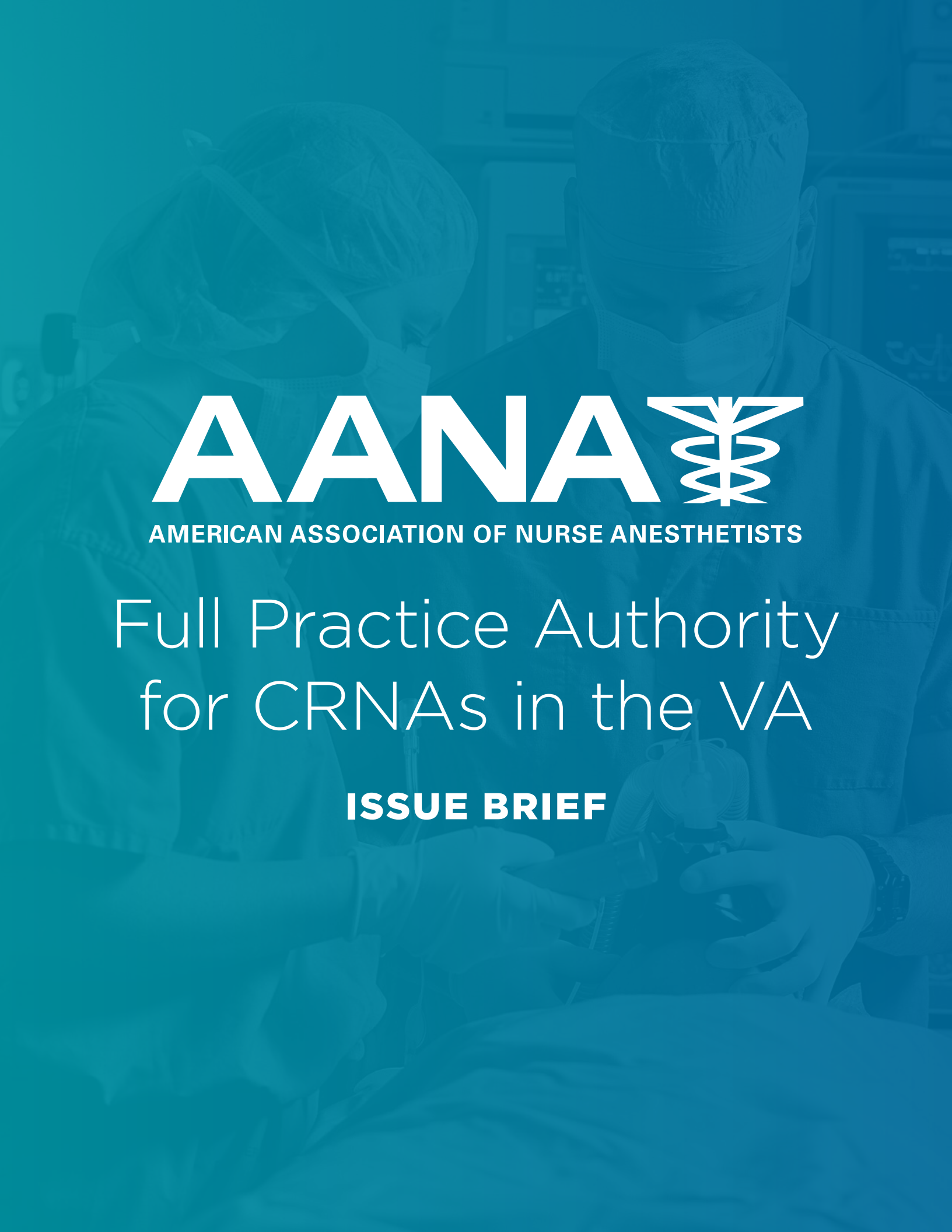

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# Full Practice Authority for CRNAs in the VA

## ISSUE BRIEF

# Background

Today, more than 1,000 Certified Registered Nurse Anesthetists (CRNAs) serve in the Veterans Health Administration (VHA), providing the highest quality care to our nation's veterans. Nationwide, CRNAs deliver more than 49 million anesthetics each year, and practice in every setting from hospital emergency rooms to ambulatory surgical centers. CRNAs have historically provided much of the anesthesia to our active duty military in combat arenas since World War I and predominate in veterans' hospitals and the U.S. Armed Services, where they enjoy full practice authority in every branch of the military.

In 2016, the VA issued a final rule granting three of the four advanced practice registered nursing (APRN) specialties full practice authority (FPA), **excluding only CRNAs.** Since then, reports have continuously highlighted a lack of access to anesthesia services in the VA, which the APRN final rule cited as a reason to revisit the decision to leave CRNAs out. The decision to exclude CRNAs will cause veterans to continue to endure dangerously long wait times for anesthesia and other services due to the ongoing underutilization of CRNAs currently working in VHA facilities.

In April 2020, the VA issued Directive 1899 allowing CRNAs full practice in some VA facilities during the COVID-19 public health emergency, to ensure that the VA had sufficient skilled providers to handle the pandemic. This is an important move in the right direction, but it's not enough. **The VA needs to make full practice authority for CRNAs permanent throughout the VA.**

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*"[This change] gives us a better ability to recruit and retain those essential providers for our teams ... we need that level of agility to respond effectively and deliver the access that you mentioned originally."*

**Dr. Jennifer MacDonald**
Chief Consultant to the Deputy Under Secretary for Health at the Department of Veterans Affairs, on full practice authority for CRNAs.

# CRNA Role in the VA During COVID-19

**Department leadership strongly recommended CRNAs be granted full practice authority in the VA during the COVID-19 health emergency because they are uniquely trained, educated and positioned.** All CRNAs have at least one year of experience as an RN in a critical care setting, with the average CRNA having 3 years of this experience before becoming a CRNA. CRNA expertise in airway management, hemodynamic monitoring, management of patients on ventilators, placement of invasive lines, and overall management of critically ill patients uniquely positions them to provide life-saving care to those suffering from COVID-19, **all without the need for physician supervision.**

During this epidemic, in order to bring increased access to veterans, the VA issued Directive 1899, which allows health care professionals to deliver care in VA facilities and VISN networks in states other than the states in which they are licensed, registered or certified (similar to what Medicare did) "so long as they hold a current, full and unrestricted license, registration or certification." It also "allows such professionals to practice and operate within the full scope of the license, registration or certification they hold." It encourages VA medical facilities to utilize VA health care professionals to practice and operate to the full scope of their licensure and registration certification to allow for increased access to care for VA beneficiaries.

This was an important first step, but with overwhelming evidence showing there are access to anesthesia care issues in the VA, **we believe that full practice authority for CRNAs needs to be made permanent.**

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*"Formalizing full practice authority for APNs would likely be a cost-effective approach to increasing the productivity of VA's existing workforce."*

**VA's Independent Assessment**

*"Develop policy to allow full practice authority for APRNs."*

**Commission on Care Recommendation**

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# Alignment with VA and Independent Recommendations

The move by the VA to allow for temporary full practice authority for CRNAs aligns with a number of assessments and recommendations that have called for implementing full practice authority for CRNAs and removing supervision requirements:

## SOURCE MATERIALS

**The VA's own Independent Assessment**

**The Bipartisan Commission on Care Report**

**The New England Journal of Medicine**

**The Administration's Executive Order 13890**

**The Bipartisan Policy Center's Rural Healthcare Task Force Report**

**The Nursing Community Coalition**

**20+ Leading Think Tanks and Organizations**

**Institute of Medicine Report on The Future of Nursing**

## COST EFFECTIVENESS OF ANESTHESIA MODELS

When physician supervision restrictions limit CRNAs' practice, health care costs escalate.

### AUTONOMOUS/CRNAS COLLABORATING WITH SURGEONS

**$2M**

***12 CRNA Staffing Cost[1]***

### CRNAS COLLABORATING WITH ANESTHESIOLOGISTS

**$2.4M**

***12 CRNA, 1 ANES[2] Staffing Cost***

### ANESTHESIA CARE TEAM (3:1 RATIO)

**$3.68M**

***12 CRNA, 4 ANES Staffing Cost***

### PHYSICIAN ANESTHESIOLOGIST ONLY

**$5.04M**

***12 ANES Staffing Cost***

*[1] Staffing costs are based on salary only. The median CRNA salary ($166,540) was taken from the 2018 AANA Compensation and Benefits Survey. Salary costs for physician anesthesiologists are based on the 75th pctl salary ($420,284) according to HR Reported data as of March 29, 2018, Salary.com*

*[2] Physician anesthesiologist*

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# Expanding Access, Decreasing Costs and Reducing Wait Times

**Removing unnecessary supervision and allowing CRNAs to practice to the full extent of their education and skills will help the VA address staffing shortages and long wait times in the most cost-effective manner possible.**

A study by the Lewin Group shows that a CRNA practicing without supervision is the most cost-effective method of anesthesia delivery. Additionally, a study comparing educational costs showed that CRNAs are more cost-effective to educate than other anesthesia professionals.

The VA, in its original APRN rule, stated that it would reconsider leaving CRNAs out of full practice authority if there was evidence that showed an issue with access to anesthesia. The evidence is clearly here, as we see reports out of the Denver VA that procedures were postponed or cancelled specifically because of a lack of access to anesthesia. Additionally, the VA's own inspector general reports indicate that dozens of VA facilities lacked sufficient anesthesia staff as well as nursing staff.

| ANESTHESIA PAYMENT MODEL | FTES / CASE | CLINICIAN COSTS PER YEAR / FTE |
|---|---|---|
| (a) CRNA Non-medically Directed | 1.00 | $170,000 |
| (b) Medical Direction 1:4 | 1.25 | $305,079 |
| (c) Medical Direction 1:2 | 1.50 | $440,157 |
| (d) Anesthesiologist Only | 1.00 | $540,314 |
| | | |
| Anesthesiologist annual pay (mean) | $540,314 | MGMA, 2014 |
| CRNA annual pay (mean) | $170,000 | AANA, 2014 |

*Comparative costs of anesthesia care based on delivery models.*

# Providing the Highest Quality Care to Our Veterans

In addition to being the most cost-effective delivery method for anesthesia, CRNAs practicing independently are also one of the **safest models of anesthesia delivery.** Multiple studies have compared the safety of anesthesia delivery for various models, including a CRNA practicing independently and supervised.

- A study published in **Medical Care** found no difference in safety outcomes based between different delivery models.
- A study published in **Health Services Research** showed no difference in outcomes between CRNA-only and Anesthesiologist-only facilities in maternal care.
- A study published in **Health Affairs** found that there was no difference in anesthesia care safety between states that had removed supervision and allowed full practice, versus those that maintained supervision.
- A study published in **Journal of Healthcare Quality** showed that CRNAs providing fluoroscopic guided injections had similar complication rates to physicians engaged in the same procedure.

**The ability of CRNAs to provide high quality care, even under the most difficult circumstances, has been recognized by every branch of the U.S. military.** CRNAs have full practice authority in the Army, Navy, and Air Force and are the predominant provider of anesthesia on forward surgical teams and in combat support hospitals, where 90% of forward surgical teams are staffed by CRNAs.

**If CRNAs are able to deliver care to our active duty military members on the battlefield independently, there is no reason they should not be able to deliver that same care to our veterans under much safer circumstances in VA facilities.**

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*"This is a zero-cost solution that would provide veterans with the access, continuity and quality of care, and reduce wait times for veterans needing care."*

**AMVETS**
June 29, 2016

# Supported by Multiple Veterans Service Organizations

During the 2016 VA rule-making period, multiple Veterans Service Organizations (VSOs) weighed in, supporting full practice authority for CRNAs in the VA:

- Air Force Sergeants Association (AFSA)
- Iraq and Afghanistan Veterans of America (IAVA)
- AMVETS
- Military Officers Association of America (MOAA)
- Paralyzed Veterans of America (PVA)
- Reserve Officers Association (ROA)
- AARP

**Now is the time to enact full practice authority for all CRNAs throughout the VA.**

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