American Society of Anesthesiologists®

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June 1, 2018

Carolyn Clancy, M.D., Executive in Charge
Veterans Health Administration
United States Department of Veterans Affairs
801 Vermont Avenue, NW
Washington, DC 2006

Dear Dr. Clancy:

On behalf of the American Society of Anesthesiologists (ASA) and our 52,000 members, I write to comment on the Department of Veterans Affairs proposed Anesthesia Directive, which would replace the long-serving Anesthesia Service Handbook and align VA Anesthesia Care Team policy with the final APRN rule (RIN 2900-AP-44).

ASA commends VA for its promulgation of a final APRN rule that maintains VA's physician-led, team-based model of care in which physician anesthesiologists and nurse anesthetists work together to provide safe anesthesia care. Regarding the proposed Anesthesia Directive, ASA encourages VA to continue to embrace policies that strengthen the Anesthesia Care Team, and to promote patient safety and the highest quality care.

In **3 c. "Anesthesia Team**", within the proposed definition of the Anesthesia Team, ASA recommends the following strengthening amendments.

1. The proposed definition includes: "The team leader should be the professional with the most advanced training and must be an anesthesiologist, when available." In the absence of a physician anesthesiologist, *ASA recommends that the operating surgeon serve as the team leader.*
2. The proposed definition of the Anesthesia Team also provides that "The conceptualization may include a daily facilitator/board runner who is available for consultation". *ASA recommends that this provision be omitted in the final Anesthesia Directive unless it is further refined with the definitions of "medical direction" and "medical supervision" included in full.*

In **5 j, "Responsibilities",** *ASA recommends that Anesthesiologist Assistants be eligible for membership on the National Anesthesia Service Field Advisory Committee.*

In **10. Appendix B: VA Certified Registered Nurse Anesthetist Practice Guidelines,** ASA supports language within paragraph 1 providing "The team approach should still be the preferred model even when a CRNA has LIP status." However, there is concerning language within Paragraph 2: "In VA, CRNAs working under physician supervision will be granted the broadest responsibilities consistent with documented clinical experience, judgment, knowledge, and technical skill. This includes administration of regional anesthesia and use of ultrasound." *ASA strongly recommends that the last sentence regarding CRNA's use of regional anesthesia and ultrasound be struck from the final Anesthesia Directive.*

Although nurse anesthetists are important members of the Anesthesia Care Team, they do not have formal education or training in chronic pain medicine. Nursing courses in pain management cannot and do not equal the in depth and vigorous years of medical training in diagnostic assessment, anatomy in normal or abnormal states, disease presentation, and in prescribing treatment necessary to safely perform chronic pain interventions. Nurse anesthetists' educational curriculum provides instruction on how to perform anesthesia as part of the Anesthesia Care Team, but it in no way prepares nurse anesthetists to diagnose and treat chronic pain.

Chronic pain is multidisciplinary, including representatives from the fields of anesthesiology, physiatry (PM&R), neurology, and psychiatry. In addition, orthopedic surgeons, family physicians, neurosurgeons, oncologists and other medical specialties provide chronic pain management services. This multi-disciplinary approach to chronic pain treatment is known to improve outcomes and is reflected in the professional societies that represent pain care medicine. For example, the membership of the American Academy of Pain Medicine (AAPM), the North American Spine Society (NASS) and the International Spine Intervention Society (ISIS) include not only anesthesiologists, but also physicians across a broad range of medical specialties.

The procedural aspects of treating chronic pain are also unique. For example, placement of an epidural for labor pain is not the same as an epidural steroid injection for chronic pain. The indications, procedures, and management of an epidural catheter placement for obstetrical analgesia are much different than those for chronic pain and the training and experience for one does not equate to being sufficient for the other. To elaborate, in providing an epidural for labor or surgical pain relief, one avoids areas with pathological changes and the target size for a successful outcome is much larger. In chronic pain interventions, the target is specific, usually limited in size, and in most cases, requires image guidance for procedural success, and often involves areas with significant anatomical abnormalities. What is a contraindication for acute pain management is often the very reason for the intervention in chronic pain. Moreover, there are significant risks involved with interventional chronic pain procedures, and nurse anesthetists' training does not prepare them to respond to medical complications.

Even in the hands of specially trained physicians, chronic pain procedures are inherently dangerous due to the anatomy and delicate structure of the spine and nerves upon which chronic pain interventions are performed. Specifically, many chronic pain procedures are administered in and near the spinal column, and, as mentioned above, involve anatomically abnormal structures. This substantially increases risks to patients. Potential complications include allergic reactions, infections, bleeding, nerve damage, spinal cord injuries (e.g., paralysis), and brain stem tissue damage – all of which can require extensive and costly medical interventions to address. Delayed diagnosis and intervention may worsen the injury, and in some cases, irreversibly. *For these reasons, ASA urges VA to omit the sentence "This includes administration of regional anesthesia and use of ultrasound" from the final Anesthesia Directive.*

For those states which require physician involvement but not supervision, *ASA encourages the addition of "physician involvement" in the Paragraph 3 sentence stating: "When physician supervision of a CRNA is required by the CRNA's State license…". ASA further encourages the addition of "unless the procedure or patient acuity indicates otherwise" immediately following the language in the third sentence "Rarely, if ever, will a 1:1 supervision ratio of a CRNA be warranted. ASA supports the language within Paragraph 3 providing: "After collegial discussions among the parties, the supervising anesthesiologist has the final authority regarding the anesthesia management."*

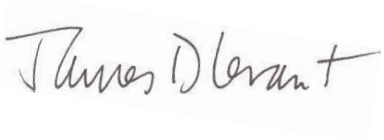
ASA Comments to VA re: Proposed Anesthesia Directive

In **13. Appendix E: Requirements for Anesthesia Professionals, 1.b.**, For the reasons stated previously, *ASA strongly encourages VA to amend the sentence "In facilities without an anesthesiologist, a Chief or lead CRNA will be designated" to read: "In facilities without an anesthesiologist, the Chief of Surgery will serve jointly as the Chief of the Anesthesia Service".*

It should also be noted that Certified Anesthesiologist Assistants (CAA) are authorized to practice in VA. Anesthesiologist Assistant master's degree programs are accredited by the Commission for the Accreditation of Allied Health Education Programs (CAAHEP), a national accrediting body certifying 2100 educational programs in 30 different allied health professions. In May 2015, Anesthesiologist Assistants certified by the CAAHEP were identified as CAAs. *ASA recommends that CAAs are recognized in the definition of the Anesthesia Team and throughout the Anesthesia Directive as CAAs and that a separate appendix for Certified Anesthesiologist Assistant Practice Guidelines be included in the final Directive.*

We again commend VA for its adoption of a final APRN rule that maintains the longstanding patient-centered, physician-led anesthesia care team. ASA appreciates this opportunity provide comment on VA's proposed Anesthesia Directive and welcomes the opportunity to partner with the Department on this, and every effort to provide Veterans with the highest quality anesthesia care; care that they have earned and deserve. A copy of our suggested revisions is attached for your review. Please do not hesitate to contact me, Manuel Bonilla, Chief Advocacy and Practice Officer, at m.bonilla@asahq.org or Nora Matus, Director of Congressional and Political Affairs, at n.matus@asahq.org or at 202-289-2222 with any questions you may have.

Sincerely,



James D. Grant, M.D., M.B.A., FASA
President
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