

The U.S. Department of Veterans Affairs (VA) “Nursing Handbook”

Frequently Asked Questions

ISSUE

The Department of Veterans Affairs’ (VA) Office of Nursing Services (ONS) has proposed a new policy document known as the “VHA Nursing Handbook.” The principal purpose of the document is to expand the role of advanced practice registered nurses (APRNs) in VA health care facilities. However, the document also includes changes to VA anesthesia care policies that will needlessly place the health and lives of Veterans at risk. Currently, the “Nursing Handbook” is under review at the Office of Management and Budget (OMB) as a proposed rule under the title “Advance Practice Registered Nurses (APRNs).” Once OMB completes its review, the proposed rule will be released in the Federal Register for public comments.

QUESTIONS

What is the controversy surrounding this issue? The “Nursing Handbook” proposed rule seeks to expand the use of APRNs in VA. The most controversial elements of the document are proposed changes to VA’s current surgical anesthesia care delivery policies. Specifically, the changes would abandon the current physician-nurse team-based model of anesthesia care in VA. This change could impact the safety and quality of surgical anesthesia care available to Veterans by removing physician anesthesiologists from Veterans’ care.

What is the current VHA policy? Currently, VHA policies regarding anesthesia care are set through the consensus “Anesthesia Service Handbook.” This handbook provides that in VA facilities, surgical anesthesia care will be provided in a “team fashion” – a physician and nurse working together to provide care, subject to “state license scope of practice” (Anesthesia Service Handbook, pg. 2). The team-based anesthesia care model - a physician anesthesiologist working with a nurse anesthetist - is one of the most common models of anesthesia care in the country and provides excellent anesthesia outcomes.

What is the ONS proposing and how does it impact VA’s current policies? Through the “Nursing Handbook,” the ONS is proposing to eliminate the requirement for anesthesia to be delivered in a team-fashion. The ONS further proposes moving toward a nurse-only or independent nurse practice model of anesthesia. The model is also often referred to as “full practice authority.” Under this model, a nurse anesthetist practices without supervision, collaboration or other relationship with a physician. The proposal conflicts directly with VA’s current team-based policies contained in the existing “Anesthesia Service Handbook” and, if implemented and permitted to supersede current policy, would fundamentally change surgical anesthesia care in VA.

What is the ONS’s rationale for this new policy? The policy was developed to address the shortage of primary care physicians in VA. The ONS believes that nurses can appropriately be used in lieu of primary care physicians in the VA to alleviate the identified provider shortages.

Is there a shortage of physician anesthesiologists in VA? While there are shortages of other health care providers in VA, the agency's own data indicates that there is no shortage of physician anesthesiologists or nurse anesthetists in VA.

The VA's September 1, 2015 analysis of staffing capabilities, "Assessment B (Health Care Capabilities)" of the "**Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs,**" reviewed provider types in shortage and did not list physician anesthesiologists as among the 12 identified in shortage (Assessment, pg. 87).

More recently, the VA released the annual **Mission Critical Occupations Report**, a document that "identifies the highest ranking ten mission critical (hard-to-fill) occupations ("top 10")" in VHA. The document, dated December 10, 2015, lists the top 5 nursing and top 5 physician specialties "hard-to-fill" occupations. Neither Physician anesthesiologists nor nurse anesthetists were included. Psychiatry, primary care and gastroenterology physicians were ranked 1, 2, and 3 respectively (Mission Critical Occupations Report, pg. 1).

A recent review of USAJobs.gov, the official employment website for the federal government, listed only 9 physician anesthesiologist vacancies throughout the entire country.

Can nurses be safely used in lieu of physician anesthesiologists or the physician-nurse team to provide anesthesia to Veterans? Anesthesia is unlike other care settings, and is particularly different from the primary care setting. It is a complex, high-risk care setting where complications can present quickly that require immediate medical attention to prevent serious injury and even death. The involvement of appropriately educated and trained physician anesthesiologists is an imperative, especially with the patients served by VA. Veterans have poorer health status than the general population, increasing the risk of complications during and surrounding the time of the surgical/anesthesia episode of care. The elimination of the team-based model of anesthesia care places the health and lives of Veterans at risk.

What do existing studies show? There are no independent studies to support the nurse-only model of anesthesia care as safe for Veterans.

VA's own internal quality program, the Quality Enhancement Research Initiative (QUERI), examined available literature regarding the question of "full practice authority" or independent practice for APRNs, including nurse anesthetists. 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" (QUERI pg.1). The paper concluded, "[t]he results of these studies do not provide any guidance on how to assign patients for management by a solo CRNA, or whether 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" (QUERI pg. 15).

Two independently funded anesthesia outcomes studies (Silber 2000 and Memtsoudis 2012) concluded outcomes are improved with the involvement of a physician anesthesiologist in anesthesia delivery.

The only two studies that claim to support the safety of the nurse-only model of anesthesia care are two advocacy studies funded by the American Association of Nurse Anesthetists. Dulisse and Cromwell ("Health Affairs") 2010 and Hogan 2010 have been cited as evidence that nurse anesthetists can provide the same level of care as physician anesthesiologists and the physician-

nurse team-based model of care. An independent reviewer concluded that there is a risk of “bias” due to the funding source.

Doesn't the Cochrane Collaboration 2014 study support the argument that there is no difference in the care provided by a nurse anesthetist and a physician anesthesiologist? No. In fact, the authors had hoped to show that there was no difference but ultimately concluded that data limitations prevented them from doing so.

In the “Background” portion of the report, the authors of the report wrote, **“We hoped that this [the review] may lead to an increase in confidence in the skills of NPAs within the anaesthetic community** and may potentially lead to greater flexibility in team roles, both within and between countries, depending on patient need (Cochrane, pg. 4) However, what the authors actually found was that they were unable to reach a conclusion about the differences between anesthesia providers because of a variety of limitations. Specifically, the authors reported, “No definitive statement can be made about the possible superiority of one type of anaesthesia care over another” (Cochrane, pg. 2). Among other challenges, the report cited the difficulty in discerning which cases were nurse-only versus the team-based model of anesthesia. Many cases purporting to be nurse-only actually included the involvement of a physician anesthesiologist. Additionally, the report cited the lack of randomized controlled trials (RCT) – studies under which a nurse anesthetist, physician anesthesiologist or team-based models would be randomly assigned to a case regardless of the health status of the patient or the type of procedure. The report concluded that **“randomization may be unacceptable to health service providers, research ethics committees and patients, particularly for high-risk patients and procedures”** (Cochrane, pg. 15), all but acknowledging that the nurse-only model of anesthesia care was too risky for providers, researchers and patients to test.

What has been the response of internal and external stakeholders? Internally, VHA's own anesthesia experts, the local facility Chiefs of Anesthesiology, are alarmed by this proposal and their exclusion from the development of the ONS policy impacting VA surgical anesthesia services. To voice their concern, 67 Chiefs of Anesthesiology came together and invoked VA's own patient safety and quality alert whistleblower program known as “Stop the Line” to express concern about the patient safety implications of the VHA Nursing Handbook. The Chiefs argued that elimination of physician involvement “would directly compromise patient safety and limit our ability to provide quality care to Veterans” (Chiefs letter, pg. 1). Additionally, more than 200 VA physician anesthesiologists invoked this “Stop the Line” policy to reiterate their continued patient safety concerns as recently as October of 2015 (AVAA letter, pg. 1).

Externally, national Veteran organizations AMVETS, the National Guard Association of the United States and the Association of the U.S. Navy have formally raised concerns with the VA Secretary regarding the application of this new policy to the surgical anesthesia setting.

How has Congress been involved? So far, a bipartisan group of more than 90 lawmakers have contacted VA and expressed their concerns about how the proposed Handbook could negatively impact patient safety for Veterans.

Additionally, report language included in House and Senate Military Construction and Veterans Affairs Appropriations bills for FY 2015 and FY 2016 provides that, as VA reviews the Nursing Handbook, it seek input from both internal and external stakeholders and that it work to ensure that the proposed “Nursing Handbook” does not conflict with other handbooks already in place, a reference to the “Anesthesia Service Handbook.”

Is the Department of Defense (DoD) the appropriate model for anesthesia care delivery in VA? There are a variety of anesthesia models in use by the DoD. There are “independent” practice models in DoD, but there are also requirements for team-based care. Physician anesthesiologists play an extensive role in providing services for the DoD. For example, the U.S. Army requires collaborative [team] arrangements for ASA physical status 3, 4, and 5 (sicker) patients and U.S.-led NATO facilities require the involvement of physician anesthesiologists in anesthesia care (Army Regulation 40-68, pg. 29; Emergency War Surgery NATO Handbook, XV-1, XV-11). The proposed Nursing Handbook would go far beyond the DoD practice, despite the fact that VA patients often have poorer health status, including more co-morbidities, than active duty military patients.

Is the nurse-only model of anesthesia care prevalent in states?

The vast majority of states require delivery of anesthesia in a team-fashion whether via supervision, collaboration or other team-based model. Medicare requires a team-based model through supervision. States are permitted to exempt themselves from the supervision requirement but all but three of 17 “Medicare opt-out states,” still recognize a state law or regulation providing for anesthesia to be delivered through collaboration or other team-based arrangement.

Why do nurse anesthetists say they practice without supervision in many settings? As referenced above, supervision is one of a number of team-based models. It may be true that in a certain states nurse anesthetists practice without supervision but in most cases they are still practicing in another team-based model, such as a collaborative model.

Does the Institute of Medicine’s (IOM) “Future of Nursing” study indicate that barriers to practice need to be eliminated so that nurses can practice to “the top of their license?” The subject matter of the “Future of Nursing” report focuses almost exclusively on the primary care setting with no meaningful discussion of the surgical anesthesia setting. The report states, “Nurses thus are poised to help bridge the gap between coverage and access, to coordinate increasingly complex care for a wide range of patients, **to fulfill their potential as primary care providers** to the full extent of their education and training, and to enable the full economic value of their contributions across practice settings to be realized” [Emphasis added] (IOM, pg.3)