VIEWPOINT

Veterans Affairs Proposed Rule for Advanced Practice Registered Nurses in the Operating Room
A Step Forward or Overstepping?

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There continue to be ongoing, system-wide changes at Veterans Affairs (VA) medical centers in an effort to address recent issues with wait times and the health care needs of our nation's veterans. In 2001, the Centers for Medicare and Medicaid Services finalized a rule allowing states the authority to decide whether certified registered nurse anesthetists (CRNAs) require physician supervision or to "opt out" and allow them to practice independently.[1] In May 2016, a similar proposed rule was released by the VA to permit full practice authority for advanced practice registered nurses (APRNs)—meaning APRNs would be able to provide health care services within their scope of practice without physician oversight.[2] The proposed rule would apply to all types of APRNs, including certified nurse practitioners, CRNAs, clinical nurse specialists, and (possibly in the future) certified nurse midwives.

In many respects, such a change could immediately expand the number of available health care professionals and address some of the VA's current workforce needs. For example, existing primary care physician workforce shortages are also anticipated in the future.[3] Therefore, using certified nurse practitioners to care for patients with chronic illness, perform screening and health promotion activities, provide prescriptions for medication and durable medical equipment, and place timely referrals would likely provide veterans with more ready access to care. This would seemingly be a win-win situation both for patients, by improving their access to care, and for APRNs, who would have the opportunity to practice their craft to a fuller extent of their license. However, an important consideration overlooked in the proposed rule is that specialty services, particularly anesthesia services provided in the operating room, are not distinguished from care provided in the primary care setting. This raises 3 main concerns that merit careful consideration.

First, how will "full practice authority" actually be defined and operationalized? The proposed rule states that APRNs would neither replace nor act as physicians and would not provide any services beyond their education or scope of practice. But, in the operating room, this would make for a very fine line as to what constitutes appropriate privileges for a CRNA and a physician. Furthermore, there are few data on this topic. A study[4] using Medicare claims comparing the practice patterns of nurse anesthetists in states that opted out after the Centers for Medicare and Medicaid Services final rule with those that did not suggests that independent CRNA practice does not adversely affect surgical outcomes. However, the list of outcomes evaluated in this study[4] were broad, and the impact of intraoperative and postoperative management by the surgical team relative to intraoperative care by the anesthesia team is not possible to distinguish. In addition, anesthesia-related complications and mortality are uncommon and challenging to accurately ascertain using claims data.[5]

Second, because the VA is a federal agency, the VA's proposed rule would supersede state statutes guiding scope of practice. This is intended to provide consistency across VA medical centers and decrease practice variability because of differences in state regulations. Despite this flexibility, in the absence of a clear definition in the proposed rule to guide what constitutes adequate training and/or appropriate privileges, there will still be substantial and inherent variability in granting privileges at the discretion of local leadership according to the needs of each VA. Because of existing internal and external pressure to quickly and aggressively improve access to care, there is the risk that APRNs may be granted privileges or put in clinical scenarios for which they may not be fully trained. For example, a physician would not finish residency in internal medicine, anesthesiology, or general surgery and then be expected to immediately practice cardiology, cardiac anesthesia, or cardiac surgery because additional years of specific and formal training are required. How will this same paradigm be adopted for CRNAs?

Third, care in the operating room moves quickly and is dynamic. In the primary care setting, the health care professional is expected to take the time necessary to elicit a full history and perform a thorough physical examination to understand the etiology of a patient's presenting complaint and order appropriate diagnostic studies. There are also numerous guidelines for the management of acute and chronic conditions that could be used as decision aids to help APRNs provide evidence-based care. By comparison, the care provided by both surgeons and anesthesiologists during the course of an operation is at best infrequently guided by high-level evidence because the intraoperative conduct of even common operations frequently defies rigorous evaluation in a randomized fashion. Therefore, decisions need to be made hastily and often in the absence of either scientific or clinical (eg, laboratory) data to inform the best course of action. If a patient were to deteriorate and is not responsive to initial therapy, would an on-call anesthesiologist unfamiliar with the patient's history or the intraoperative clinical course to that point then be called? Or is the expectation that the operating surgeon will need to be more involved on both sides of the curtain in the future?

The impetus behind this proposed rule is clearly a desire to improve access to veterans and to improve the timeliness of care for them as well. Because APRNs provide an invaluable service in both the VA and private sector, using them to make care more efficient is an appealing way to leverage an existing, and possibly underused, resource to help rectify recent problems related to wait times for veterans in the outpatient primary care setting. However, are there similar problems with wait times for the operating room that CRNAs with independent practice authority could help remedy? It would be useful to know whether the current VA anesthesia workforce is sufficient to maintain a team-based approach between CRNAs and anesthesiologists or whether patient flow through the operating room and wait times for elective surgical cases could be improved with changes to the existing dynamic.

The VA sought input from a number of parties, including nursing and physician societies, patient groups, and congressional committees. While expanding the practice of APRNs in the primary care setting was generally supported, concerns were raised regarding the scope of practice in the operating room and for some specialty services. Although specific concerns were not explained in the proposed rule, groups such as the American Medical Association have stated that physician-led, team-based care should remain the standard.[6] As the largest integrated health system in the United States, it is almost certain the precedent set by the VA will be emulated by other health systems. As such, the final structure and eventual implementation of this proposed rule deserve careful consideration.

The VA leadership continues to seek innovative ways to improve care while working within the constraints of the system's existing infrastructure and allocated resources. Issues related to wait times and access need to be addressed head-on, but only after carefully examining where bottlenecks exist and, just as importantly, ensuring appropriate care is being provided to each veteran by the right health care professional. The underlying issue is not about what type of practitioner is providing care because we believe there are many cases in which it is appropriate and even necessary for experienced APRNs to provide independent patient care. However, the emphasis cannot be so firmly on access that we neglect to do the hard work of determining appropriate limits based on training. After all, global changes intended to improve efficiency will only help to the extent that the right changes are being made in the right places.

ARTICLE INFORMATION

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