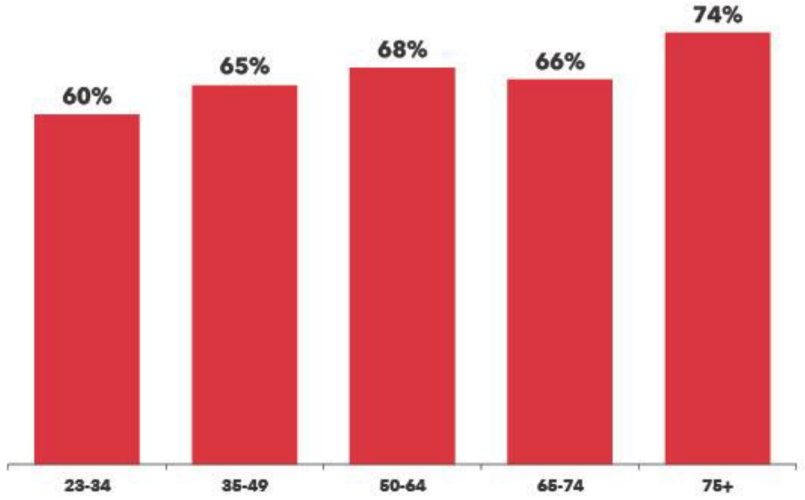


Veterans receiving VA care are significantly more likely (88%) to have multiple conditions than those not receiving VA care (55%)

Physician preference for **primary care**

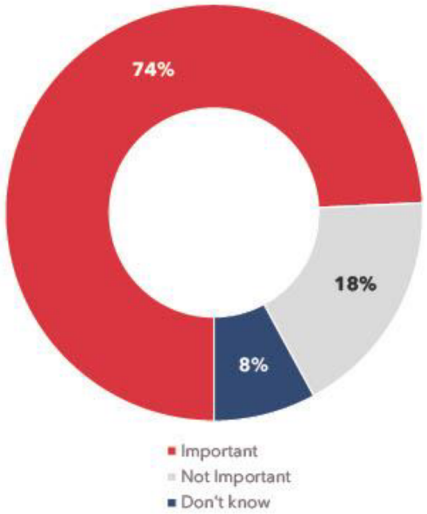
Do you prefer a physician or a nurse to provide your primary health care services?



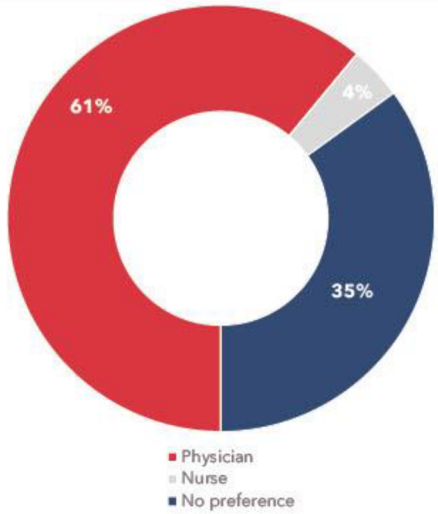


Physician preference for **anesthesia care**

In your opinion, is it important that your anesthesia care during surgery be provided by a physician anesthesiologist?



Would you prefer to have a physician or nurse administer anesthesia during surgery?



Veterans of every age, gender, race, and medical condition prefer physician-administered anesthesia care

Physician preference for **anesthesia care**

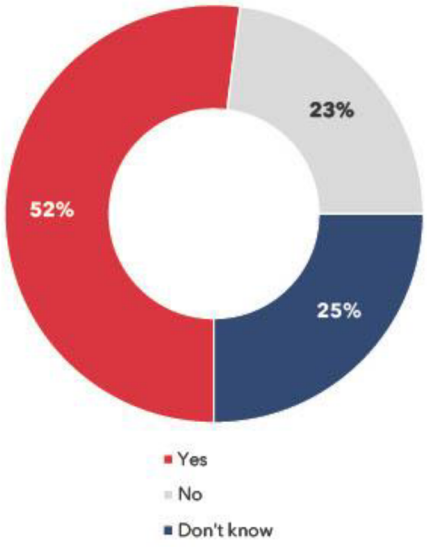
Do you agree or disagree with the following statements?	Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree
Surgery and anesthesia are inherently dangerous. Many VA patients have underlying medical conditions such as diabetes, high blood pressure, heart disease, arthritis, or chronic pain that put them at greater risk for surgical complications. Requiring physician involvement is a necessary safeguard.	61%	31%	6%	2%
Not one top-rated civilian hospital in the U.S. allows nurse-only anesthesia care. Veterans deserve the same level of high-quality care during surgery as non-veterans get at top-rated hospitals.	64%	27%	7%	2%
If the VA replaces physician anesthesiologists with nurse anesthetists there will be two standards of care: one lower standard of care for veterans in VA facilities and the other a higher standard of care for non-veterans in virtually every other hospital in the United States.	39%	32%	20%	8%

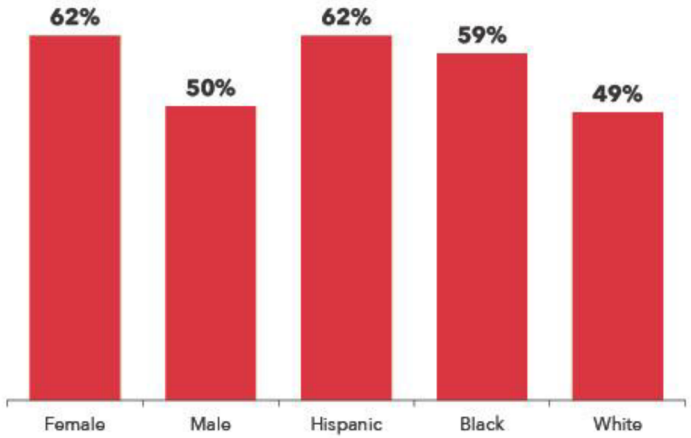
Details may not sum to total due to rounding.

REINGOLD

Seeking physician-led care **outside VA**

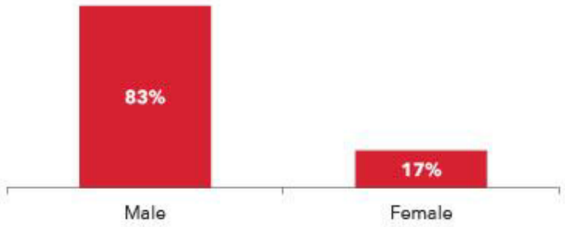
If only a nurse anesthetist were available to oversee your anesthesia care at a VA facility, would you opt to instead receive your care from a physician outside a VA facility to ensure you had a physician anesthesiologist during surgery?



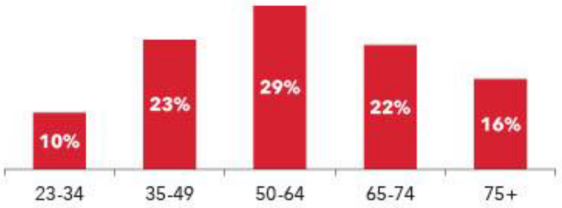


Demographics

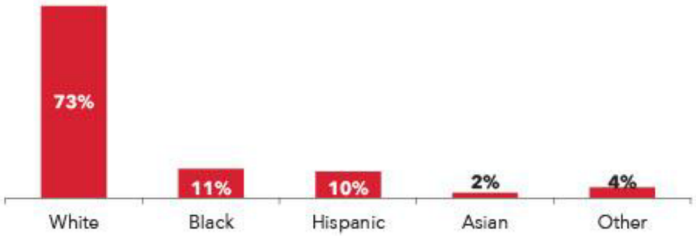
Gender



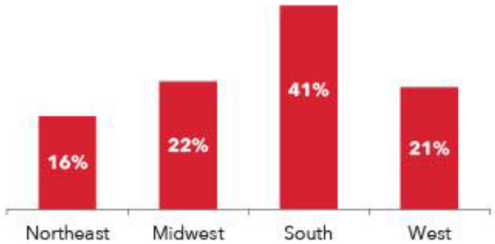
Age



Race



Region



Prepared Statement of National Conference of State Legislatures

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Statement for the Record

On behalf of
National Conference of State Legislatures

Hearing on
"VA's Federal Supremacy Initiative: Putting Veterans First?"

Provided to
United States House of Representatives
Committee on Veterans' Affairs
Subcommittee on Health

September 19, 2023

Brian Patrick Kennedy
Speaker Pro Tempore
Rhode Island General Assembly
President, NCSL

Sabrina N. Lewellen
Deputy Director - Senate
Assistant Secretary of the Senate
Arkansas General Assembly
Staff Chair, NCSL

Tim Storey
Chief Executive Officer
NCSL

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The National Conference of State Legislatures (NCSL) is a bipartisan organization representing the legislatures of the nation's 50 states, five territories and Washington, D.C. NCSL's mission is to strengthen the institution of the legislatures, provide connections between the states and serve as the voice of state legislatures in the federal system of government. NCSL is pleased to provide the subcommittee with the following statement for the record on state trends regarding scope of practice.

Background

Scope of practice refers to the activities and procedures that a provider or professional with a specific level of education, training or competency is authorized to engage in as defined by state professional regulatory boards, typically with guidance or instruction from the state legislature. All health professionals have a defined scope of practice.

In addition to practice authority, a provider may also have prescriptive authority. In general, practice authority refers to the legally required relationship that each provider must have with a physician or state regulatory board to practice. Prescriptive authority is the ability to prescribe or administer a drug, vaccine or procedure as granted by the state regulatory board, statute and/or delegated by the supervising physician.

States set their own scope of practice standards, which may be informed by factors such as access to care, safety, professional competency, cost and more. Scope of practice requirements may vary widely from state to state. The most reliable source of information on any given professionals' scope of practice is the corresponding state board or regulatory agency.

Recent State Trends

To date, NCSL has tracked 480 scope of practice-related bills across 13 health professional categories in the 2023 state legislative sessions. Of the 480, 147 bills have been enacted in state legislatures as of September.

2022 & 2023 Legislative Sessions by the Numbers

Health Profession	**2022 Enacted**	**2023 Enacted** *as of September 2023*
Addiction Counselors	3 bills	20 bills

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Certified Nurse Midwives	N/A*	13 bills
Community Health Workers	3 bills	15 bills
Community Paramedics	2 bills	8 bills
Dental Hygienists	6 bills	14 bills
Dental Therapists	1 bill	5 bills
Dentists*	2 bills	8 bills
Licensed Professional Counselors	3 bills	6 bills
Nurse Practitioners	14 bills	26 bills
Optometrists	5 bills	5 bills
Peer Support Specialists	7 bills	11 bills
Pharmacists	5 bills	18 bills
Physician Assistants	9 bills	24 bills

Please note that we currently only track dentists' authority to perform teledentistry, and we did not track certified nurse midwives until the 2023 session.

Advanced practice registered nurses and physician assistants continue to be the most common professions that state legislatures look at regarding scope of practice. Most of the legislation regarding these two professions relates to making COVID-19 flexibilities and changes to scope of practice laws permanent. For additional context, 36 states had executive orders addressing scope of practice or out-of-state licensing in 2020. Of those, 17 states expanded the scope of practice of APRNs and PAs using executive orders.

Other legislative trends include establishing certification and licensure requirements for addiction counselors, community health workers and peer support specialists and modifying/defining pharmacists' prescriptive authority.

State Scope of Practice Trends Among Veterans Affairs Occupations

Due to the immense variation in state scope of practice laws and regulation, the following information is intended to be a snapshot of overall trends and does not attempt to capture in full detail all state activity or variation within this area. In particular, the information presented below reflects the most common questions and requests that NCSL receives from state legislators.

Dentistry

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Dental Hygienists

Dental Hygienists are licensed health professionals primarily focused on oral disease prevention. Direct access is defined by the American Dental Hygienists Association as the ability of a dental hygienist to initiate treatment based on his or her assessment of a patient's needs without the specific authorization of a dentist, treat the patient without the presence of a dentist and maintain a provider-patient relationship.

State scope of practice laws within the area of direct access by dental hygienists vary.

- **Nine states** do not allow direct access by dental hygienists.
- **Twenty-six states** require a dental hygienist to have a collaborative agreement with a dentist that outlines certain policies and procedures for direct access, including supervision needed.
- **Eleven states** require dental hygienists to meet certain educational or experience requirements before being granted direct access.
- **Five states** do not require supervision by a dentist when practicing in direct access settings.

Other areas in which state scope of practice laws vary for dental hygienists include:

- Ability to provide dental hygiene diagnosis.
- Prescriptive authority (fluoride, topical medications and Chlorhexidine).
- Administering local anesthesia.
- Ability to supervise dental assistants.
- Formulation of treatment plans.
- Provision of sealants.
- Providing prophylaxis without prior examination by a dentist.

Dental Assistants

Dental assistants operate under the direction of a dentist and/or dental hygienist. In general, they may prepare or sterilize equipment, prepare patients for treatment, assist the dentist during treatment, complete administrative tasks and provide patients with instructions for oral health procedures. Each state varies in the number of tasks that a dental assistant may be delegated to perform, and some states offer differing levels of certification for dental assistants. In general, the higher the level of certification, the more expanded the scope of practice. All relevant state laws may be found here.

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Diagnostics

According to the American Society for Clinical Laboratory Science, 10 states currently have laboratory personnel licensure requirements (California, Hawaii, Florida, Louisiana, Montana, Nevada, New York, North Dakota, Tennessee and West Virginia). All other states do not explicitly regulate the scope of practice for clinical laboratory science professions in state statute.

Emergency Medicine

The National EMS Scope of Practice Model, developed in 2007 and most recently revised in 2019, provides a national standard for EMR, EMT, AEMT and paramedic education, certification, licensure and credentialing. All 50 states, the district and the territories have adopted the model as their foundation for state regulatory requirements for EMS clinicians.

Mental Health and Suicide Prevention

NCSL does not currently have any information on the scope of practice of marriage and family therapists or rehabilitation counselors.

Addiction Counselors

Addiction counselors may also be referred to by states as substance abuse counselors, alcohol and drug counselors or chemical dependency counselors. All 50 states credential some type of addiction counselor with varying levels of educational requirements.

- **Twenty-nine states** require a high school diploma or higher.
- **Eleven states** and the district require an associate degree or higher.
- **Ten states** require a bachelor's degree or higher.

Scope of practice can vary significantly depending on the type of credentials offered by the state and the education and/or competencies required to obtain the credential.

Licensed Professional Counselors

According to the American Counseling Association, licensed professional counselors (LPCs) are mental health service providers with master's degrees, trained to work with individuals, families, and groups in treating mental, behavioral and emotional problems and disorders. Scope of practice laws for LPCs vary in diagnostic authority.

- **Thirty-four states** explicitly outline a licensed professional counselor's ability to diagnose patients in state statute.

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- **Fifteen states** do not outline whether a licensed professional counselor is able to provide a diagnosis.
- **One state** does not allow licensed professional counselors to provide patients with a diagnosis.

Peer Support Specialists
According to the Substance Abuse and Mental Health Services Administration, peer support workers are people who have been successful in the recovery process and help others experiencing similar situations. States credential or certify peer support specialists through a variety of different pathways.

- **Eight states** use both state and private entities for certification.
- **Eighteen states and the district** use only a state agency or board.
- **Twenty states** use private entities for certification.

Psychologists
Six states, the Defense Department, U.S. Public Health Service and the Indian Health Service grant prescriptive authority to appropriately trained licensed psychologists. These states include Colorado, Idaho, Illinois, Iowa, Louisiana and New Mexico. All six states have implemented rigorous education and clinical hour requirements for psychologists who wish to apply for prescriptive authority. A few examples of such requirements include a postdoctoral master's degree in clinical psychopharmacology and/or completing a pharmacology residency.

In **44 states and the district**, psychologists do not have any prescriptive authority. They maintain the authority to diagnose, implement psychological and behavioral interventions and establish therapeutic relationships among other duties.

Nursing
Registered Nurses (RNs) and Licensed Practical Nurses/Vocational Nurses (LPN/VNs)
All 50 states have a board of nursing that regulates the practice of registered nurses and licensed practical/vocational nurses and APRNs, often at the direction of the state's legislature. Some states may choose to regulate certified nurse midwives through other boards or departments that are dedicated to the practice of midwifery.

Both RNs and LPN/VNs work autonomously within their scope of practice and level of

competence as part of collaborative teams. In general, LPN/VNs are responsible for assisting RNs in providing nursing care to their patients, which often includes recording a patient's health history, performing physical assessments and measuring vital signs, performing wound care, administering intramuscular, oral rectal and topical medications, providing patient education and more. A registered nurse's scope of practice includes administering and monitoring medications, developing care plans, delegating tasks to other professionals, supervising care provided by LPN/VNs, obtaining vital signs, recognizing abnormalities, wound care and performing basic life support. State statutes for both RNs and LPNs vary in specifically allowable tasks and duties.

Advanced Practice Registered Nurses

Advanced Practice Registered Nurses (APRNs) are licensed nurses with post-graduate education and training in nursing. There are four types of APRNs, including nurse practitioners, certified nurse midwives, certified registered nurse anesthetists and clinical nurse specialists.

States vary in their definitions of nurse practitioner practice authority.

- **Eighteen states and the district** have full independent practice and prescriptive authority.
- **Three states** have full independent practice but require a transition to independent prescribing period.
- **Three states** have full independent practice but require a physician relationship to prescribe.
- **Twelve states** have a transition to independent practice and prescribing period.
- **Fourteen states** require CNMs to maintain a relationship, either collaborative or supervisory, for both practice and prescriptive authority.

Certified Nurse Midwife (CNM) practice authority also varies by state.

- **Twenty-four states and the district** have full independent practice and prescriptive authority.
- **Two states** have full independent practice but require a transition to independent prescribing period.
- **Five states** have full independent practice but require a physician relationship to prescribe.
- **Four states** have a transition to independent practice and prescribing period.

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- **Fifteen states** require CNMs to maintain a relationship, either collaborative or supervisory, for both practice and prescriptive authority.

Clinical Nurse Specialists are another category of APRNs that have a defined scope of practice in most state law. According to the National Council of State Boards of Nursing, there are four types of practice authority for a CNS:

- Full independent practice authority: States that have independent practice authority have no requirement for a written collaborative agreement, supervision or conditions for practice. Some may require a period of practice under a collaborative or supervisory agreement before allowing independent practice. **Thirty-four states and the district** fall under this category for CNSs.
- Reduced practice authority: Other states are classified as reduced if a written agreement specifies the SOP and medical acts allowed with or without a general supervision requirement, direct supervision is required or other conditions must be met in order to practice. **Eleven states** are classified as reduced.
- Supervision required: **Pennsylvania** does not grant a CNS any advanced practice authority.
- Unspecified practice authority: **Four states** either do not have data or they do not recognize a CNS as an APRN.

Please note that certified registered nurse anesthetists (CRNAs) will be covered in more detail below.

Pharmacy

NCSL does not currently have information on the scope of practice of clinical pharmacist practitioners or pharmacy technicians.

According to the National Alliance of State Pharmacy Associations, prescriptive authority for pharmacists in all 50 states falls somewhere on the continuum between collaborative prescribing and autonomous prescribing. Collaborative prescribing, or dependent prescribing, indicates that a pharmacist has a collaborative practice agreement (CPA), which is a formal agreement or relationship between a pharmacist and prescriber, usually a physician. These collaborative agreements identify what functions are delegated to the pharmacist in addition to their typical scope of practice and what conditions must be met to prescribe. Autonomous

prescribing, or independent prescribing, usually indicates that a pharmacist's prescriptive authority comes directly from the state and no delegation is required.

Most often, states have a statewide protocol, which is issued by an authorized state body, based on state statute and regulation that specifies the conditions that need to be met to prescribe a specified medication or the categories of medications included in their authority. Prescriptive authority could include prescribing medications, modifying drug therapy, giving vaccines and/or conducting lab tests.

Prescriptive Authority:

- All **50 states** allow pharmacists to prescribe naloxone.
- **Twenty-eight states and the district** allow pharmacists to prescribe hormonal contraceptives.
    - Two additional states (New York and Maine) have recently passed legislation that will allow pharmacists to prescribe hormonal contraceptives in 2024.
- **Eighteen states** allow pharmacists to prescribe tobacco cessation aids.
- **Several states** allow pharmacists to dispense pre-exposure prophylaxis and post-exposure prophylaxis for HIV prevention without a doctor's prescription.

Prescription adaptation can be defined as a pharmacist modifying a medication regimen from the original prescriber to improve a patient's health outcome, either independently or in collaboration with the original prescriber (e.g., physician, nurse practitioner). This can include modifying the quantity of a prescription (e.g., changing a 30-day supply to a 60-day supply) or switching a patient to a different medication that has the same effect as the previously prescribed drug (i.e., therapeutic substitution). The adaptation cannot change the type of medication or the outcome that the original prescriber intended. Some states have used this as a way to help patients in rural areas avoid unnecessary travel to the doctor's office to modify a prescription.

Prescription Adaptation:

- **Five states** (Colorado, Idaho, Indiana, Maryland and Maine) allow prescription adaptation.
- **Forty-five states** do not allow for prescription adaptation.

Some states have given pharmacists the authority to prescribe additional medications as well, usually for treating minor acute conditions. All **50 states** allow pharmacists to administer vaccinations, but some limit the types of vaccines they can administer and/or restrict their authority by patient age.

Primary Care
All **50 states** allow physicians to broadly practice medicine under the law. This includes diagnosing, treating, correcting, advising or prescribing medication. State law varies on the types of tasks and activities that may be delegated to nurses, physician assistants or other medical professionals.

Physician Assistants
Details on physician assistant scope of practice are included in the section below.

Patient Centered Care & Cultural Transformation
NCSL does not currently have any information on acupuncturist or massage therapists' scope of practice.

Rehabilitation & Prosthetic Services
NCSL does not currently have any information on the scope of practice of art therapists, audiologists, blind rehabilitation specialists, chiropractors, dance/movement therapists, drama therapists, kinesiotherapists, music therapists, occupational therapists, occupational therapist assistants, orthotist and/or prosthetists, physical therapist assistants, recreational therapists or speech language pathologists.

Physical Therapists
All 50 states allow some type of direct access to a physical therapist. This means that physical therapists may see a patient without a physician referral in at least one circumstance. According to the American Physical Therapy Association, **20 states** allow unrestricted direct access, **27 states and the district** have direct access with provisions and **three states** have limited patient access to physical therapists without a referral.

Social Work Services
There are a variety of different types of licensed social workers in each state. In general, there

are bachelor's level-licensed social workers and master's level-licensed social workers (often broken down into Licensed Master Social Workers and Licensed Clinical Social Workers). Each license authorizes the individual to engage in a different scope of practice. In general, only LCSWs may provide independent clinical services to clients in all states. Licensed social workers do not have any prescriptive authority.

Specialty Care

NCSL does not have information on the scope of practice of dieticians, genetic counselors, ophthalmology technicians, podiatrists, perfusionists, respiratory therapists, therapeutic medical physicists or therapeutic radiology technologists.

Optometrists

Doctors of optometry (O.D.s/optometrists) provide more than two-thirds of primary eye health care in the United States. Optometrists are one of three types of eye care providers, alongside ophthalmologists (specialists who focus on more advanced surgical procedures) and opticians (who fit and/or fulfill corrective eye wear at the direction of either an optometrist or ophthalmologists). Ophthalmologists are physicians authorized to perform all the services that optometrists can, with additional authority for other medical tasks and surgery.

As health care providers, optometrists are trained to examine, diagnose, treat and manage eye disorders, diseases and injuries that manifest in the eye. In addition to providing eye and vision care, they may also play a key role in an individual's general health and well-being. Optometrists can detect systemic diseases, provide vaccinations and prescribe medications.

Optometrists can prescribe certain classifications of controlled substances depending on state law and/or rules and regulations. Schedule II controlled substances include hydrocodone only.

- **Thirty-five states** grant optometrists schedule II (Hydrocodone only)-V prescribing authority.
- **Eight states** give schedule III-V authority to optometrists.
- **Seven states and the district** have schedule IV-V authority or no authority to prescribe controlled substances.

States may also grant optometrists injectable authority as part of their overall scope of practice.

- **Twenty-four states** allow optometrists to administer injections, including but not

limited to, the treatment of anaphylaxis.

- **Seventeen states and the district** allow optometrists to administer injections to treat anaphylaxis only.
- **Nine states** do not allow optometrists to administer injections.

Optometrists may have the authority to perform ophthalmic procedures in some states.

- **Seven states** give surgical and/or laser privileges to optometrists.
- **Five states** allow optometrists to remove lumps and bumps.
- **Twelve states** have specific allowable procedures outlined in state statute.
- **Twenty-six states and the district** limit optometrists to examination, diagnosis and treatment.

Scope of Practice for CRNAs and PAs

This section contains scope of practice information on professions that have had a high prevalence of legislation over the last two sessions. Additionally, NCSL has fielded a variety of questions on these professions from state legislators in recent years.

Certified Registered Nurse Anesthetists (CRNAs)

Education

All CRNAs have at least a master's degree from a program accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs and have completed at least 2,000 clinical hours. Anesthesiologists have completed medical school and a four-year anesthesiology residency program, including at least 12,000 clinical hours.

CRNAs must complete at least 100 credits of continuing education every four years to maintain their certification through the National Board of Certification and Recertification for Nurse Anesthetists. Anesthesiologists must complete at least 125 continuing medical education credits every five years. Some states may require more stringent continuing education requirements to maintain licensure.

CRNA Practice Authority & Prescriptive Authority

According to the National Council of State Boards of Nursing, each state may fall under two types of practice authority for Certified Registered Nurse Anesthetists (CRNA):

1) States that have independent practice authority have no requirement for a written

collaborative agreement, supervision or conditions for practice (such as Utah). Some may require a period of practice under a collaborative or supervisory agreement before allowing independent practice. **Thirty-four states, the district and CRNAs working in the U.S. military** fall under this category.

2) Other states are classified as not independent if a written agreement specifies the SOP and medical acts allowed with or without a general supervision requirement, direct supervision is required or other conditions (such as Indiana which requires supervision by a physician). **Fourteen states** are classified as not independent.

Please note that New York does not currently recognize CRNAs as APRNs.

Thirty-three states allow CRNAs to obtain prescriptive authority for controlled substances. Some states allow CRNAs to prescribe these substances automatically. Other states require an application. Most states with prescriptive authority require additional educational, licensing or oversight requirements to be met for this prescriptive authority.

Regardless of state law, CRNAs in a hospital or ambulatory setting may still require supervision as the Centers for Medicare & Medicaid Services (CMS) have a federal requirement mandating physician oversight to qualify for Medicare reimbursement. As of 2023, 24 states and Guam have chosen to opt-out of this requirement by sending an attestation from the governor that states the boards of medicine have been consulted, it is consistent with state law and it is in the best interest of the state's citizens.

Physician Assistant

Education

Physician assistants (PAs), also referred to as physician associates, are licensed clinicians who practice medicine in every specialty and setting. Most often, PAs work on providing care through patient-centered, team-based medical practice. PAs have obtained a master's degree and have spent over 2,000 hours in clinical rotations. For PAs, supervision requirements include the legally required collaborative or contractual agreements that a physician assistant must have with a physician to provide patient care. This may be determined at the practice level or at the state level by the state medical board or within statute.

Physician assistants are required to take a recertification examination every 10 years and earn 100 continuing medical education credits every two years to maintain certification with the

National Commission on Certification of Physician Assistants. Some states may require more stringent continuing education requirements to maintain licensure.

Practice & Prescriptive Authority

Physician assistants are required to be supervised by a physician in **26 states and four territories.** In **19 states, the district and American Samoa**, PAs may practice in collaboration with a physician. Recent legislation passed in **five states** allows physician assistants to practice independently or have a transition to an independent practice period.

Generally, PAs can prescribe medication with the collaboration or approval of a supervising physician. Some states do not allow PAs to prescribe Schedule II substances or limit the length of prescriptions. Specific protocols and procedures surrounding the ability to prescribe for PAs differ by state.

Additional Resources

- 50-State Scope of Practice Landscape Website and Legislative Database, NCSL
    - This site provides nonpartisan, unbiased and objective policy information about the scope of practice laws in the 50 states, the district and territories. The site and corresponding database include information on the following practitioners:
        - Addiction Counselors
        - Certified Nurse Midwives
        - Community Health Workers
        - Community Paramedics
        - Dental Hygienists
        - Dental Therapists
        - Dentists
        - Licensed Professional Counselors
        - Nurse Practitioners
        - Optometrists
        - Peer Support Specialists
        - Pharmacists
        - Physician Assistants

NCSL takes no position on state legislation or laws mentioned in linked material, nor does NCSL

endorse any third-party publications. Resources are cited for informational purposes only.

NCSL Contacts:
Lauren Kallins, Legislative Director-HHS, State Federal Affairs (lauren.kallins@ncsl.org)
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Prepared Statement of American Nurses Association

The American Nurses Association (ANA) would like to thank the House Veterans' Affairs Subcommittee on Health for this opportunity to submit a statement for the record with respect to the subcommittee's oversight hearing on "VA's Federal Supremacy Initiative: Putting Veterans First?" As the voice of our nation's nurses, ANA is committed to working with the House Veterans' Affairs Committee and the U.S. Department of Veterans' Affairs (VA) to ensure that our nation's veterans and their families have access to highly qualified healthcare professionals during their time of need. With this mission in mind and given how nurses provide care for VA patients on a national basis, ANA supports the VA's ongoing efforts to develop national practice standards for nurses and other providers. This initiative gives nurses needed flexibility to practice across state lines, improving VA capacity to meet veterans' needs in more areas of the country.

The VA has struggled for years to recruit and retain nurses and other healthcare professionals, which has in turn adversely impacted veterans' access to timely, high-quality care. This predicament has gotten worse since the COVID–19 pandemic. According to a report published last year by the VA' Office of Inspector General, 91 percent of VA facilities reported severe shortages for nurses during Fiscal Year 2022.[1] As the VA works to address this nursing shortage crisis, it cannot afford to underutilize its existing nursing workforce.

Registered Nurses (RNs) have a critical role in the care of patients within the VA. RNs are frequently the provider who has the most contact with patients, and therefore offer unique insights into the needs of their patients. Unfortunately, nurse burnout is worsening the shortage of nurses nationwide. ANA's most recent survey shows that almost half of nurses are considering leaving their current position and a lower, but not insignificant, percent are considering changing professions and leaving nursing entirely.[2] This would allow RNs to practice at the top of their license and would provide flexibility to the VA by allowing nurses to practice where they are most needed within the VA system.

Certified Registered Nurse Anesthetists (CRNAs) play a vital role in providing anesthesia care across the care continuum, ranging from general anesthesia to regional anesthesia to non-opioid pain management. Past studies have shown that CRNAs can render high-quality anesthesia care without physician supervision.[3] In fact, CRNAs in other federal health systems and the armed services have been granted full practice authority. This is why it is crucial for the VA to promptly develop and issue national standards that empower Certified Registered Nurse Anesthetists (CRNAs) employed within the VA healthcare system to practice to the full extent of their education and licensure.

In closing, ANA appreciates this opportunity to share the nursing community's perspective on how the VA can utilize the federal supremacy initiative to expand access to care for veterans and their families. We stand ready to work with this subcommittee and the full committee to advance this mission. Should you have any questions, please reach out to Tim Nanof, Vice President of Policy and Government Affairs, at (301) 628–5081 or Tim.Nanof@ana.org.

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[1] OIG Determination of Veterans Health Administration's Occupational Staffing Shortages Fiscal Year 2022 (va.gov)

[2] https://www.nursingworld.org/practice-policy/work-environment/health-safety/disaster—preparedness/coronavirus/what-you-need-to-know/annual-survey—third-year

[3] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2008.0966

Prepared Statement of Nursing Community Coalition

September 18, 2023

The Honorable Mariannette Miller-Meeks
Chairwoman
House Committee on Veterans' Affairs
Subcommittee on Health
364 Cannon House Office Building
Washington, DC 20003

The Honorable Julia Brownley
Ranking Member
House Committee on Veterans' Affairs
Subcommittee on Health
550 Cannon House Office Building
Washington, DC 20515

Dear Chairwoman Miller-Meeks and Ranking Member Brownley:

On behalf of the 47 undersigned organizations representing the Nursing Community Coalition (NCC), we appreciate the opportunity to submit a statement for the record regarding the Subcommittee's hearing on, "VA's Federal Supremacy Initiative: Putting Veterans First?" The NCC is a cross section of education, practice, research, and regulation within the nursing profession representing Registered Nurses (RNs), Advanced Practice Registered Nurses (APRNs),[1] nurse leaders, boards of nursing, students, faculty, and researchers. Together, we write in support of removing barriers to practice and allowing for Certified Registered Nurse Anesthetists (CRNAs) to practice to the full extent of their education and abilities within the Department of Veterans Affairs' (VA).

As the largest segment of the health care profession[2], nursing is involved at every point of care. We recognize that, particularly during these unprecedented times, ensuring the health care of our veterans and patients across the country is crucial. By providing anesthesia services across the entire care continuum, CRNAs not only bring much needed support and expertise during this crisis, but their full range of skills are imperative in the future as well. The VA has acknowledged the benefits of allowing Advance Practice Registered Nurses (APRNs) to work to the top of their scope, writing in their 2022-2028 Strategic plan, "Data demonstrates that Full Practice Authority (FPA) for APRNs has a positive impact on wait times in Mental Health, Specialty Care and Primary Care."[3] We encourage the VA to develop National Standards for CRNAs to allow them to practice to the top of their scope for the benefit of veterans.

[1] APRNs include certified nurse-midwives (CNMs), certified registered nurse anesthetists (CRNAs), clinical nurse specialists (CNSs) and nurse practitioners (NPs).
[2] United States Census Bureau. (2021) Who are our Health Care Workers? Retrieved from: https://www.census.gov/library/stories/2021/04/who-are-our-health-care-workers.html
[3]Department of Veterans Affairs Fiscal Years 2022-28 Strategic Plan. Retrieved from: https://department.va.gov/wp-content/uploads/2022/09/va-strategic-plan-2022-2028.pdf

Various studies, recommendations, and outcomes have consistently found that anesthesia care by CRNAs is equally safe with or without physician supervision.[4] Other federal health care systems, the Army, Navy, and Air Force, have been utilizing full practice authority for CRNAs.[5] In addition to their skill set in general anesthesia, CRNAs are also taking the lead on non-opioid or opioid sparing pain management practices, a critical skill in light of the ongoing opioid epidemic and the prevalence of chronic pain among veterans.

Our nation's veterans and their families deserve access to timely, cost effective, and high-quality care within the VA health system. Removing these barriers for CRNAs helps meet this aim. If our organizations can be of any assistance, or if you have any questions, please contact the Nursing Community Coalition's Executive Director, Rachel Stevenson at rstevenson@thenursingcommunity.org.

Sincerely,

Academy of Medical-Surgical Nurses
American Academy of Ambulatory Care Nursing
American Academy of Emergency Nurse Practitioners
American Academy of Nursing
American Association of Colleges of Nursing
American Association of Critical-Care Nurses
American Association of Heart Failure Nurses
American Association of Neuroscience Nurses
American Association of Nurse Anesthesiology
American Association of Nurse Practitioners
American College of Nurse-Midwives
American Nephrology Nurses Association
American Nurses Association
American Nursing Informatics Association
American Organization for Nursing Leadership
American Psychiatric Nurses Association
American Public Health Association, Public Health Nursing Section
American Society of PeriAnesthesia Nurses
Association for Radiologic and Imaging Nursing
Association of Community Health Nursing Educators
Association of Nurses in AIDS Care
Association of periOperative Registered Nurses
Association of Public Health Nurses
Association of Rehabilitation Nurses
Commissioned Officers Association of the U.S. Public Health Service
Dermatology Nurses' Association
Friends of the National Institute of Nursing Research
Gerontological Advanced Practice Nurses Association
Hospice and Palliative Nurses Association
International Association of Forensic Nurses
National Association of Clinical Nurse Specialists
National Association of Hispanic Nurses

[4] Dulisse, B., & Cromwell, J. (2010). No harm found when nurse anesthetists work without supervision by physicians. Health Affairs, 29,1469-1475.Retrieved from: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2008.0966
[5] Department of the Army, Army Regulation, Medical Services: Clinical Quality Management, 2009 p.26 Retrieved from: https://www.qmo.amedd.army.mil/credentialing/FY%2004/Regulations/AR%2040-68.pdf

National Association of Neonatal Nurse Practitioners
National Association of Neonatal Nurses
National Association of Nurse Practitioners in Women's Health
National Association of Pediatric Nurse Practitioners
National Association of School Nurses
National Black Nurses Association
National Council of State Boards of Nursing
National Forum of State Nursing Workforce Centers
National League for Nursing
National Nurse-Led Care Consortium
National Organization of Nurse Practitioner Faculties
Nurses Organization of Veterans Affairs
Organization for Associate Degree Nursing
Society of Urologic Nurses and Associates
Wound, Ostomy, and Continence Nurses Society

cc:
Representative Amata Coleman Radewagen
Representative Jack Bergman
Representative Greg Murphy
Representative Derrick Van Orden
Representative Morgan Luttrell
Representative Jen Kiggans
Representative Mike Levin
Representative Chris Deluzio
Representative Greg Landsman
Representative Nikki Budzinski

Prepared Statement of American Academy of Family Physicians

September 19, 2023

The Honorable Mariannette Miller-Meeks
Chair
House Veterans' Affairs Committee
Subcommittee on Health
U.S. House of Representatives
364 Cannon House Office Building
Washington, DC 20515

The Honorable Julia Brownley
Ranking Member
House Veterans' Affairs Committee
Subcommittee on Health
U.S. House of Representatives
550 Cannon House Office Building
Washington, DC 20515

Dear Chair Miller-Meeks and Ranking Member Brownley:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 129,600 family physicians and medical students across the country, I applaud the subcommittee for its focus on the health and well-being of our nation's veterans. I write in response to the hearing: "VA's Federal Supremacy Initiative: Putting Veterans First?" related to the Department of Veterans Affairs' (VA) ongoing public listening sessions, to share the family physician perspective and the AAFP's policy recommendations regarding the development of National Standards of Practice.

Among other recommendations detailed below, the AAFP urges Congress to work with the VA to:

- Maintain and support physician-led, team-based primary care through the VA's existing Patient Aligned Care Team (PACT) model, which incorporates clinical and support staff who deliver all primary care functions and coordinate remaining patient needs, including specialty care.
- Designate additional VA graduate medical education (GME) slots for primary care specialties to address the current and projected shortages at VA facilities.
- Expand efforts to partner with community-based primary care physicians to ensure veterans have access to timely, comprehensive, and quality care.

While the Academy supports a wide variety of efforts by policy makers to improve access to health care services, including incorporating nonphysician practitioners (NPPs), we believe physician-led, team-based primary care is what's best for patient care and outcomes. Patients are best served when their care is provided by an interprofessional, interdependent team led by a physician to support comprehensive care delivery and achieve better health, better care, and lower costs. Nowhere is this more important than at the VA, which delivers multifaceted medical care to veterans, including those with traumatic brain injuries and other serious medical and mental health issues. Our nation's veterans deserve high-quality, accessible health care delivered by a physician-led care team that can address holistic patient needs, communicate effectively, and empower care team members to utilize their skills, training, and abilities to the full extent of their professional capacity.

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The AAFP has previously shared our serious concerns regarding the VA's efforts to develop National Standards of Practice for physicians and other health professionals that supersede state scope of practice and licensure laws. State licensing boards play a leading role in protecting patient safety, ensuring that medical care is provided in accordance with state laws, and investigating and taking disciplinary action to address wrongdoing. Such laws are often the result of extensive debate by state legislatures, sometimes spanning several years and involving negotiations among all stakeholders. However, the VA's decision to circumvent state scope of practice laws and regulations will make it impossible for state boards to oversee physicians and NPPs employed by the VA, which could lead to unintended consequences. **We urge Congress to work with the VA to ensure adequate oversight of all licensed health care team members, including by coordinating with relevant state licensing boards.**

The VA's policies have implications for standards of care far beyond the Department, making it vitally important for there to be a meaningful process in place to collect, disseminate, and include stakeholder input while developing these national standards. The AAFP appreciates Congress' interest in the VA's process, as well as its efforts to provide a transparent process by which public stakeholders are offered an adequate opportunity to review and provide meaningful input into the development of national practice standards.

Congressional Recommendations
Primary care is the only health care component where an increased supply is associated with better population health and more equitable outcomes. Even though primary care comprises the largest number of physicians in the U.S. health system, primary care accounts for only eight percent of the VA's budget.[1] The COVID-19 pandemic highlighted the urgency of building and financing a robust, well-trained, and accessible primary care system in our country. We urge the committee to consider the following recommendations to improve primary care for our nation's veterans:

- Importance of Primary Care Team-Based Care

  The ability to deliver high-quality primary care depends on the availability, accessibility, and competence of a primary care workforce working as a team to effectively meet the health care needs of all patients. The VA, as the largest integrated health care system in the nation, has been a leader for decades in increasing veteran access to care through team-based care. In fact, a 2021 National Academies of Sciences, Engineering, and Medicine report highlighted the VA's PACT model, launched in 2010, as a successful interprofessional primary care model. The PACT model incorporates clinical and support staff who deliver all primary care functions and coordinate the remaining needs, including specialty care. The model has been shown to reduce hospitalizations, specialty care visits, emergency department use, and increased overall mental health visits but decreased visits with mental health specialists outside of a primary care setting.[2,3,4] **We applaud the VA as a leader in team-based primary care and encourage Congress to ensure the PACT model continues.**

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[1] https://www.graham-center.org/content/dam/rgc/documents/publications-reports/reports/Investing-Primary-Care-State-Level-PCMH-Report.pdf
[2] https://nap.nationalacademies.org/read/25983/chapter/1
[3] https://pubmed.ncbi.nlm.nih.gov/23529710/
[4] https://www.ajmc.com/view/the-patient-centered-medical-home-in-the-veterans-health-administration

Depending on the specific practice needs, a team-based approach can include various combinations of physicians, psychologists, nurses, physician assistants, pharmacists, social workers, case managers, and other health care professionals. Members of the team share information and assist in decision making based on their unique skills – all with the common goal of providing the safest, best possible care to patients. **We urge Congress to preserve and invest in team-based primary care to ensure all veterans, regardless of geography, have the best care possible.**

- Increase VA GME Funds to Address Primary Care Shortage

  The VA plays an important role in training physicians – it has supported more than 11,000 Graduate Medical Education (GME) positions and is nearing the end of an expansion to add 1,500 new positions that began in 2015.[5] In 2020, the VA spent $1.6 billion on GME, generally by partnering with teaching hospitals to have residents from those hospitals' training programs rotate with a VA medical facility for a period of time.[6] We know most physicians are trained at large academic medical centers in urban areas, and evidence indicates physicians typically practice within 100 miles of their residency program.[7] As a result, the current distribution of trainees leads to physician shortages in medically underserved and rural areas. Unlike Medicare and Medicaid, the VA does control the type of residents it trains and where these residents are located. Additionally, a 2022 VA Office of Inspector General report indicated that 43% of VA facilities report a severe shortage of primary care physicians.[8] **We urge Congress to designate additional VA GME slots for primary care specialties to address the current and projected shortage at VA facilities.**

Physician Assistants (PAs)
NPPs are an integral part of physician-led health care teams. However, NPPs cannot substitute for physicians, especially when it comes to diagnosing complex medical conditions, developing comprehensive treatment plans, ensuring that procedures are properly performed, and managing highly involved and complicated patient cases. While the AAFP greatly values the contribution of all non-physicians, no other healthcare professionals come close to the four years of medical school, three-to-seven years of residency training, and 12,000-16,000 hours of clinical training that is required of physicians. By contrast, PA programs are two-to-three years in length, have no residency requirement, and require only 2,000 hours of clinical care.[9]

While PAs are crucial members of the care team, the skills and acumen obtained by physicians throughout their extensive education and training make them uniquely qualified to oversee and supervise patients' care. Studies have shown that patients are 15 percent more likely to be prescribed antibiotics by NPPs than physicians, and 8.4 percent of PAs prescribed opioids to over half of their patients, compared to 1.3 percent of physicians.[10,11] As such, the VA removing scope of practice safeguards could allow PAs that have not been adequately trained to independently provide services that are outside the scope of their licensure, which could ultimately lead to a lower standard of care

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[5] https://pubmed.ncbi.nlm.nih.gov/35020616/
[6] Ibid.
[7] https://www.aafp.org/pubs/afp/issues/2013/1115/p704.html
[8] https://www.va.gov/oig/pubs/VAOIG-22-00722-187.pdf
[9] https://www.ama-assn.org/practice-management/scope-practice/scope-practice-education-matters
[10] https://pubmed.ncbi.nlm.nih.gov/29378672/
[11] https://pubmed.ncbi.nlm.nih.gov/32333312/

for veterans.

Moreover, physicians working in the VA are supposed to have their licenses reviewed every two years, unlike NPPs—including PAs—who are appointed for an indefinite time, meaning that their credentials are reviewed before they are hired and may never be reviewed again.[12] As such, according to multiple Government Accountability Office (GAO) audits, the VA is doing an inadequate job of overseeing its NPPs, which could negatively impact patient care. Over the past few years, the VA Office of Inspector General has reported multiple cases of quality and safety concerns regarding VA practitioners, with issues ranging from lacking appropriate qualifications to poor performance and misconduct.[13,14] **We strongly urge Congress to work with the VA on this issue and to put patients first by prioritizing team-based care led by a physician, which has a proven track record of success in improving the quality of patient care, reducing costs, and allowing all healthcare professionals to spend more time with their patients**.

Pharmacists
Physicians work closely with pharmacists daily, and therefore fully appreciate the important role pharmacists play in the delivery of high-quality healthcare. A pharmacist's unique role ensures the safe, effective, and appropriate use of medications. However, physician-led team-based care has a proven track record of success in improving the quality of patient care, reducing costs, and allowing all health care professionals to spend more time with their patients. Additionally, a recent survey of U.S. voters showed that 95 percent said it is important for a physician to be involved in their diagnosis and treatment decisions.[15] Team-based care requires leadership, and physician expertise is widely recognized as integral to quality medical care.

The AAFP strongly supports arrangements and collaborative agreements where the pharmacist is part of an integrated, physician-led, team-based approach to care. However, we are concerned that expanding services provided by a pharmacist in limited but significant ways could potentially lead to fragmented care and worsen the quality of patient care and outcomes. Fragmentation of care remains one of the biggest challenges in the healthcare system, and pharmacists, unlike physicians, are not trained to independently perform patient examinations, diagnose, formulate a treatment plan, or prescribe medication. Although pharmacists should not diagnose patients, they are qualified to deal with issues of medication use, medication tolerability, patterns of medication use, assessment of therapeutic response, and dosing adjustments.

Our nation's veterans deserve to be provided with the best possible medical care, and they deserve a VA system that capitalizes on the respective education and training of physicians and their care teams while considering important scope of practice limitations. Also, we believe creating one standard for all physicians is impractical and not consistent with the practice of medicine, especially when considering the 40 specialties and 87 subspecialties in which physicians can be trained.[16] The AAFP urges this subcommittee and the VA to continue collecting and thoughtfully implementing stakeholder input while developing the National Standards of Practice. We appreciate the opportunity to comment and stand ready to work with Congress and the VA to ensure our nation's veterans have access to high-quality, physician-led primary care.

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[12] https://www.gao.gov/assets/700/697173.pdf
[13] https://www.gao.gov/assets/710/702090.pdf
[14] https://www.gao.gov/assets/710/702090.pdf
[15] https://www.ama-assn.org/system/files/scope-of-practice-protect-access-physician-led-care.pdf
[16] https://www.abms.org/board-certification/abms-board-certification-report

Please contact Kyle Gerron, Manager of Legislative Affairs, at 202-232-9033 or kgerron@aafp.org with any questions or concerns.

Sincerely,

Sterling Ransone, Jr., MD, FAAFP
American Academy of Family Physicians, Board Chair

Jewish War Veterans of the USA

Statement for the Record

"VA's Federal Supremacy Initiative: Putting Veterans First?"

Before the House Veterans Affairs Committee Subcommittee on Health

September 19, 2023

Presented by

Ken Greenberg
National Executive Director

Chairwoman Miller-Meeks, Ranking Member Brownley, members of the Health Subcommittee and full Committee on Veterans Affairs, thank you for holding this important hearing on the Department of Veterans Affairs National Standards of Practice (NSP). We commend the Committee for focusing on *VA's Federal Supremacy Initiative: Putting Veterans First?*

National Standards of Practice

JWV as an organization supports the concept of national standards of care that protect our nation's veterans and ensure that they have access to high-quality care. VA is applauded for creating more than 50 standards for clinical specialties. The standards mean that health care professionals in a specific occupation can perform within VA, regardless of their state registration, certification, or licensure.

Why is this important? While some clinical specialties have uniform requirements across the states, others have scopes of practice that vary widely from state to state. These differences will affect the patient care veterans receive. That said, JWV has strong concerns about VA's national standards of practice for health professionals within the VA system that could lower the standard of care available to veterans. Let's look at one example highlighted below.

NSP for Eye Care Health Care Professionals

As an example, JWV is concerned about the future of veterans' surgical eye care as in September 2022, VA modified its Community Care "Standardized Episode of Care (SEOC): Eye Care Comprehensive" guideline by removing language that provided that "only ophthalmologists can perform invasive procedures, including injections, lasers, and eye surgery." By removing this sentence, VA is implicitly authorizing optometrists to perform ophthalmic surgery on veterans they refer to the Community Care program in the few states where it is permitted by state licensure laws.

JWV's concern begins with VA removing this language without any opportunity for public or the veteran community to comment. We are extremely concerned that this important patient safeguard was removed and poses an increased risk to veterans requiring surgical eye care. Veterans have benefitted from established, consistent, high-quality surgical eye care for decades because VA maintained a long-standing policy that restricts the performance of therapeutic laser eye surgery to ophthalmologists and medical or osteopathic doctors who specialize in eye and vision care in VA medical facilities.

This policy is consistent with the standard of medical care in most states. It also ensures that there is a system-wide quality standard for surgical eye care and that all veterans have access to the eye care provider with the appropriate education, training and professional experience needed to perform their eye surgery.

JWV remains concerned that VA wants to adopt a national standard of practice that could allow optometrists to perform surgery on the eyes of veterans, even though optometrists do not have the necessary level of medical education or surgical training to be a surgeon. While JWV acknowledges that optometrists play a very critical role in delivering quality eye health care for our nation's veterans, we strongly believe that optometrists should not be allowed to perform eye surgery on veterans because they do not have the requisite training or medical degree to do so.

JWV urges VA to immediately reinstate the language back into the SEOC: "only ophthalmologists can perform invasive procedures, including injections, lasers, and eye surgery." JWV remains ready to work with VA as well as HVAC officials as VA seeks to establish national standards of practice roles for optometry and ophthalmology within the VA health system.

Thank you for the opportunity to submit this statement for the record. Please do not hesitate to contact JWV on this specific NSP on eye care or any other proposed NSP.

Jewish War Veterans
of the United States of America

Founded in 1896

1811 R Street, NW
Washington, DC 20009

Email: jwv@jwv.org

(202) 265-6280

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JWV is A Jewish Voice for Veterans and a Veteran's Voice for Jews

Prepared Statement of American Society of Retina Specialists

The American Society of Retina Specialists (ASRS) is the largest retina organization in the world, representing over 3,500 board-certified ophthalmologists who have completed fellowship training in the medical and surgical treatment of retinal diseases. The mission of the ASRS is to provide a collegial open forum for education, to advance the understanding and treatment of vitreoretinal diseases, and to enhance the ability of its members to provide the highest quality of patient care.

ASRS counts many veterans and physicians who have trained at Veterans Affairs (VA) hospitals as its members. We thank the committee for this hearing and appreciate the opportunity to share our deep concern about a potential, *unprecedented* scope of practice expansion for optometrists providing care in VA facilities.

As the VA continues to develop standards of practice for numerous allied health professionals providing necessary care to veterans in VA facilities, we ask for Congress' oversight to ensure veterans' eye health is protected. **We ask for your support to prevent the VA from proposing standards for optometrists that allow them to perform surgical or invasive procedures, which are currently well outside of the majority of state licensing restrictions and standard optometric training.**

Significant Differences in Training

Retina specialists, like other ophthalmologists, have completed four years of medical school, a hospital internship, and three years of ophthalmology residency training, and then completed an additional two-year retina fellowship. During their education, retina specialists receive extensive one-on-one training in surgical techniques and managing potential complications—both ocular and systemic. Successfully operating on eyes requires meticulous and finely honed microsurgical techniques. While it is frequently performed with little or no complications, that success is directly attributable to the proficiency of retina specialists and other ophthalmologists. These delicate procedures carry the risk of irreversible vision loss if not performed at an expert level.

Optometrists, by comparison, have no such training. The typical optometric education rarely goes beyond the post-graduate level and mainly focuses on examining the eye for vision prescriptions, dispensing corrective lenses, performing some eye screening functions, and prescribing topical medications. While optometrists are an integral part of the eyecare team, they are generally not permitted to perform invasive procedures on the general population, so expanding their scope through the VA poses risks to veterans they would not face if they sought care from private facilities.

Current Scope of Practice Issues

We believe our fears that a proposed standard would vastly and inappropriately expand optometrists' scope of practice in the VA are not unfounded. In September 2022, the VA removed language from its Community Care "Standardized Episode of Care: Eye Care Comprehensive" guidelines stating "only ophthalmologists can perform invasive procedures, including injections, lasers, and eye surgery." This change was made without input from the ophthalmic community and we believe presages what will be included in the proposed standards of practice—without congressional oversight.

The effort to expand optometrists' scope of practice in the VA system mirrors similar attempts on the state level. In nearly every state, there have been attempts to modify state licensing requirements to allow optometrists to perform surgical procedures. Yet, they have only been successful in a handful of states. In 2022, California Governor Gavin Newsom vetoed an optometric surgery bill specifically citing the lack of training as the rationale behind his decision. We ask Congress to urge VA to approach this issue like so many states have to date and prevent potential harm to veterans' eye health.

Most importantly, preventing the VA from expanding the scope of optometric practice will protect all patients, not just veterans. While state-based efforts have not been overall successful, a national standard that allows optometrists to perform surgery could inappropriately prompt further changes at the state level. Congress must step in to ensure the VA Supremacy Project does not have unintended consequences beyond the VA system.

Potential Negative Tradeoffs

Empowering untrained optometrists to perform surgical procedures would be an unprecedented break with current standards of care. Since there is no standard for training optometrists to perform surgical procedures and very few states where it

is permissible, allowing optometrists to perform procedures in the VA is essentially offering up our Nation's veterans as unwitting guinea pigs in a trial of untrained professionals' surgical skill.

The argument for allowing optometrists to perform procedures is generally that it will expand access to eye care for veterans. While ASRS agrees that veterans deserve timely access to care, we do not believe that quality of care should be shortchanged to meet that goal. Veterans are a precious group of patients who have risked their lives for the safety and security of our Nation. We owe it to them to ensure they do not receive sub-standard care. **If an identifiable access issue exists, we urge Congress to work with the VA to find other, more appropriate means of addressing it rather than lowering the quality of eye care for veterans.**

ASRS thanks the committee for holding this hearing to investigate this issue. We believe Congress shares our goal of providing the nation's veterans with the highest standard of care and hope it will join us in advocating against allowing optometrists to perform surgical and invasive procedures. We would be happy to provide you with any assistance or additional information you may need. Please contact Allison Madson, vice president of health policy, at allison.madson@asrs.org for assistance.

Prepared Statement of American Association of Nurse Practitioners

The American Association of Nurse Practitioners (AANP) appreciates the opportunity to submit a statement for the record to the House Veterans' Affairs Subcommittee on Health hearing entitled "VA's Federal Supremacy Initiative: Putting Veterans First?" AANP represents the more than 355,000 nurse practitioners (NPs) in the United States and is committed to empowering all NPs to advance high-quality, equitable care, while addressing health care disparities through practice, education, advocacy, research, and leadership (PEARL).[1] For the record, we support our certified registered nurse anesthetist (CRNA) colleagues in their efforts to seek Full Practice Authority (FPA) in the Department of Veterans Affairs (VA) and encourage the VA to move forward with a process to implement this policy. As outlined below, the VA previously authorized NPs to practice to the full extent of their education and clinical training within VA facilities, and this decision has yielded positive results for our nation's veterans.

NPs are advanced practice registered nurses (APRNs) who are prepared at the masters or doctoral level to provide primary, acute, chronic and specialty care to patients of all ages and backgrounds. Daily practice includes assessment; ordering, performing, supervising and interpreting diagnostic and laboratory tests; making diagnoses; initiating and managing treatment including prescribing medication and non-pharmacologic treatments; coordinating care; counseling; and educating patients and their families and communities. NPs currently provide a substantial portion of the high-quality[2], cost-effective[3] care that our communities require, including the over 5,000 NPs practicing within VHA facilities.[4] NPs are also essential to addressing issues of health equity, as they provide a substantial portion of health care in rural areas and areas of lower socioeconomic and health status.[5, 6, 7]

NPs practice in nearly every health care setting including VHA facilities, schools and school-based clinics, hospitals, Indian Health Services facilities, emergency rooms, urgent care sites, private physician or NP practices (both managed and owned by NPs), skilled nursing facilities (SNFs), nursing facilities (NFs), colleges and universities, retail clinics, public health departments, nurse managed clinics, homeless clinics, and home health. NPs hold prescriptive authority in all 50 states and the District of Columbia. Currently, twenty-seven states and D.C. are full prac-

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[1] https://www.aanp.org/advocacy/advocacy-resource/position-statements/commitment-to-addressing-health-care-disparities-during-covid–19

[2] https://www.aanp.org/images/documents/publications/qualityofpractice.pdf.

[3] https://www.aanp.org/images/documents/publications/costeffectiveness.pdf.

[4] 81 Fed. Reg. 90198, 90200. (Based on VHA payroll data from August 31, 2016, the VHA employees 5,444 NPs).

[5] Davis, M. A., Anthopolos, R., Tootoo, J., Titler, M., Bynum, J. P. W., & Shipman, S. A. (2018). Supply of Healthcare Providers in Relation to County Socioeconomic and Health Status. *Journal of General Internal Medicine*, 4–6. https://doi.org/10.1007/s11606–017–4287–4

[6] Xue, Y., Smith, J. A., & Spetz, J. (2019). Primary Care Nurse Practitioners and Physicians in Low-Income and Rural Areas, 2010–2016. *Journal of the American Medical Association*, 321(1), 102–105. https://jamanetwork.com/journals/jama/fullarticle/2720014

[7] Andrilla, C. H. A., Patterson, D. G., Moore, T. E., Coulthard, C., & Larson, E. H. (2018). Projected Contributions of Nurse Practitioners and Physicians Assistants to Buprenorphine Treatment Services for Opioid Use Disorder in Rural Areas. *Medical Care Research and Review*, Epub ahead. https://doi.org/10.1177/1077558718793070

tice authority (FPA) states because their licensure laws allow full and direct access to NPs.[8] In the majority of states, NPs are authorized under FPA to practice to the full extent of their education and clinical training without a regulated relationship with a physician.

As you know, on December 14, 2016, the VA finalized rulemaking to authorize NPs to practice to the full extent of their education and clinical training within VA facilities. That final rule recognized the value of NPs in the VA system, and that implementing VA FPA would increase access to high-quality care for veterans.[9] This approach is in line with the majority of states as well as the Indian Health Service. Many federal agencies, including the Federal Motor Carrier Safety Administration, Social Security Administration, United States Marshals Service, United States Coast Guard, the Public Health Services Corps, the Federal Employees Health Benefits Program, recognize the importance and quality of care provided by NPs. We have been pleased to see that the VA has implemented FPA for NPs across all VA facilities since the rule was published and that data demonstrates that FPA has had a positive impact on wait times in mental health, specialty care and primary care for our Nation's veterans.[10]

These findings are consistent with research outside of the VA which has also shown that NPs are essential to ensuring patients have access to high-quality health care, particularly among rural and underserved populations. According to the Medicare Payment Advisory Commission (MedPAC), APRNs and PAs comprise approximately one-third of our primary care workforce, and up to half in rural areas.[11] MedPAC also found that, among all clinician types, NPs on average had the highest share of allowed charges associated with low-income subsidy (LIS) beneficiaries, which includes Medicaid beneficiaries. "In 2019, 41 percent of the allowed charges billed by NPs who practiced in primary care were for LIS beneficiaries, as were 36 percent for NPs who practiced in specialty care compared with 28 percent for primary care physicians and PAs and 25 percent for specialty care physicians and PAs." [12] A 2019 study of Medicaid participation of buprenorphine waivered providers in Virginia found that buprenorphine waivered NPs were more likely to treat Medicaid patients compared to physicians and the probability of an NP treating a large number of Medicaid patients was higher among NPs relative to physicians.[13] A recent study published in *Health Affairs* also found that from 2011–2019 the number of psychiatric-mental health NPs (PMHNPs) treating Medicare beneficiaries grew by 162 percent, compared to a 6 percent drop in psychiatrists during that same period.[14] The study also found that the proportion of all mental health prescriber visits provided by PMHNPs to Medicare beneficiaries increased from 12.5 percent to 29.8 percent during that same period, exceeding 50 percent in rural, full practice authority regions.[15]

In 2010 the Institute of Medicine (IOM) issued *The Future of Nursing: Leading Change, Advancing Health report*, which called for the removal of laws, regulations, and policies that prevent APRNs from providing the full scope of health care services they are educated and trained to provide. This position was reaffirmed by the National Academy of Medicine (previously the IOM) in their 2021 *The Future of Nursing 2020–2030: Charting a Path to Achieve Health Equity report*.[16] The World Health Organization's *State of the World's Nursing 2020* report also recommends modernizing regulations to authorize APRNs to practice to the full extent of their education and clinical training, noting the positive impact it would have on addressing health care disparities and health care access within vulnerable communities.[17] The merits of the high-quality care provided by NPs have been widely praised by

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[8] https://www.aanp.org/advocacy/state/state-practice-environment.

[9] 81 Fed. Reg. 90198 (December 14, 2016).

[10] https://department.va.gov/wp-content/uploads/2022/09/va-strategic-plan–2022–2028.pdf (at page 33).

[11] https://www.medpac.gov/wp-content/uploads/2022/06/Jun22__MedPAC__Report__to__Congress__SEC.pdf (see Chapter 2.)

[12] https://www.medpac.gov/wp-content/uploads/2023/03/Mar23__MedPAC__Report__To__Congress__SEC.pdf (Page 135).

[13] Saunders, Heather, et.al (2022). Medicaid Participation Among Practitioners Authorized to Prescribe Buprenorphine. *Journal of Substance Abuse Treatment*, Epub. https://pubmed.ncbi.nlm.nih.gov/34148758/.

[14] Cai, Arno, et.al (2022). Trends in Mental Health Care Delivery by Psychiatrists and Nurses Practitioners in Medicare, 2011–2019. *Health Affairs*, 41(9), 1222–1230. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2022.00289

[15] *Ibid*.

[16] The Future of Nursing 2020–2030 National Academies. (see Page 363).

[17] https://apps.who.int/iris/bitstream/handle/10665/331673/9789240003293-eng.pdf

bipartisan stakeholders such as the American Enterprise Institute [18] and the Brookings Institution [19], as well as bipartisan recognition from multiple administrations.[20, 21] Additionally, the Federal Trade Commission has highlighted how barriers to practice on APRNs are unnecessary and limit competition.[22] Decades of evidence demonstrates that NPs provide high-quality, cost—effective health care with high patient satisfaction both inside and outside of the VA, examples of studies include:

- A recent study utilizing VA data from FY 2013 found significant savings, 6–7 percent lower costs, for highly complex diabetic patients who had an NP as their primary provider compared to those with a physician.[23] Other researchers found even greater savings, 12–13 percent lower costs when examining diabetic patients with varying degrees of complexity served by the VA. For a single VAMC this equated to an annual savings of just over $14 million exemplifying the efficiency and effectiveness of NP delivered care in the VA.[24]
- Results from 806,434 patients at 530 Veterans Health Administration (VA) facilities found that patients assigned to primary care nurse practitioners were less likely to utilize additional services, had no difference in costs and experienced similar chronic disease management compared to physician-assigned patients.[25]
- Meta-analysis of studies comparing the quality of primary care services of physicians and NPs demonstrates the role NPs play in reinventing how primary care is delivered. The authors found that comparable outcomes are obtained by both providers, with NPs performing better in terms of time spent consulting with the patient, patient follow ups and patient satisfaction.[26]
- The outcomes of NP care were examined through a systematic review of 37 published studies, most of which compared NP outcomes with those of physicians. Outcomes included measures such as patient satisfaction; patient perceived health status; functional status; hospitalizations; emergency department visits; and biomarkers such as blood glucose, serum lipids and blood pressure. Newhouse, et al., conclude that NP patient outcomes are comparable to those of physicians.[27]
- A 2022 Morning Consult poll found that 82 percent of patients support authorizing NPs to practice to the full extent of their education and clinical training.[28]

Last, we would also like to take this opportunity to directly address the misinformation that has been raised with respect to the NP profession and the care provided to patients. To be clear, contrary to the Statement for the Record submitted by the American Medical Association (AMA), the VA is not currently hosting a listening session on NPs and there is no open feedback period on NPs (the VA finalized NP Standards of Practice in 2016). Yet, the AMA still used their opportunity to provide feedback to the subcommittee to denigrate their NP colleagues. In doing so, the AMA referenced non-peer reviewed reports with small sample sizes (such as those from the Hattiesburg Clinic and the National Bureau of Economic Research)

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[18] https://www.aei.org/research-products/report/nurse-practitioners-a-solution-to-americas-primary-care-crisis/.

[19] https://www.brookings.edu/wp-content/uploads/2018/06/AM__Web__20190122.pdf.

[20] https://www.govinfo.gov/content/pkg/FR–2019–10–08/pdf/2019–22073.pdf (see Section 5).

[21] https://www.healthaffairs.org/do/10.1377/forefront.20220404.728371/. (ACO REACH also includes a nurse practitioner services benefit enhancement designed to reduce barriers to care access, particularly for individuals with limited access to physicians. Through waivers, this strategy would authorize nurse practitioners to certify patient needs (for example, for hospice) and order and supervise certain services (for example, cardiac rehabilitation).

[22] https://www.ftc.gov/system/files/documents/reports/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolicypaper.pdf.

[23] Morgan, et.al (2019). Impact of Physicians, Nurse Practitioners, And Physician Assistants On Utilization and Costs for Complex Patients. *Health Affairs*, 38(6), 1028–1036. https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.00014.

[24] Rajan, et. al (2021) "Health care costs associated with primary care physicians versus nurse practitioners and physician assistants". https://pubmed.ncbi.nlm.nih.gov/34074952/.

[25] Liu, C. F., Hebert, P. L., Douglas, J. H., Neely, E. L., Sulc, C. A., Reddy, A., & Wong, E. S. (2020).Outcomes of primary care delivery by nurse practitioners: Utilization, cost, and quality of care. *Health Services Research*, 55(2), 178–189. https://pubmed.ncbi.nlm.nih.gov/31943190/

[26] Naylor, M.D. and Kurtzman, E.T. (2010). The Role of Nurse Practitioners in Reinventing Primary Care. *Health Affairs*, (5), 893–99. https://pubmed.ncbi.nlm.nih.gov/20439877/

[27] Newhouse, R.P., Stanik-Hutt, J., White, K.M., Johantgen, M., Bass, E.B., Zangaro, G., Wilson, R.F., Fountain, L., Steinwachs, D.M., Heindel, L., & Weiner, J.P. (2011). Advanced practice nurse outcomes 1999–2008: A systematic review. *Nursing Economics*, 29(5), 1–22. https://pubmed.ncbi.nlm.nih.gov/22372080/

[28] https://connectwithcare.org/wp-content/uploads/2022/04/Telehealth__MC-Branded__PPT__Final.pdf.

while ignoring the substantial body of well-conducted, independent research that has shown that NPs provide high-quality care comparable to their physician colleagues. Arbitrary barriers to practice, such as those promoted by the AMA, do not improve patient care and do not support patient access to treatment.

For example, after Congress authorized NPs to prescribe buprenorphine for the treatment of opioid use disorder in the *Comprehensive Addiction Recovery Act*, states without restrictive practice environments for NPs saw a significantly larger increase in waived clinicians (particularly rural counties) than more restrictive states.[29] This is just one example that demonstrates that policies that prevent clinicians from practicing to the full extent of their education and clinical training only harm patients. Additionally, the AMA references two Government Accountability Office (GAO) reports that they claim show that the VA is doing an inadequate job of supervising and disciplining non-physician practitioners. However, they do not mention that these reports also included discussion of oversight of physicians, who are actually the most common provider type in the 57 case studies that were included. For reference, only two of the case studies included NPs (neither of which found wrongdoing by the NP), and 25 case studies involved physicians with multiple individuals having their VA employment terminated due to their conduct. To infer that these reports were limited to non-physicians is not an accurate representation of the reports.

In closing, AANP recognizes and appreciates the contributions of all members of the health care team to high-quality patient care, and it is essential that all health care professionals be authorized to work to the top of their education and clinical training to best serve our nation's veterans. This is consistent with the team-based care model endorsed by the National Academy of Medicine which focuses on constructing a team that is tailored to meet the specific needs of the patient.[30] AANP is pleased to take this opportunity to highlight the success of the VA's decision in 2016 to authorize NPs in VHA facilities to practice to the full extent of their education and clinical training. AANP hopes the objectively positive results yielded for our veterans is instructive to the subcommittee. We look forward to working with the subcommittee on ways to continue to improve the health care of our nation's veterans. We thank the subcommittee for holding a hearing on this important topic.

[29] Barnett, Michael L., Lee, Dennis, & Frank, Richard G. (2019). In Rural Areas, Buprenorphine Waiver Adoption Since 2017 Driven by Nurses Practitioners And Physician Assistants. *Health Affairs*, 38(12), 2048–2056. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2019.00859.

[30] https://www.aanp.org/advocacy/advocacy-resource/position-statements/team-based-care.

Prepared Statement of Blinded Veterans Association

September 19, 2023

The Honorable Mariannette Miller-Meeks, MD
House Committee on Veterans' Affairs
Subcommittee on Health
364 Cannon House Office Building
Washington, DC 20003

The Honorable Julia Brownley
House Committee on Veterans' Affairs
Subcommittee on Health
364 Cannon House Office Building
Washington, DC 20003

Dear Chairwoman Miller-Meeks and Ranking Member Brownley,

On behalf of the thousands of veterans experiencing sight loss, the Blinded Veterans Association (BVA) want to thank you for holding today's hearing, entitled, *"VA's Federal Supremacy Initiative: Putting Veterans First?"*. We specifically wish to express our concern with the approach that the Department of Veterans Affairs (VA) appears to be taking in establishing national scope of practice standards, particularly one for VA-employed optometrists.

As the only national Veterans Service Organization (VSO) chartered by the United States Congress that is exclusively dedicated to assisting veterans and their families coping with blindness and vision loss, ensuring that our nation's veterans have access to the highest quality eye care is a top priority for the BVA**.** While we appreciate VA's efforts to protect and boost access to needed health care services, including eye and vision care services, **our organization strongly believes that VA should not establish a standard that could lower the standard of care, particularly for surgical eye care services, available to veterans.**

Our members know all too well that eye tissue is extremely delicate, and once damaged, it is often impossible to fix. While optometrists play an important role in addressing the eye care needs of veterans, they are not medical doctors who have the training and experience needed to perform invasive surgical procedures. While some procedures are higher risk than others, no invasive procedures are without risk, particularly when performed by inexperienced providers.

Veterans have benefitted from established, consistent, and high-quality surgical eye care for decades because VA has maintained a long-standing policy that restricts the performance of therapeutic laser eye surgery to ophthalmologists—medical or osteopathic doctors who specialize in eye and vision care— in VA medical facilities. This policy is consistent with the standard of medical care in the overwhelming majority of states. It also ensures that there is a system-wide quality standard for surgical eye care and that all veterans have access to the eye care provider with the appropriate education, training, and professional experience needed to perform their eye surgery.

We are very concerned that VA has been developing its national standard of practice (NSP) for optometry without including all critical perspectives necessary to maintain the high-quality eye care our nation's veterans have earned. To ensure the safety and well-being of all veterans in need of eye care, especially surgical eye care, we have been urging VA to fully and equally engage all providers on the eye care team as its standards are being drafted and before any draft national standards are released for public comment.

Much of eye-related care is provided in a team-based approach, and only by hearing from all clinicians involved in that team will VA truly be able to understand the full breadth of services that are provided to veterans, and which types of clinicians are best trained and most equipped to furnish these services.

Unfortunately, we have heard that in the development process of the optometry national standard of practice that VA has not yet fully received or incorporated feedback from ophthalmologists.

Ophthalmologists, due to their extensive training and clinical experience, have a unique perspective on the types of services that veterans may require. They are also routinely the leaders of the clinician teams that provide eye-related services, and their feedback is critical when determining what services should be included in the scope of practice standards for all eye-care providers, including optometrists.

We strongly recommend that VA include ophthalmologists on the teams and workgroups preparing the optometry national standard of practice. We urge you and your Subcommittee members to work together to ensure that the VA takes the appropriate actions to implement our recommendation.

Clinical experience matters, and optometrists do not have the necessary level of medical education or surgical training to be a surgeon. BVA recognizes that optometrists play a very critical role in delivering quality eye health care for our nation's veterans. However, BVA strongly believes that optometrists should not be allowed to perform eye surgery on veterans. Optometrists categorically do not have the requisite training to do so.

One reason we are so concerned about the future of veterans' surgical eye care is that it has come to our attention that in September 2022, VA modified its Community Care "Standardized Episode of Care (SEOC): Eye Care Comprehensive" guideline by removing language that has provided that "only ophthalmologists can perform invasive procedures, including injections, lasers, and eye surgery." By removing this sentence, VA has authorized private sector optometrists to perform ophthalmic surgery on veterans referred under the Community Care program in the few states where permitted by state licensure laws. VA removed this language without any opportunity for the veteran community and public at large to comment.

BVA is extremely concerned that VA has removed an important patient safeguard, posing increased risk to veterans requiring surgical eye care. We have urged VA to immediately reinstate the following language back into the SEOC: "only ophthalmologists can perform invasive procedures, including injections, lasers, and eye surgery." To date, VA has not acted on our recommendation.

Thank you for the opportunity to provide our comments regarding VA's effort to establish national scope of practice standards and their potential effect on our nation's veterans. Should you have any questions or require any further information, please do not hesitate to contact Donald D. Overton, Jr. (Executive Director) via email: doverton@bva.org.

Sincerely,

Donald D. Overton, Jr.
Executive Director

Prepared Statement of Fleet Reserve Association

FLEET RESERVE ASSOCIATION
YOUR MISSION • YOUR VOICE
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September 26, 2023

The Honorable Mariannette Miller-Meeks, MD
Chairwoman
House Committee on Veterans' Affairs
Subcommittee on Health
364 Cannon House Office Building
Washington, D.C. 20003

The Honorable Julia Brownley
Ranking Member
House Committee on Veterans' Affairs
Subcommittee on Health
364 Cannon House Office Building
Washington, D.C. 20003

Dear Chairwoman Miller-Meeks and Ranking Member Brownley,

On behalf of the thousands of former sailors, marines, and Coast Guard personnel that we proudly represent, the Fleet Reserve Association (FRA) wants to thank you for holding a hearing, entitled, *"VA's Federal Supremacy Initiative: Putting Veterans First?"* on September 19, 2023. We specifically wish to express concern with the Department of Veterans Affairs' (VA's) approach to establishing national scope of practice standards, particularly with respect to VA-employed optometrists.

The FRA is a congressionally chartered, non-profit organization that represents the interests of the Sea Service community. One of our top priorities is ensuring the safety of the veterans who served our country. **We strongly believe that the VA should not establish national scope of practice standards that would put these men and women and their families at risk.**

We are extremely concerned that the VA seems to be on track toward establishing a national optometry standard that would allow optometrists to perform laser surgeries. Such a standard would put our nation's veterans at substantial risk and be a complete reversal of long-standing policy that only allows ophthalmologists to perform therapeutic laser eye surgery in VA medical facilities. This significant change could result in serious adverse outcomes for patients. Eye surgery is one of the most difficult and delicate surgeries. Optometrists are not trained to provide these types of surgical procedures. Surgery should be reserved for surgeons. ***Eye surgery in particular is best left to trained and experienced ophthalmic surgeons***.

A standard that allows optometrists to furnish surgical services would be out of step with the majority of states, most of which prohibit optometrists from performing surgeries of any type. The VA's optometry national standard of practice should be consistent with what most of the country deems to be safe and most appropriate. Veterans deserve the highest level of care, and therefore optometrists must NOT be allowed to perform laser surgery in VA facilities.

Thank you for overseeing this process and for the opportunity to provide our comments. If you have any questions or require any additional information, please do not hesitate to contact DLP, John R. Davis (john@fra.org).

Sincerely,

John R. Davis
Director, Legislative Programs

Prepared Statement of American Pharmacists Association

AMERICAN PHARMACISTS ASSOCIATION
STATEMENT FOR THE RECORD

BEFORE THE U.S. HOUSE OF REPRESENTATIVES COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH

VA'S FEDERAL SUPREMACY INITIATIVE: PUTTING VETERANS FIRST?

September 19, 2023

2215 Constitution Ave. NW
Washington, DC 20037

800 237 2742
pharmacist.com

Chair Miller-Meeks, Ranking Member Brownley, and distinguished Members of the Subcommittee:

On behalf of our nation's over 334,000 pharmacists[1] including over 6,000 VA pharmacists,[2] the American Pharmacists Association (APhA) is pleased to submit the following Statement for the Record to the U.S. House of Representatives Committee on Veterans' Affairs Subcommittee on Health for the open hearing, "VA's Federal Supremacy Initiative: Putting Veterans First?"

APhA is the largest association of pharmacists in the United States advancing the entire pharmacy profession. APhA represents pharmacists and pharmacy personnel in all practice settings, including community pharmacies, hospitals, long-term care facilities, specialty pharmacies, community health centers, physician offices, ambulatory clinics, managed care organizations, hospice settings, and government facilities. Our members strive to improve medication use, advance patient care, and enhance public health.

Pharmacists are highly trained medication experts providing accessible[3] direct patient care and medication distribution nationwide in all geographical areas to under-/uninsured[4], commercially insured, Medicaid/Medicare eligible patients, and most pertinent to this Statement, to our nation's veterans. Pharmacists and pharmacy personnel clearly demonstrated their essential role throughout the COVID-19 pandemic by administering 300+ million COVID-19 vaccines, conducting 42+ million COVID-19 tests, and contributing to billions of dollars in savings.[5,6] Pharmacists in the VA setting participate in team-based care delivery and practice all duties as indicated by their license plus additional duties as indicated within their scope of VA employment and consistent with the practice standard. This includes remaining accessible for the provision of direct patient care, ordering and distribution of medications, and ordering and administration of vaccines among other duties in acute care, transitions of care, and substance use disorder, depending on credentialing.[7]

We recognize that the VA published an interim final rule which confirmed that VA health care professionals, including pharmacists, may practice their profession consistent with the scope and requirements of their VA employment "notwithstanding any State license, registration, certification, or other requirements."[8] In addition, this interim final rule confirms VA's authority in 38 CFR 17.419 to establish national standards of practice, which will standardize a health care professional's practice in all VA locations, by invoking the Supremacy Clause of the U.S. Constitution to preempt state laws.[9]

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[1] https://www.bls.gov/ooh/healthcare/pharmacists.htm
[2] https://vacareers.va.gov/careers/pharmacy-jobs/
[3] https://pharmacist.com/Advocacy/Issues/Inequity-to-COVID-19-Test-to-Treat-Access-Pharmacists-can-help-if-permitted
[4] https://www.pharmacist.com/Publications/Pharmacy-Today/Article/serving-underserved-populations
[5] https://pharmacist.com/Practice/COVID-19/The-Essential-Role-of-Pharmacy-in-Response-to-COVID-19/Infographic
[6] https://pharmacist.com/Practice/COVID-19/The-Essential-Role-of-Pharmacy-in-Response-to-COVID-19
[7] https://www.pbm.va.gov/PBM/CPPO/Clinical_Pharmacy_Practice_Office_ResourcesAndTools.asp
[8] https://www.federalregister.gov/d/2020-24817/p-3
[9] https://www.ecfr.gov/current/title-38/chapter-I/part-17/subject-group-ECFRdbd8d11c1202212/section-17.419

Support of VA National Standards of Practice, Clinical Pharmacist Standard, and Clinical Pharmacist Practitioner Standard

APhA is supportive of the VA's efforts to establish national standards of practice under the Supremacy Clause of the Constitution, including establishing national standards for the categories of clinical pharmacist and clinical pharmacist practitioner specific to the VA system. Assuring that America's veterans can access the same level and type of care regardless of the VA location they enter is paramount. National standards of practice allow this to occur without barriers of different state regulations, scopes, or other considerations at risk of preventing high-quality and consistent care delivery. In addition, decreasing the variances between the level and type of care increases the likelihood of timely access to equitable care to improve health outcomes.

Specific to and within the VA system, APhA supports the clinical pharmacist national standard and the clinical pharmacist practitioner (CPP) national standard. APhA affirms that pharmacists in all healthcare settings practice clinically, as evidenced by the significant contributions pharmacists make to improved access, care, and outcomes across the healthcare continuum. These contributions are further exemplified by the substantial education, training, and experience received by pharmacists. With their extensive experience, pharmacists bring a wealth of knowledge and application of direct practice skills to the field. It is worth noting that pharmacists since 2000 have graduated as a Doctor of Pharmacy (PharmD), ensuring a high standard of education and clinical training in the profession.[10]

The national standards of practice describe a set of services that are reflective of contemporary pharmacist practice, and because they will be implemented nationwide, provide an excellent model for the private sector, where there is currently state-to-state variability. These standards support the ability of pharmacists to improve access to medication treatments, using their professional judgment and expertise to address the needs of patients across a spectrum of public health priorities. In addition, it allows the credentialing of pharmacists to prescribe and manage drug therapy independently across a wide variety of patient care settings. Finally, the national standards outline services reflective of pharmacists practicing at a level consistent with their individual education, training, experience, and practice setting as well as providing comprehensive medication management (CMM) services within team-based models of care. APhA also appreciates the proposed credential pathway for pharmacists to transition from clinical pharmacists to CPPs in the VA. Outside of the VA system, APhA maintains consistent support that all "pharmacists should have the authority and support to practice to the full extent of their education, training, and experience in delivering patient care in all practice settings and activities."[11]

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[10] The Council on Credentialing in Pharmacy. Credentialing in pharmacy. Am J Health-Sys Pharm. 2001:58(1);69-76. https://doi.org/10.1093/ajhp/58.1.69

[11] 2017, 2023 Contemporary Pharmacy Practice (July/August 2012; reviewed 2016, 2019, 2021, 2023). J Am Pharm Assoc. 2023:63;1265-81. https://www.japha.org/article/S1544-3191(23)00158-9/pdf

Pharmacists can Ameliorate Health Care Worker Shortages
Recognizing that medically underserved areas exist, and other types of health care workers are exiting their practice settings, pharmacists and pharmacy personnel are uniquely positioned to relieve some of the consequences of health care workforce shortages. Pharmacists' scope of practice has grown substantially across the country over the last 25 years, unlocking an array of new opportunities for pharmacists to provide added services and value to patients. Although there are similarities in the foundational services pharmacists provide to their patients, there is variability in the types of expanded services, collaboration potential, and spectrum of autonomy of practice between states due to differences in state laws and regulations. In order to leverage pharmacists to their full potential, as a part of an interprofessional and collaborative health care team, there is a need to align their scope of practice with their education and training. VA's national standard of practice for the clinical pharmacist practitioner and clinical pharmacist does just that.

Pharmacists' Scope of Practice and Impact on Patient Outcomes
Pharmacists' foundational scope of practice traditionally has been limited to making medication therapy recommendations that require prescriber approval to make medication changes. Examples include assessing medication therapies; recommending over-the-counter medications to patients and prescription products to prescribers; patient education; prevention and wellness services; CMM services, including medication adherence, focused on optimizing the use of medications; and safe dispensing of medications.

All 50 states trust pharmacists to prescribe and order medications through collaborative practice agreements (CPAs) or autonomous prescribing. Examples of services that pharmacists provide under CPAs (per the individual agreement) include anticoagulation management, where the pharmacist orders or performs International Normalized Ratio (INR) tests and makes warfarin dosage adjustments; and hypertension management, where the pharmacist monitors the patient's blood pressure; medication management, including initiating, modifying, and discontinuing therapy; and working with the patient on lifestyle modifications to achieve targeted clinical goals.

In recent years, there has been an expansion in pharmacists' ability to provide services in response to public health needs and disease states via statewide protocols (SWPs). Examples of SWPs include provision/prescribing of HIV PrEP/PEP, hormonal contraceptives, tobacco cessation, and naloxone, and testing and treating for acute ailments such as influenza, streptococcal infections, COVID-19, and other ailments. Pharmacists have the authority to initiate HIV PrEP in 12 states[12] and HIV PEP in 14 states[13], via prescriptive authority, statewide protocol, or other means. Eleven states allow pharmacists to test and treat for influenza,

[12] Arkansas, California, Colorado, Idaho, Illinois, Maine, Montana, Nevada, New Mexico, Oregon, Utah, Virginia
[13] Arkansas, California, Colorado, Idaho, Illinois, Maine, Missouri, Montana, Nevada, New Mexico, New York, Oregon, Utah, Virginia

streptococcal infections, and/or COVID-19 via prescriptive authority, statewide protocol, or other means.[14]

Pharmacists have a positive direct impact on patient outcomes and health care expenditures. Approximately 50% of all U.S. adults have one or more chronic disease conditions and 86% of total U.S. health care costs are attributed to chronic conditions.[15] Pharmacists have a return on investment of 4:1 when providing disease-state management through autonomous practice efforts and sustained collaboration on team-based care models.[16] If a patient inadvertently runs out of a life-sustaining medication, pharmacists can review and supply an additional fill to avoid an urgent or emergent situation until the patient can access additional patient care team members. Pharmacists provide direct access to life-saving services and preventative services such as naloxone for opioid overdose, hormonal contraceptives for pregnancy prevention[17], and immunizations for vaccine-preventable diseases. Interprofessional team-based care models that incorporate a pharmacist are shown to increase the quality of care and improve patient outcomes.[16] Finally, pharmacists want to spend more time with patients and the VA national standard of practice will allow them to do so.[18]

APhA would like to thank the Subcommittee for the opportunity to submit a statement in support of VA establishing a national standard of practice for health care professionals and, in particular, for clinical pharmacists and clinical pharmacist practitioners within the VA system. Pharmacists and pharmacy personnel remain steadfast in providing high quality, safe, accessible, equitable, and timely patient care and medications to our nation's veterans and can serve as a solution to addressing other health care worker gaps. Please contact Doug Huynh, JD, APhA Director of Congressional Affairs, at dhuynh@aphanet.org if you have any additional questions or additional information. Thank you again for the opportunity to provide comments on this important issue.

[14] Arkansas, Colorado, Delaware, Idaho, Illinois, Iowa, Kansas, Michigan, Minnesota, New Mexico, Virginia
[15] Holman HR. The Relation of the Chronic Disease Epidemic to the Health Care Crisis. ACR Open Rheumatol.2020 Mar;2(3): 167–173. doi: 10.1002/acr2.11114
[16] Murphy EM, Rodis JL, Mann HJ. Three ways to advocate for the economic value of the pharmacist in health care. J Am Pharm Assoc (2003).2020 Nov-Dec;60(6):e116-e124. doi: 10.1016/j.japh.2020.08.006
[17] Rodriguez MI, Hersh A, et al. Association of Pharmacist Prescription of Hormonal Contraception with Unintended Pregnancies and Medicaid Costs. Obstet Gynecol. 2019 Jun;133(6):1238-1246. doi: 10.1097/AOG.0000000000003265.
[18] https://www.drugtopics.com/view/pharmacists-want-more-time-patients

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VA Document for the Record, Briefings and Engagements

BRIEFINGS & ENGAGEMENTS

Date	Stakeholder Name	Stakeholder	Type
2/28/2020	American Association of Nurse Anesthetists	Association	Email / Letter
5/11/2020	Association of VA Anesthesiologists (AVAA)	Association	Email / Letter
9/14/2020	Association of VA Anesthesiologists (AVAA)	Association	Email / Letter
11/20/2020	Congress	Federal	Presentation
12/4/2020	Accreditation Council on Art Education	Association	Email / Letter
1/6/2021	American Psychiatric Association (APA)	Association	Presentation
2/8/2021	American Association of Nurse Anesthetists	Association	Email / Letter
2/9/2021	Association of VA Anesthesiologists (AVAA)	Association	Email / Letter
2/11/2021	Association of Social Work Boards (ASWB)	Association	Presentation
2/23/2021	AMVETS + American of Foreign Wars	VSO	Email / Letter
2/23/2021	AMVETS + American of Foreign Wars	VSO	Email / Letter
3/1/2021	Congress	Federal	Presentation
3/5/2021	National Council of State Boards of Nursing	Association	Presentation
3/12/2021	American Nurses Association	Association	Presentation
4/2/2021	American Association of Colleges of Nursing	Association	Presentation
4/7/2021	Academy of Nutrition Dietetics	Association	Presentation
4/8/2021	Health and Human Services	Federal	Presentation
4/9/2021	Academy of Doctors of Audiology	Association	Email / Letter
4/9/2021	American Academy of Ophthalmology	Association	Email / Letter
4/11/2021	American Academy of Audiology	Association	Email / Letter
4/11/2021	American Speech-Language-Hearing Association	Association	Email / Letter
4/17/2021	American Art Therapy Association	Association	Email / Letter
4/19/2021	Commission on Accreditation of Allied Health Education Program	Association	Presentation
4/20/2021	American Therapeutic Recreation Association	Association	Presentation
4/20/2021	Department of Defense (Federal Chiefs)	Federal	Presentation
4/20/2021	National Association for Drama Therapy	Association	Email / Letter
4/21/2021	American Dance Therapy Association	Association	Email / Letter
4/21/2021	Dance/Movement Therapy Certification Board	Association	Email / Letter
4/22/2021	Joint Commission of Pharmacy Practitioners	Association	Presentation
4/22/2021	National Association of Boards of Pharmacy	Association	Presentation
4/23/2021	National Council for Therapeutic Recreation Certification	Association	Presentation
4/26/2021	National Association for Drama Therapy	Association	Email / Letter
4/27/2021	American Art Therapy Association	Association	Email / Letter
4/27/2021	Art Therapy Credentials Board	Association	Email / Letter
4/27/2021	New Jersey Art Therapy Association	Association	Email / Letter
4/27/2021	New Mexico Regulation and Licensing Department	State	Email / Letter
4/28/2021	Accreditation Council on Art Education	Association	Email / Letter
4/28/2021	Department of Defense (Federal Chiefs)	Federal	Presentation
4/29/2021	Academy of Neurogenic Communication Sciences and Disorders	Association	Presentation
4/29/2021	American Board of Swallowing and Swallowing Disorders	Association	Presentation
4/29/2021	American Speech-Language-Hearing Association	Association	Presentation
4/29/2021	Dysphagia Research Society	Association	Presentation

Date	Stakeholder Name	Stakeholder	Type
5/1/2021	American Chiropractic Association	Association	Presentation
5/1/2021	Federation of Chiropractic Licensing Boards	Association	Presentation
5/6/2021	Art Therapy Credentials Board	Association	Email / Letter
5/7/2021	American Optometric Association (AOA)	Association	Presentation
5/11/2021	National Association of VA Optometrists (NAVAO)	Association	Presentation
5/12/2021	American Academy of Optometry	Association	Presentation
5/12/2021	Association of Social Work Boards (ASWB)	Association	Presentation
5/13/2021	Council on Social Work Education	Association	Presentation
5/14/2021	Armed Forces Optometric Society (AFOS)	Association	Presentation
5/17/2021	Association of Schools and Colleges of Optometry	Association	Presentation
5/18/2021	Association of Regulatory Boards of Optometry	Association	Presentation
5/18/2021	Federation of State Medical Boards	Association	Email / Letter
5/19/2021	Congress	Federal	Email / Letter
5/20/2021	Association of Social Work Boards (ASWB)	Association	Presentation
5/24/2021	Accreditation Council on Optometric Education	Association	Presentation
5/26/2021	Association of Chiropractic Colleges	Association	Presentation
5/26/2021	National Board of Examiners in Optometry (NBEO)	Association	Presentation
5/27/2021	American Academy of Optometry	Association	Presentation
6/2/2021	National Association of VA Optometrists (NAVAO)	Association	Email / Letter
6/3/2021	American Medical Association (AMA)	Association	Presentation
6/3/2021	National Certification Commission for Acupuncture and Oriental Medicine	Association	Email / Letter
6/7/2021	Armed Forces Optometric Society (AFOS)	Association	Email / Letter
6/7/2021	Association of Regulatory Boards of Optometry	Association	Email / Letter
6/7/2021	Association of Schools and Colleges of Optometry	Association	Email / Letter
6/8/2021	American Optometric Association (AOA)	Association	Email / Letter
6/9/2021	Federation of State Medical Boards	Association	Presentation
6/9/2021	The American Board for Certification in Orthotics, Prosthetics & Pedorthics (ABC)	Association	Presentation
6/11/2021	Accreditation Council on Optometric Education	Association	Email / Letter
6/15/2021	American Academy of Optometry	Association	Email / Letter
6/15/2021	Department of Defense	Federal	Presentation
6/16/2021	Association of Social Work Boards (ASWB)	Association	Presentation
6/16/2021	National Board of Examiners in Optometry (NBEO)	Association	Email / Letter
6/16/2021	National Society of Genetic Counselors	Association	Email / Letter
6/21/2021	National Association of Government Employees	Union	Presentation
6/28/2021	National Federation of Federal Employees	Union	Presentation
7/1/2021	Congress	Federal	Presentation
7/7/2021	The American Board for Certification in Orthotics, Prosthetics & Pedorthics (ABC)	Association	Presentation
7/12/2021	American Medical Association (AMA)	Association	Presentation
7/13/2021	American Legion	VSO	Presentation
7/13/2021	AMVETS (American Veterans)	VSO	Presentation
7/13/2021	Disabled American Veterans	VSO	Presentation
7/13/2021	Enlisted Association of the National Guard of the United States	VSO	Presentation
7/13/2021	Fleet Reserve Association (FRA)	VSO	Presentation
7/13/2021	Iraq and Afghanistan Veterans of America (IAVA)	VSO	Presentation

Date	Stakeholder Name	Stakeholder	Type
7/13/2021	Military Officers Association of America (MOAA)	VSO	Presentation
7/13/2021	Minority Veterans of America (MVA)	VSO	Presentation
7/13/2021	Paralyzed Veterans of America	VSO	Presentation
7/13/2021	Reserve Officers Association	VSO	Presentation
7/13/2021	The Enlisted Association (TREA)	VSO	Presentation
7/13/2021	The Independence Fund	VSO	Presentation
7/13/2021	Veterans and Military Families for Progress	VSO	Presentation
7/13/2021	Veterans of Foreign Wars	VSO	Presentation
7/13/2021	Wounded Warrior Project	VSO	Presentation
7/14/2021	American Society of Radiologic Technologists	Association	Presentation
7/14/2021	Pharmacy Technician Certificate Board	Association	Presentation
7/20/2021	American Society for Clinical Pathology (ASCP)	Association	Email / Letter
7/20/2021	Department of Defense	Federal	Email / Letter
7/21/2021	American Counseling Association	Association	Presentation
7/26/2021	American Association for Marriage and Family Therapy	Association	Presentation
7/27/2021	National Nurses Union (NNU)	Union	Presentation
7/28/2021	American Medical Association (AMA) + Coalition of Medical Societies	Association	Email / Letter
7/29/2021	American Osteopathic Association	Association	Email / Letter
8/2/2021	Congress	Federal	Email / Letter
8/3/2021	Association of State and Provincial Psychology Boards (ASPPB)	Association	Presentation
8/12/2021	Council of Colleges of Acupuncture and Herbal Medicine	Association	Email / Letter
8/12/2021	Health and Human Services	Federal	Email / Letter
8/25/2021	American Association of Nurse Anesthetists	Association	Email / Letter
8/25/2021	American Registry of Radiologic Technologists	Association	Presentation
9/1/2021	Service Employees International Union (SEIU)	Union	Presentation
9/3/2021	American Occupational Therapy Association	Association	Presentation
9/7/2021	Congress	Federal	Email / Letter
9/8/2021	American Psychological Association (APA)	Association	Presentation
9/15/2021	Congress	Federal	Email / Letter
9/24/2021	Congress	Federal	Email / Letter
9/28/2021	American Society of Anesthesiologists (ASA)	Association	Email / Letter
9/29/2021	American Federation of Government Employees	Union	Presentation
9/29/2021	Congress	Federal	Email / Letter
9/30/2021	Michigan DO Board	State	Email / Letter
9/30/2021	Wisconsin DO Board	State	Email / Letter
10/5/2021	National Association for Alcoholism and Drug Abuse Counselor (NAADAC)	Association	Email / Letter
10/5/2021	West Virginia Department of Health and Human Resources Bureau for Medical Services	State	Email / Letter
10/7/2021	American Association of Nurse Anesthetists + Coalition of Medical Societies	Association	Email / Letter
10/12/2021	National Council of State Boards of Nursing	Association	Presentation
10/12/2021	Tri-Council for Nursing CEOs	Association	Presentation
10/13/2021	American Medical Association (AMA)	Association	Email / Letter

Date	Stakeholder Name	Stakeholder	Type
10/18/2021	Congress	Federal	Presentation
10/18/2021	VetsFirst	VSO	Presentation
10/18/2021	Vietnam Veterans of America	VSO	Presentation
10/19/2021	National Association of Government Employees	Union	Presentation
10/20/2021	Service Employees International Union (SEIU)	Union	Presentation
10/26/2021	American Federation of Government Employees	Union	Presentation
10/26/2021	National Federation of Federal Employees	Union	Presentation
10/28/2021	Commission on Rehabilitation Counselor Certification (CRCC)	Association	Email / Letter
11/1/2021	Congress	Federal	Email / Letter
11/3/2021	American Medical Association (AMA)	Association	Presentation
11/4/2021	American Psychiatric Association (APA)	Association	Presentation
11/17/2021	American Federation of Government Employees	Union	Presentation
11/17/2021	National Federation of Federal Employees	Union	Presentation
11/18/2021	National Association of Government Employees	Union	Presentation
11/18/2021	Service Employees International Union (SEIU)	Union	Presentation
12/2/2021	American Association of Nurse Anesthetists	Association	Email / Letter
12/2/2021	Joint Commission	Federal	Presentation
12/6/2021	American Psychiatric Association (APA)	Association	Email / Letter
12/7/2021	Congress	Federal	Presentation
12/16/2021	American Academy of Family Physicians (AAFP)	Association	Presentation
12/16/2021	American Medical Association (AMA) + Coalition of Medical Societies	Association	Email / Letter
12/16/2021	Congress	Federal	Email / Letter
12/21/2021	Congress	Federal	Email / Letter
1/5/2022	National Council of State Boards of Nursing	Association	Presentation
1/6/2022	American Psychiatric Association (APA)	Association	Presentation
1/12/2022	Federation of State Medical Boards	Association	Email / Letter
1/14/2022	Congress	Federal	Email / Letter
1/19/2022	Association of VA Anesthesiologists (AVAA)	Association	Email / Letter
1/19/2022	Congress	Federal	Email / Letter
1/26/2022	Association of VA Anesthesiologists (AVAA)	Association	Presentation
2/1/2022	Association of VA Anesthesiologists (AVAA)	Association	Email / Letter
2/14/2022	National Association of Government Employees	Union	Presentation
2/17/2022	American Society of Anesthesiologists (ASA)	Association	Email / Letter
2/17/2022	Joint Commission of Pharmacy Practitioners	Association	Presentation
2/24/2022	National Federation of Federal Employees	Union	Presentation
3/1/2022	American Society of Anesthesiologists (ASA)	Association	Email / Letter
3/3/2022	National Association of Government Employees	Union	Email / Letter
3/9/2022	Congress	Federal	Email / Letter
3/10/2022	National Academic Affiliations Council (NAAC)	Association	Presentation
3/15/2022	National Association of Government Employees	Union	Presentation
3/23/2022	American Society of Radiologic Technologists	Association	Presentation
3/23/2022	Veteran Service Organizations (VSO)	VSO	Email / Letter
3/29/2022	National Federation of Federal Employees	Union	Presentation
3/31/2022	Congress	Federal	Email / Letter
4/7/2022	Congress	Federal	Email / Letter

Date	Stakeholder Name	Stakeholder	Type
4/13/2022	Alaska State Public Health Laboratories Department of Health & Social Services	State	Email / Letter
4/13/2022	Georgia Department of Community Health	State	Email / Letter
4/13/2022	Iowa Bureau of Radiological Health	State	Email / Letter
4/14/2022	Arizona Department of Health Services, Public Health Licensing Services, Special Licensing	State	Email / Letter
4/14/2022	Illinois Emergency Management Agency	State	Email / Letter
4/14/2022	Kentucky Board of Medical Imaging and Radiation Therapy	State	Email / Letter
4/14/2022	Utah Department of Commerce, Division of Occupational and Professional Licensing	State	Email / Letter
4/14/2022	New Jersey Department of Environmental Protection, Radiation Protection Element	State	Email / Letter
4/14/2022	South Carolina Radiation Quality Standards Association	State	Email / Letter
4/15/2022	Tennessee Department of Health Board of Radiologic Imaging and Radiation Therapy	State	Email / Letter
4/18/2022	Minnesota Department of Health	State	Email / Letter
4/18/2022	Oregon Board of Medical Imaging	State	Email / Letter
4/19/2022	Nevada Radiation Control Program	State	Email / Letter
4/19/2022	North Dakota Medical Imaging and Radiation Therapy Board	State	Email / Letter
4/20/2022	Nebraska Department of Health and Human Services, Division of Public Health, Office of Medical and Specialized Health	State	Email / Letter
4/20/2022	Ohio Bureau of Environmental Health and Radiation Protection	State	Email / Letter
4/21/2022	Montana Board of Radiologic Technologists	State	Email / Letter
4/25/2022	Tom Daschle	Other (individual)	Email / Letter
4/27/2022	Virginia Board of Medicine	State	Email / Letter
4/29/2022	Kansas State Board of Healing Arts	State	Email / Letter
5/4/2022	Arkansas Department of Health-Radiation Control	State	Email / Letter
5/5/2022	American Society of Anesthesiologists (ASA)	Association	Email / Letter
5/5/2022	Association of VA Anesthesiologists (AVAA)	Association	Email / Letter
5/6/2022	Review of Optometry Magazine	Other (Media)	Email / Letter
5/22/2022	American Psychiatric Association (APA)	Association	Presentation
5/24/2022	Congress	Federal	Email / Letter
6/15/2022	American Federation of Government Employees)	Union	Presentation
6/16/2022	National Association of Government Employees	Union	Presentation
6/22/2022	Service Employees International Union (SEIU)	Union	Presentation
6/28/2022	National Federation of Federal Employees	Union	Presentation
7/1/2022	Academy for Certification of Vision Rehabilitation & Education Professionals	Association	Email / Letter
7/1/2022	Veteran Service Organizations (VSO)	VSO	Email / Letter
7/5/2022	National Federation of Federal Employees	Union	Presentation
7/6/2022	American Society of Anesthesiologists (ASA)	Association	Presentation
7/22/2022	FL Congressional Delegation (9 Members of Congress): Representative Daniel Webster,	Federal	Email / Letter

Date	Stakeholder Name	Stakeholder	Type
	Representative Byron Donalds, Representative Vern Buchanan, Representative Maria Elvira Salazar, Representative Bill Posey, Representative C. Scott Franklin, Representative Kat Cammack, Representative Neal Dunn, Representative Maria Diaz-Balart		
7/28/2022	National Federation of Federal Employees	Union	Presentation
7/28/2022	National Nurses Union (NNU)	Union	Email / Letter
7/29/2022	Joint Commission on Allied Health Personnel in Ophthalmology	Association	Email / Letter
8/1/2022	National Council of State Boards of Nursing	Association	Presentation
8/8/2022	Association of VA Anesthesiologists (AVAA)	Association	Email / Letter
8/18/2022	National Association of Government Employees	Union	Presentation
8/18/2022	National Federation of Federal Employees	Union	Presentation
8/24/2022	Veteran Service Organizations (VSO)	VSO	Presentation
8/27/2022	American Legion Convention	VSO	Presentation
9/15/2022	National Federation of Federal Employees	Union	Presentation
9/20/2022	National Federation of Federal Employees	Union	Email / Letter
9/29/2022	Federation of State Medical Boards	Association	Presentation
9/29/2022	Congress	Federal	Presentation
10/7/2022	The American Board for Certification in Orthotics, Prosthetics & Pedorthics (ABC)	Association	Email / Letter
10/20/2022	National Federation of Federal Employees	Union	Presentation
10/25/2022	Armed Forces Optometric Society (AFOS)	Association	Presentation
10/25/2022	Association of Schools and Colleges of Optometry	Association	Presentation
10/25/2022	Congress	Federal	Email / Letter
10/26/2022	National Nurses Union (NNU)	Union	Presentation
10/27/2022	Association of Schools and Colleges of Optometry (ASCO)	Association	Presentation
10/27/2022	National Association of VA Optometrists (NAVAO)	Association	Presentation
10/31/2022	National Nurses Union (NNU)	Union	Presentation
11/2/2022	American Medical Association (AMA)	Association	Email / Letter
11/15/2022	Review of Ophthalmology	Association	Email / Letter
11/16/2022	American Federation of Government Employees)	Union	Presentation
11/17/2022	Review of Ophthalmology	Association	Email / Letter
11/30/2022	Association of VA Anesthesiologists (AVAA)	Association	Email / Letter
12/7/2022	American Black Chiropractic Association	Association	Presentation
12/7/2022	American Chiropractic Association	Association	Presentation
12/7/2022	Association of Chiropractic Colleges	Association	Presentation
12/7/2022	Congress of Chiropractic State Associations	Association	Presentation
12/7/2022	Council on Chiropractic Education Accredited Doctor of Chiropractic Programs	Association	Presentation
12/7/2022	Federation of Chiropractic Licensing Boards	Association	Presentation
12/7/2022	Foundation for Chiropractic Progress	Association	Presentation
12/7/2022	International Chiropractors Association	Association	Presentation
12/7/2022	National Board of Chiropractic Examiners	Association	Presentation
12/7/2022	Women Chiropractors	Association	Presentation
12/7/2022	World Federation of Chiropractic	Association	Presentation
12/13/2022	Blinded Veterans Association	VSO	Presentation

Date	Stakeholder Name	Stakeholder	Type
12/14/2022	American Optometric Association (AOA) and Armed Forces Optometric Association (AFOS	Association	Presentation
12/20/2022	American Optometric Association (AOA) and Armed Forces Optometric Association (AFOS)	Association	Presentation
1/18/2023	American Federation of Government Employees)	Union	Presentation
1/18/2023	Service Employees International Union (SEIU)	Union	Presentation
1/19/2023	American Federation of Government Employees)	Union	Email / Letter
1/19/2023	National Association of Government Employees	Union	Presentation
1/19/2023	National Federation of Federal Employees	Union	Presentation
2/6/2023	Veterans Service Organization (VSO)	VSO	Presentation
2/7/2023	Veterans Service Organization (VSO)	VSO	Presentation
2/23/2023	National Association of Government Employees	Union	Email / Letter
2/23/2023	American Academy of Physician Assistants	Association	Email / Letter
2/28/2023	Armed Forces Optometric Association (AFOS)	Association	Presentation
3/14/2023	Illinois Department of Professional Regulation Orthotics & Prosthetics Licensure	State	Email / Letter
3/14/2023	Georgia Composite Medical Board	State	Email / Letter
3/14/2023	Pennsylvania State Board of Medicine	State	Email / Letter
3/14/2023	Alabama Board of Prosthetists and Orthotists	State	Email / Letter
3/14/2023	American Academy of Orthotists & Prosthetists	Association	Email / Letter
3/14/2023	Pennsylvania State Board of Medicine	State	Email / Letter
3/14/2023	Alabama Board of Prosthetists and Orthotists	State	Email / Letter
3/14/2023	American Orthotic and Prosthetic Association	Association	Email / Letter
3/14/2023	Arkansas Board of Orthotics, Prosthetics & Pedorthics	State	Email / Letter
3/14/2023	Board of Certification/Accreditation	Association	Email / Letter
3/14/2023	Florida Board of Orthotics & Prosthetics	State	Email / Letter
3/14/2023	Iowa Board of Podiatry	State	Email / Letter
3/14/2023	Kentucky Board of Prosthetics, Orthotics and Pedorthics	State	Email / Letter
3/14/2023	Minnesota Board of Podiatric Medicine	State	Email / Letter
3/14/2023	National Commission on Orthotic and Prosthetic Education (NCOPE)	Association	Email / Letter
3/14/2023	Oklahoma State Board of Medical Licensure and Supervision	State	Email / Letter
3/14/2023	Tennessee Department of Health: Board of Podiatric Medical Examiners	State	Email / Letter
3/14/2023	Texas Orthotists and Prosthetists Advisory Board	State	Email / Letter
3/14/2023	The American Board for Certification in Orthotics, Prosthetics & Pedorthics (ABC)	Association	Email / Letter
3/14/2023	The Ohio Occupational Therapy, The Ohio Occupational Therapy, Physical Therapy, and Athletic Trainers (OTPTAT) Board	State	Email / Letter
3/14/2023	Washington, Washington Orthotist and Prosthetist Advisory Committee	State	Email / Letter
3/14/2023	Hawaii Department of Health	State	Email / Letter
3/14/2023	New York State Committee for Medical Physicists	State	Email / Letter
3/14/2023	Texas Medical Physicists Licensure Advisory Committee	State	Email / Letter
3/14/2023	Florida Advisory Council of Medical Physicists	State	Email / Letter

Date	Stakeholder Name	Stakeholder	Type
3/14/2023	American Board of Medical Physicists, Inc.	Association	Email / Letter
3/14/2023	American Board of Radiology	Association	Email / Letter
3/14/2023	Canadian College of Physicists in Medicine	Association	Email / Letter
3/14/2023	Commission on Dietetics Registration	Association	Email/Letter
3/14/2023	Alabama Board of Examiners for Dietetics and Nutritionists	State	Email / Letter
3/14/2023	Alaska Department of Commerce, Community, and Economic Development	State	Email / Letter
3/14/2023	Arkansas Dietetics Licensing Board	State	Email / Letter
3/14/2023	D.C. Board of Dietetics and Nutrition	State	Email / Letter
3/14/2023	Delaware Board of Dietetics/Nutrition	State	Email/Letter
3/14/2023	Florida Dietetic & Nutrition Practice Council	State	Email / Letter
3/14/2023	Georgia Board of Dietitians	State	Email / Letter
3/14/2023	Guam Board of Allied Health Examiners	State	Email / Letter
3/14/2023	Hawaii Department of Health	State	Email / Letter
3/14/2023	Idaho Board of Medicine	State	Email / Letter
3/14/2023	Illinois Department of Financial and Professional Regulation	State	Email/Letter
3/14/2023	Indiana Professional Licensing Agency	State	Email / Letter
3/14/2023	Iowa Bureau of Professional Licensure	State	Email / Letter
3/14/2023	Kansas Health Occupations Credentialing	State	Email / Letter
3/14/2023	Kentucky Board of Licensure and Certification for Dietitians and Nutritionists	State	Email / Letter
3/14/2023	Louisiana Board of Examiners in Dietetics and Nutrition	State	Email / Letter
3/14/2023	Maine Board of Licensing of Dietetic Practice	State	Email/Letter
3/14/2023	Maryland Board of Dietetic Practice	State	Email / Letter
3/14/2023	Massachusetts Board of Registration of Dietitians and Nutritionists, Massachusetts Board of Registration of Dietitians and Nutritionists	State	Email / Letter
3/14/2023	Minnesota Board of Dietetics and Nutrition Practice	State	Email / Letter
3/14/2023	Mississippi Council of Advisors in Dietetics	State	Email / Letter
3/14/2023	Missouri Committee of Dietitians	State	Email / Letter
3/14/2023	Montana Board of Medical Examiners	State	Email / Letter
3/14/2023	Nevada Dietician Licensing Unit	State	Email / Letter
3/14/2023	New Hampshire Board of Licensed Dietitians	State	Email / Letter
3/14/2023	New Mexico Regulation & Licensing Department	State	Email / Letter
3/14/2023	New York State Board for Dietetics & Nutrition	State	Email / Letter
3/14/2023	North Carolina Board of Dietetics	State	Email/Letter
3/14/2023	North Dakota Board of Dietetic Practice	State	Email / Letter
3/14/2023	State Medical Board of Ohio	State	Email / Letter
3/14/2023	Oklahoma State Board of Medical Licensure and Supervision	State	Email / Letter
3/14/2023	Oregon Board of Licensed Dietitians	State	Email / Letter
3/14/2023	Pennsylvania State Board of Nursing	State	Email / Letter
3/14/2023	Junta Examinadora De Nutricionistas Y Dietistas De Puerto Rico	State	Email/Letter
3/14/2023	Board of Dietetics Practice for Rhode Island Department of Health	State	Email / Letter

Date	Stakeholder Name	Stakeholder	Type
3/14/2023	South Carolina Panel for Dietetics	State	Email / Letter
3/14/2023	South Dakota Board of Medical and Osteopathic Examiners	State	Email / Letter
3/14/2023	Tennessee Board of Dietitians/Nutritionist Examiners	State	Email / Letter
3/14/2023	Texas Department of Licensing and Regulation Dietitians	State	Email / Letter
3/14/2023	Utah Dietitian Licensing Board	State	Email/Letter
3/14/2023	Vermont Office of Professional Regulation: Dietitians	State	Email / Letter
3/14/2023	Washington State Department of Health Dietitian and Nutritionist	State	Email / Letter
3/14/2023	West Virginia Board of Licensed Dietitians	State	Email / Letter
3/14/2023	Wisconsin Dietitians Affiliated Credentialing Board	State	Email / Letter
3/14/2023	Wyoming Dietetics Licensing Board	State	Email/Letter
3/16/2023	National Association of Government Employees	Union	Presentation
3/21/2023	Congress	Federal	Presentation
3/24/2023	AMVETS (American Veterans)	VSO	Email / Letter
4/7/2023	National Association of Government Employees	Union	Email / Letter
4/13/2023	American Federation of Government Employees)	Union	Email / Letter
4/19/2023	American Society of Retina Specialists (ASRS)	Association	Email / Letter
4/19/2023	Board of Certification/Accreditation (BOC)	Association	Presentation
4/20/2023	American Federation of Government Employees)	Union	Email / Letter
4/21/2023	AMVETS + American of Foreign Wars	VSO	Email / Letter
4/25/2023	West Virginia Board of Licensed Dietitians	Association	Presentation
4/26/2023	Congress	Federal	Presentation
5/1-2/2023	FY23 VA Anesthesia Leadership Consortium – Southeastern States Network	Association	Presentation
5/16/2023	American Society of Anesthesiologists – Legislative Conference 2023	Association	Presentation
5/16/2023	Puerto Rico Department of Health	State	Email/Letter
5/16/2023	California Department of Public Health	State	Email/Letter
5/16/2023	Hawaii Department of Health	State	Email/Letter
5/16/2023	Louisiana State Board of Medical Examiners	State	Email/Letter
5/16/2023	West Virginia Office of Laboratory Science	State	Email/Letter
5/16/2023	Tennessee Medical Laboratory Board	State	Email/Letter
5/16/2023	New York State Education Department	State	Email/Letter
5/16/2023	Nevada Department of Health and Human Services	State	Email/Letter
5/16/2023	Montana Board of Clinical Practitioners	State	Email/Letter
5/16/2023	Florida Department of Health	State	Email/Letter
5/16/2023	American Society for Clinical Pathology (ASCP)	Association	Email/Letter
6/1-2/2023	FY23 VA Anesthesia Leadership Consortium – Western States Network	Association	Presentation
6/5/2023	American Psychiatric Association (APA)	Association	Presentation
6/5/2023	American Academy of Ophthalmology	Association	Presentation
6/8/2023	North Dakota Board of Dietetic Practice	State	Presentation
6/20/2023	Congress	Federal	Presentation
6/20/2023	American Optometry Association	Association	Presentation
6/21/2023	National Association of Government Employees	Union	Email / Letter
6/27/2023	National Federation of Federal Employees	Union	Email / Letter

Date	Stakeholder Name	Stakeholder	Type
6/28/2023	American Federation of Government Employees)	Union	Email / Letter
7/12/2023	American Federation of Government Employees)	Union	Presentation
7/17/2023	American Medical Association (AMA)	Association	Presentation
8/8/2023	National Council of State Boards of Nursing	Association	Presentation
8/9/2023	National Association of Government Employees	Union	Presentation
8/10/2023	American Association of Nurse Anesthesiologists	Association	Presentation
8/14/2023	Association of VA Ophthalmologists (AVAO)	Association	Presentation
8/24/2023	Kentucky Department of Veterans Affairs State Conference	Association	Presentation
8/24/2023	NSP Listening Session 1: Audiologist, Chiropractor, Occupational Therapist, Physical Therapist, Speech Language Pathologist	Association	Presentation
8/31/2023	NSP Listening Session 2: Acupuncturist, Genetic Counselor, Massage Therapist, Optometrist, Perfusionist, Podiatrist, Respiratory Therapist, Therapeutic Radiologic Technologist	Association	Presentation
9/7/2023	NSP Listening Session 3: Clinical Pharmacist Practitioner, Dental Assistant, Dental Hygienist, Dentist, Diagnostic Radiologic Technologist, Medical Technologist, Nuclear Medicine Technologist, Pharmacist, Pharmacy Technician, Radiologist Assistant, Social Worker	Association	Presentation
9/12/2023	FY23 VA Anesthesia Leadership Consortium – Midwestern States Network Consortium	Association	Presentation
9/14/2023	NSP Listening Session 4: Emergency Medical Technician/Paramedic, Physician, Physician Assistant	Association	Presentation